Maternal and Child Health Services Title V Block Grant

Virginia

FY 2018 Application/ FY 2016 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

COMMONWEALTH of VIRGINIA

Department of Health

Marissa J. Levine, MD, MPH, FAAFP
State Health Commissioner

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July 15, 2017

Michele Lawler, M.S., R.D.
Acting Director
Division of State and Community Health
Maternal and Child Health Bureau

Health Resources and Services Administration
Room 5C-26. Parklawn Building
5600 Fisher Lane
Rockville, MD 20857

Dear Ms. Lawler:

I am pleased to submit Virginia's Maternal and Child Health Services Block Grant Application for Fiscal Year 2018. Virginia's Application, in response to the grant announcement HRSA-18-022, has been submitted through the Electronic Handbook (EHB) as required.

I am grateful for your continued partnership in improving the health of Virginia's mothers, adolescents, and children, including children with special health care needs.

I look forward to working with you and your staff during the coming year as we continue to implement our maternal and child health activities. Should you or your staff have questions regarding our application, you may contact me at (804) 864-7691 or by email at Cornelia.Deagle@vdh.virginia.gov.

Sincerely,

Cornelia Deagle

Cornelia Deagle, PhD, MSPH
Director, Division of Child and Family Health
Title V Director

Enclosure: *Maternal and Child Health Services Title V Block Grant FY18 Application/FY16 Annual Report*

cc: Marissa J. Levine, MD, MPH, FAAFP, State Health Commissioner

I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix C of the 2015 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.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 January 2015; expires December 31, 2017.

I.E. Application/Annual Report Executive Summary

The Title V Maternal and Child Health Services Block Grant (Title V) is a critical resource for improving the health and well-being of women, infants, children, and adolescents across the Commonwealth of Virginia.

Virginia's Title V allocation for federal fiscal year 2018 (FY18) is approximately $12 million, with a required state match of approximately $9 million.

Section 32.1-77 of the Code of Virginia authorizes the Virginia Department of Health (VDH), led by the State Health Commissioner, to prepare and administer the state Title V plan for maternal and child health (MCH) services and services for children with special health care needs (CSHCN). The VDH *Plan for Well-Being* highlights a number of agency MCH priorities, including reducing unplanned pregnancy, reducing infant mortality, and improving maternal health. See Attachment 1.

While MCH programs are available for all women, infants, and children, emphasis is placed on women of child-bearing age, low-income populations, and those with limited access to health care. Virginia's Title V programs are also intentionally **family-driven**. Family representatives are included in MCH team meetings, attend conferences, and contribute to reports.

FY16-20 State Priorities

At the beginning of the current five-year grant cycle, a statewide MCH needs assessment was conducted using a mixed-method design incorporating qualitative and epidemiological data. Results informed the FY16 Title V proposal.

State priorities for Title V funds are determined based on ongoing needs assessment efforts and reviewed annually. The table below lists the priorities selected for FY16 alongside priorities that have been updated for FY18. Updates have been made throughout the state Title V action plan to reflect noted changes in MCH priority needs and are detailed within this application. Key priority shifts are starred and explained below.

FY16-17 Priorities	FY18-20 Updated Priorities
1. Decrease tobacco use in households and among pregnant women.	1. Decrease smoking among pregnant women and in households with children.
2. Increase the number of infants who are ever breastfed as well as those breastfed exclusively for 6 months.	2. Support optimal mental health and social-emotional development of all children.*
3. Decrease low-risk cesarean deliveries in pregnant women at 39 weeks or less gestation.	3. Support the physical and emotional well-being of women and their children.*
4. Increase safe sleep practices, including increasing the number of infants placed on their backs to sleep.	4. Increase safe sleep practices.
5. Improve access to health care services and the use of medical home for children with and without special health care needs.	5. Promote the importance of medical home among providers and families.
6. Promote independence and transition of young adults with and without special health care needs.	6. Promote independence and transition of young adults with and without special health care needs.
7. Increase children and adolescents engaging in physical activity	7. Increase access to oral health services.*
8. Reduce injuries, violence, and suicide among Title V populations.	8. Reduce injuries, violence, and suicide among Title V populations.

Developmental Screening

The breastfeeding priority was changed to supporting healthy child development, to include increasing developmental screening rates (NPM 6), for two reasons. First, Virginia's breastfeeding rates (both breastfeeding initiation and breastfeeding at 6 months) have been relatively strong for the last ten years and are often above the national average. VDH will continue collaborations to provide and promote breastfeeding education and support services. For example, the 5-Star Breastfeeding-Friendly Hospital Initiative will continue to be chaired by the Title V Director and coordinated by the Maternal and Infant Health (MIH) Coordinator. VDH will also maintain its online breastfeeding training module and provide continuing education credits to Virginia providers at no-cost.

Second, the Title V Director has prioritized allocating Title V resources to addressing gaps in financial support for key MCH efforts. A gap in developmental screening was identified in FY17. Virginia ranks 28th in the nation for conducting developmental screening for children. Many children are not screened as early as necessary for appropriate referrals and treatment, and most are not screened at all for adverse family experiences. In FY18, a pilot to promote parent-administered developmental screenings and screening for adverse childhood experiences

(ACEs) in partnership with the Virginia Chapter of the American Academy of Pediatrics (VA-AAP), pediatric practices, early childhood care providers, and home visiting programs (e.g. MIECHV) will be included in Title V-funded early child health efforts in VDH, CYSHCN, and home visiting.

Oral Health

The physical activity priority will also be changed. While important, the Virginia Foundation for Healthy Youth (VFHY) maintains a strong multi-pronged program for reducing childhood obesity that includes nutrition education and promotion of physical activity. Many other partners, including the Obesity Action Coalition, public school divisions, and various community-based programs, also focus on reducing obesity among children and youth.

However, oral health care for children and pregnant women was identified as a Title V gap. Oral health (NPM 13) will be "reprioritized in" FY18 to facilitate serving more children with fluoride varnish and developing stronger oral health surveillance mechanisms for children and pregnant women by working with dental providers.

State Performance Measures (SPMs)

The low-risk cesarean priority was expanded to encompass birth spacing, unintended pregnancy, maternal mental health screening, and infant mortality disparities. SPMs were revised to clarify intent and better reflect population needs.

Services for Pregnant Women, Infants, and Children, Including Children with Special Health Care Needs

In accordance with federal requirements, at least thirty percent of federal Title V funds support services for CSHCN and at least thirty percent support preventive and primary care services for children ages 1 to 22. Funds also support local safety net services for women and infants.

Services for Children and Youth with Special Health Care Needs (CYSCHN)

VDH's CYSHCN programs serve youth from birth to age 21 that have, or are at an increased risk for, a chronic physical, developmental, behavioral, or emotional condition, and who also require health and related services of a type or amount beyond that required by children generally. Approximately 50% of the state's federal allocation serves this vulnerable population. Most CYSHCN efforts are provided in partnership with health care systems and universities. In FY16, the CYSHCN program served over 7,800 families.

Care Connection for Children (CCC)

The CCC program is a statewide network of six regional centers of excellence that provide care coordination services to reduce barriers that families face when trying to access care. Such services include, but are not limited to: medical insurance benefit evaluation and referral (including Medicaid), linkage to a primary care provider/medical home, referrals to necessary resources and specialty services, family-to-family support via parent coordinators, support from Virginia Department of Education (DOE) state educational consultants, and a pool of funds for uninsured or underinsured families with no other means for obtaining life-preserving medications and durable medical equipment. In FY16, the CCC program served 3,156 families.

An external evaluation of the program was completed in FY16. In the final report, evaluators concluded, "the CCC program structure and processes are closely aligned with [AMCHP] national standards and best practices" for providing care coordination services. Since the CCC program serves a large number of children on Medicaid, the report outlined options for leveraging additional funding sources (Medicaid) to diversify program funding.

Child Development Centers (CDCs)

The CDC program serves families with children who are suspected of having behavioral or developmental disorders (e.g. autism, ADD/ADHD, learning disabilities, anxiety, PTSD, mood disorders). Five regional centers provide multidisciplinary assessments of each child, as well as diagnoses and short-term care coordination to link families to necessary services. The program helps to respond to state and national shortages of developmental and behavioral

pediatric service providers. In FY16, the CDC program served 3,172 families, resulting in 4,419 diagnoses and 5,945 referrals for additional services.

In FY16, an external evaluation concluded that the program complies with national best practices for CYSHCN. Families reported a high rate of satisfaction with services provided, referrals, and timeliness of care.

Sickle Cell and Bleeding Disorders

The Virginia Sickle Cell Program (SCP) serves children with sickle cell disease from birth until their 21st birthday. The SCP partners with the Virginia Newborn Screening (NBS) program for automatic referral of infants with a positive screen into care. VDH also contracts with specialty providers to ensure infants receive assistance from social workers, educational consultants, and support in transitioning from pediatric to adult care. The SCP served over 1,000 young people in FY16.

The Virginia Bleeding Disorders Program (VBDP) serves clients of all ages with hemophilia and other related conditions. Services provided include insurance case management, care coordination, and a pool of funds for the purchase of blood factor for income-eligible clients. Over 300 clients were served in FY16.

Selected FY18 Activities for CYSHCN

- Staff will continue to partner with the Virginia Commonwealth University (VCU) Center for Family Involvement, which houses Family 2 Family (F2F), Parent 2 Parent, and LEND (Leadership Education in Neurodevelopmental and Related Disabilities). The center director, Dana Yarborough, is the primary family advisor to the state Title V program. She also co-facilitates meetings of DOE's Family Engagement Network (FEN), which the CYSHCN director attends.
- Parent representatives will continue attending quarterly meetings of the statewide CCC directors.
- All CYSHCN programs refer potentially eligible children to Medicaid, FAMIS, compassionate use, and SSI programs. Application assistance and follow-up are provided, as needed.
- CCC staff will pursue national case management certification as funding permits.
- The standard approach to care detailed in the *Care Coordination Notebook: Financing and Managing Your Child's Health Care* will inform program improvements.
- The CCCs and VBDP will partner with the VDH Dental Health Program to improve access to dental care for CYSHCN.
- The CDCs will provide multidisciplinary diagnostic evaluations and refer these children to services.
- The VBDP will provide coordinated, family-oriented, multidisciplinary services for persons with bleeding disorders and support families who infuse at home.
- The Hearing Aid Loan Bank will provide gap-filling services to families of children with hearing loss.
- Through local health departments (LHDs), the SCP will offer screening, referral, counseling and follow-up services to Virginians at risk for sickle cell disease and their families.
- The CYSHCN team will continue to develop the medical neighborhood concept, including development of transition and medical home training modules for families and providers.
- CCC, VBDP and SCP staff will assist families with the development of transition plans based on best practices.

Services for Children, Pregnant Women, and Infants

Selected FY18 Activities for Children Ages 1-22, Pregnant Women, and Infants

- Title V funds will be allocated to Virginia's 35 LHDs to address safe sleep, substance use (including tobacco), unintended pregnancy, breastfeeding, and access to care in their communities.
- VDH will collaborate to reduce the number of uninsured individuals, including partnering with the Department of Medical Assistance Services (DMAS) to increase enrollment. DMAS administers Medicaid as well as Virginia's Children's Health Insurance Program (CHIP), which is called Family Access to Medical Insurance Security (FAMIS). The Title V Director currently serves on CHIPAC (Children's Health Insurance Program Advisory Committee).
- The Injury and Violence Prevention Program will continue initiatives to prevent child and adolescent injury and suicide through other funding sources (e.g. CDC).

- Title V funds will to support the Virginia Youth Survey via partial staff funding.
- The Maternal and Child Fatality Review Teams will examine the circumstances of death and make recommendations for interventions.
- Partners will screen women for tobacco use during both pregnancy and the interconception period and refer to the Virginia Quitline for smoking cessation counseling. Pregnant women will be offered 10 counseling calls.
- Staff will continue to develop and promote prenatal care resources via social media in partnership with LHDs, March of Dimes, Virginia Hospital and Healthcare Association (VHHA), ACOG, and VA-AAP.
- VHHA, VDH, and other partners will collaborate through a quality improvement program to promote safe sleep practices.

Title V State Leadership

While turnover in key leadership and MCH positions has presented challenges, VDH has identified opportunities to strategically reframe and strengthen the state Title V leadership team.

Prior to FY16, Dr. Lilian Peake, the previous Title V Director, was promoted to Deputy Commissioner of Population Health. Dr. Peake assigned the role of Title V Director to Cornelia Deagle, PhD, MSPH. Dr. Deagle also serves as MCH Director and Director of the Division Child and Family Health. Dr. Deagle designated Marcus Allen, MPH, as the CYSHCN Director.

In FY16 and FY17, two critical full-time positions were added to the MCH/Title V team. First, the MIH Coordinator position was established to be the "hub" of MCH programs. Second, the Title V Block Grant and Special Projects Coordinator position was established to provide consistent, focused day-to-day oversight of the budget and program activities and to staff "special projects" opportunities that become available through MCHB, NGA, or AMCHP. These additional positions were necessary to grow the MCH program and formalize the state MCH/Title V Executive Team. See needs assessment update for details.

Title V funds are now understood to be a foundation of the larger MCH program (e.g. NBS, MIECHV, and other efforts). FY18 will present opportunities to implement a more cohesive vision for state MCH efforts and mobilize strategic partnerships to move the needle on national and state performance measures.

For further details on Virginia's Title V program, please contact Dr. Cornelia Deagle, Title V Director, at Cornelia.Deagle@vdh.virginia.gov.

II. Components of the Application/Annual Report

II.A. Overview of the State

Geographic Description

The Commonwealth of Virginia is geographically located in the mid-Atlantic area of the United States. It is bordered by Washington D.C., the nation's capital; Maryland to the north; the Atlantic Ocean to the east; North Carolina to the south; and Tennessee, West Virginia and Kentucky to the west. Virginia encompasses 42,774 square miles (110,784 km2) making it the thirty-fifth largest state by area.

The Virginia Department of Health (VDH) has grouped its 134 localities (cities and counties) into 35 health districts and 5 health planning areas. The Northern area, composed of Loudoun, Fairfax, Alexandria, Arlington and Prince William health districts located just south of Washington, D.C., is densely populated and includes six of the twenty highest income counties in the United States. However, with over 150 languages spoken in the area, and limited translation and interpretation services, communication can be problematic and interfere with access to health services. In addition, residents of this area experience severe traffic congestion on a daily basis. Conversely, the Southwest Area, made up of Lenowisco, Cumberland Plateau, Mount Rogers, West Piedmont, New River, Alleghany and Roanoke health districts, bordered by West Virginia, Kentucky and Tennessee, is rural with a rugged and mountainous terrain and is the least populous and least racial/ethnically diverse. Its terrain and vast geographic area pose many transportation barriers. Ice and snow during the winter months can hamper travel.

The East Central Area is composed of Southside, Piedmont, Crater, Chesterfield, Richmond, Henrico, Chickahominy, Three Rivers and Rappahannock health districts. West Central area is made up of Pittsylvania/Danville, Central Virginia, Thomas Jefferson, Central Shenandoah, Rappahannock/Rapidan and Lord Fairfax. These two areas have a mix of urban, suburban and rural areas. The urban areas are home to large state universities/ colleges and are business districts. The suburban areas are more residential than industrial. The rural areas are agricultural. The Eastern area, composed of Western Tidewater, Chesapeake, Virginia Beach, Portsmouth, Norfolk, Hampton, Peninsula, and Eastern Shore health districts, runs along the east coast (Chesapeake Bay and Atlantic Ocean) and includes the Eastern Shore, a peninsula separated from the mainland by the Chesapeake Bay. The Eastern Shore Health District is very sparsely populated and has a high level of poverty. The Eastern area has the largest concentration of military bases and facilities of any metropolitan area in the world. The coastal area has many bridges and tunnels that create transportation barriers to services. Individuals in the area also experience severe traffic congestion on a daily basis. Occasionally, hurricanes and tropical storms affect the area and can result in flooding and environmental health concerns.

Demographic Description

Virginia's population is continually growing and evolving. It reached 8,411,808 million in 2016, maintaining the Commonwealth's position as the 12th most populous state in the country, with an annual growth rate of about 4.8% between 2014 and 2015. In 2015, among people reporting one race alone, 70.5 percent identified as non-Hispanic White, 19.7 percent identified as non-Hispanic Black, and 6.3 percent identified as Asian. Compared with the nation as a whole, Virginia had a slightly higher proportion of individuals who identified as Black or African-American. The proportion of individuals who identified as Hispanic (8.9%) was significantly lower than the national average (17.4%). However, between 2000 and 2010, the Hispanic population in Virginia grew by 92%. Seventy percent of Virginia's population resides in the three major metropolitan areas of the state (Northern Virginia, Virginia Beach, and Richmond).

Within Virginia, two metropolitan areas are clearly much more densely populated and developed than other areas of the state: The Northern area (Arlington, Alexandria) has the largest number of housing units and people per square mile, followed closely by the Hamptons Road area (Virginia Beach, Norfolk, Newport News). In 2010, Arlington County (Northern area) had a housing density of 3495.4 housing units per square mile, while the city of Norfolk was at 1757.3 homes per square mile. In contrast, Alleghany County (in the Southside area) had a housing density rate of 13.1 homes per square mile. Housing density is closely correlated with population density. In this, too, the Northern and Hampton Roads areas have the highest population density rates, while the Southside area has the lowest in the state. In 2010, 75.5% of Virginia's population lived in urban areas, lower than the national average of 80.7%.

Between 2000 and 2010, the Commonwealth's growth rate of 13% outpaced the nation's of 9.7%, and was only slightly lower than the 14.4% growth rate of the prior decade. This rendered Virginia the 17th fastest growing state in the U.S. Virginia is the only state in which natural increase (more births than deaths) and net in-migration (in-migration less out-migration) contributed equal shares to population growth. Virginia's metropolitan areas account for 82 percent of the population growth and 70 percent of the state's population. Rural and small-town Virginia represent a diminishing share of the state's population. While some urban localities (such as Fairfax, Chesterfield and Chesapeake) have large increases in population, they may not register as among those with the fastest rate of growth, due to the size of their population.

Virginians, like Americans as a whole, are growing older and more diverse. The largest absolute growth projected from 2010 to 2030 is in the 65+ age group, when the elderly are expected to comprise almost 19 percent of the total population. In 2050, the number of individuals aged 65+ is projected to reach 83.7 million, almost double the estimate of 43.1 million in 2012. Another way to assess the relative impact of aging is through the age dependency ratio, which is the number of children (17 years old or younger) plus the number of elderly (65 and older) per 100 individuals ages 18 through 64. Viewed through this lens, Virginia compares relatively well with other states: In 2014, Virginia had the fifth lowest age dependency ratio in the nation at 58.8. Another measure is the "old age dependency ratio" (the number of elderly per 100 individuals 18 to 64). Using this measure, Virginia was sixth lowest in the nation. These rates vary widely in Virginia and range from a low of 13.4 in Northern Virginia, to 34.4 in the Eastern area, and 29.5 in the Southside area. With regards to healthcare, older adults in Virginia comprise 11% of people receiving Medicaid services, yet drive more than 20% of Virginia's total Medicaid spending, and 50% of Medicaid spending on long-term care services. As the population continues to grow and age over the next 20 years, many more people will become dependent on Medicare and Medicaid for health insurance coverage.

The average age of the population will increase as the baby boom generation enters retirement age. The population of Virginians age 65+ will grow from 13.8% of the total population in 2014, to almost 25% by 2025 when there will be more than 2 million Virginians in this age group. By 2030, nearly one in every five Virginians is projected to be 65 years or older. As the Baby Boomer generation ages, the gap in life expectancy between males and females is expected to narrow, due in large part to advances in healthcare.. Women of that generation are also better educated than in the past and will be less likely to live in poverty. Some 70% of Virginia's seniors today live in metro areas, including Northern Virginia, Hampton Roads and Richmond. However, the localities with the highest proportion of seniors tend to be rural localities, as young people have left and/or retirees have moved in. Aging boomers have fewer children to care for them as they become elderly parents and grandparents. Delayed fertility and increased longevity may facilitate the likelihood of 'sandwich responsibilities for children of boomers': those caring for their own children and their parents as well. This may create greater family stressors which can impact the growth and wellbeing of the children within the household.

According to the 2000 U.S. Census, 9.7% of all children (179,596) in Virginia are being raised in a home where the grandparent or another relative is the head of household, often without a parent present at all. Additionally, 60,675

grandparents in Virginia report they are raising their grandchildren. Of these, 35% identify as Black or African-American, 6% identify as Hispanic or Latino, 3% identify as Asian, and 56% identify as White. Grandparents raising grandchildren must establish legal custody in order to enroll grandchildren in school, access medical records, and apply for benefits. The process of gaining legal custody or guardianship can often be expensive and time-consuming. In Virginia, 16% of households in which the grandparent(s) are raising the children live in poverty. In addition, the financial cost of caring for children can be overwhelming for those on a fixed income. Many grandparents make significant employment changes in order to care for children, including delaying retirement or quitting work earlier than planned.

The minority population (all of whom identify as Hispanic or a race other than White only) has grown since 1980. Approximately 48% of Virginia's population was born in another state or nation. New residents from other states tend to be younger, better educated and earn more than native Virginians. As of 2012, there were more than 947,320 foreign-born Virginians, an increase from about 570,000 in 2000. Immigrants tended to be younger and divided between the less- and better-educated population segments. The mix of immigrants in Virginia included a higher percentage of Asians compared to the national average. Virginia's most racially and ethnically diverse communities are located in Northern Virginia and the Tidewater area. In the Tidewater area, where the population is mostly comprised of non- Hispanic White and non- Hispanic Black populations, is also home to one of the largest Asian populations in the state.

The distribution of Virginia's Hispanic population is highly uneven across the state and is concentrated in the three major metropolitan areas and selected rural areas. As of 2011, Hispanic populations in Northern Virginia make up a large minority of the population of that specific county: Manassas Park City (33%), Manassas City (31%), Prince William County (20%), Arlington County (15%); Fairfax County (the largest county in Virginia – 16%). Additionally, a number of rural localities in Virginia show a significant increase in the number of Hispanic residents. Included among them is Galax City in Southwest Virginia, with 13% of its population identifying as Hispanic. Among Hispanic populations in Virginia, 47% are foreign-born.

Economy

Poverty has a significant impact on individuals and society at large. Children who live in poverty are likely to suffer from poor nutrition during infancy, experience increased emotional distress, and be at an increased risk of academic failure and teenage pregnancy. Adult men and women who live in poverty are at high risk of poor health and violence. Poverty can also affect seniors' ability to care for themselves or to obtain prescription medication. Virginia had the 12th lowest poverty rate (11.8%) in the nation in 2014, which was slightly lower than the national average of 15.5%. According to the Virginia Plan for Well-Being, one in ten Virginians are living below the federal poverty level, which in 2014 was $12,061. African-American populations, Hispanic populations, and households headed by a single female are more likely to face poverty or near poverty.

In 2014, poverty rates again rose for every area except the Northern, Central, and Southside areas. Southside still had the highest percentage of individuals (21.3%) living below the poverty level of any area in the state, followed by the Southwest area (20.8%). With poverty levels of 16% each, the Eastern and West Central areas did not fare much better. At the other end of the scale, the Northern area had the lowest percentage of individuals living below the poverty level (6.5%), followed by the Central (12.4%) and Hampton Roads (13.2%) areas. Among Virginia's peers, Maryland had the lowest poverty rate in 2014 at 9.7%, while North Carolina and Tennessee both had considerably higher rates -- 13.2 and 15%, respectively. New Hampshire ranked top in the nation with a poverty rate of 5.6%.

In 2014, Virginia's median household income was $64,792, exceeding the national average of $53,657. In

comparison, Maryland led all states with a median household income of $76,165 in 2014, while North Carolina ($46,784) and Tennessee ($43,716) had notably lower average wages. In Virginia, the Northern area (Falls Church City) had the highest median household income ($121,250) in 2014. In 2014, Danville city (Southside area) had the lowest median household income in the state ($30,588).

Between 2005 and 2014, Virginia's per capita income grew at a rate of just 0.36%, compared to a national average growth rate of 0.56% over the same period. Within Virginia, the Eastern area experienced the fastest growth rate at 0.81%. In 2014, Virginia ranked 10th among the states with an average per capita personal income of $50,345, which was a slight increase from the previous year's average income of $49,750. Virginia's relation to its peer states with per capita income has stayed the same for well over a decade: Lower than Maryland, which in 2014 stood at $54,176, but higher than North Carolina ($39,171) and Tennessee ($40,457). Within Virginia, the Northern area had the highest per capita personal income in 2014 at $66,121. The Southside and Southwest areas had the lowest per capita personal income at $32,150 and $32,763, respectively. The number of households receiving supplemental nutrition program support in Virginia was 940,932 in 2013. The total number of adults and children receiving TANF in 2013 was 64,080.

Employment

Due to the prolonged high rates of unemployment as a result of the 2007- 2009 recession, poverty rates in Virginia have seen small but steady increases over the past six years. In fact, although many states have seen minor reductions across certain years, poverty rates on the whole have been increasing nationwide since the start of the decade. The national unemployment rate (2016) is currently at its lowest rate since 2007: 4.9%. As of 2016, Virginia’s unemployment rate was 3.9%, ranking 14th among the states.

South Dakota had the lowest unemployment rate at 2.5%. Virginia's 2016 rate was lower than its peers, North Carolina (5.4%), Tennessee (4.3%) and Maryland (4.6%). Across the state, the unemployment rate varied in 2016 from a high of 10.5% in Buchanan county (Southwestern) to a low of 2.2 % in Arlington County (North). In the last decade, the Southside and Southwest areas have routinely experienced higher rates of unemployment than other areas, largely due to the loss of manufacturing jobs and limited economic growth.

Health

In 2015, Virginia ranked 21st in terms of health. Strengths included low incidence of infectious disease, a low percentage of children in poverty, and low violent crime rates. Challenges included a large disparity in health status by education level, high prevalence of smoking, and low per capita public health funding. Challenges also included a high prevalence of obesity and diabetes at 28.5% and 9.7% respectively. Additionally, smoking rates in 2015 were at 19.5%.

In the past 5 years, the rate of preventable hospitalizations decreased 34% from 74 to 49 discharges per 1,000 Medicare enrollees. In the past 20 years, cancer deaths decreased 11% from 212.8 to 189.3 per 100,000 people. Since 1990, cardiovascular deaths decreased 42% from 413.2 to 239.1 per 100,000 individuals.

WIC data on children shows the significant increasing trend in overweight and obesity. In 2009, 33.5% WIC children were overweight or obese as compared to 32.1% in 2014. The prevalence of smoking also varies by race and ethnicity in the state; 15.2% of Hispanic populations smoked in 2014 compared to 19.5% of non-Hispanic Black populations and 20.2% percent of non-Hispanic Whites populations.

Health Insurance

Based on the latest U.S. Census Bureau estimates, the national average of uninsured people under age 65 was 13.5% in 2014 -- a substantial improvement over 2013 (16.7%), and due in large part to improvements in access made possible by the Affordable Care Act. Virginia's rate was 12.5% in 2014, also a notable improvement over the 14% uninsured rate in 2013. In 2013, local uninsured rates dropped slightly in all areas of Virginia except the Hampton Roads area. The Eastern (17.1%), Southside (16.7%), Valley (16.3%), and Southwest (16.0%) areas had the highest uninsured rates. The Northern area had the lowest rate at 12.4% uninsured.

According to the 2011/2012 National Survey of Children's Health, about 94.7% of Virginia's children ages 0-17 were currently insured, higher than the US rate of 94.5%. About 10.8% of those surveyed reported lacking consistent insurance coverage in past year, lower than the national rate of 11.3%. Assuring children and adolescents are covered by insurance is a priority in Virginia. For example, the Children's Health Insurance Program Advisory Committee (CHIPAC) meets regularly to develop recommendations to improve access to health coverage.

According to Virginia Health Care Foundations' Profile of the Uninsured, the majority of the uninsured (72.9%) in Virginia are part of working families. Over half of the uninsured (50.5%) are part of families with at least one full-time worker, though only 6.3% of the total uninsured are part of families with two-full time workers. An estimated 22.4% are part of families with at least one part-time worker (and none working full-time), and 26.3% are part of families with no working adults. The majority (79.7%) of the uninsured are U.S. citizens. Among children, 87.4% of uninsured are U.S. citizens, compared to 78.7% of uninsured adults. The uninsured in Virginia are from diverse racial/ethnic backgrounds: 46% identify as non-Hispanic White; 22.8% identify as non-Hispanic Black; 21.6% identify as Hispanic; 6.9% identify as Asian/Pacific Islander; and 2.8% identify as with other or multiple racial/ethnic backgrounds. However, Hispanic populations are uninsured at higher rates than any other ethnic group (32%). Among these different groups, non-Hispanic White populations are the least likely to be uninsured in Virginia (10.7%). In Virginia, the uninsured were less likely than those with insurance to report having a regular provider, a routine checkup, or a flu shot, and were more likely to report unmet needs for care due to cost, even after adjusting for health and socioeconomic status.

Housing

In 2012, 8% of Virginia's children lived in crowded housing; 17% of these children were in immigrant families. For the same year, the national rate of children living in crowded housing was 14%. In 2011, 69% of Virginia's children lived in low-income households where housing costs exceeded 30% of income. This was slightly higher than the national rate of 66%. Forty-six percent were children in immigrant families, roughly the same percent (51%) as for the US. According to the 2011/2012 National Survey of Children's Health, with respect to neighborhood amenities, 53% of Virginia children lived in neighborhoods with a park, sidewalks, a library, and a community center, similar to the national rate of 54%. Conversely 9% of Virginia children live in neighborhoods with poorly kept or dilapidated housing, lower than the national rate of 16.2%. Eighty-six percent of children live in supportive neighborhoods, about the same as the national rate (82%). Almost 91% live in neighborhoods that are usually or always safe, higher than the national rate of 86.6 %.

Education

Completion of high school or its equivalent is increasingly the minimum level of education sought by employers. Additionally, unemployment rates are lower, and lifetime earnings substantially higher for high school graduates when compared with non-high school graduates. According to the Virginia Department of Education, graduation rates

continued to improve in nearly every Virginia area in 2014-2015, albeit modestly in most, and the statewide average rose to 90.5%. The Northern (92.2%), North Central (91.6%) and Eastern (91.7%) areas had rates that exceeded the statewide average. The remaining areas except Southside (87.4%) were all close to the state average: Central (89.7%), Southwest (90.4%), West Central (89.5%), and Hampton Roads (89.4%). Virginia's cohort graduation rate in 2014 was 85.3%, earning a rank of 23rd best in the nation. Virginia's rate was lower than Tennessee (87.2%) and Maryland (86.1%) but higher than North Carolina (83.9%). At 90.5%, Iowa again had the highest four-year adjusted cohort graduation rate for 2014.

Dropout rates for 2015 were lower than 2014 for most of Virginia's eight areas, with the statewide average decreasing from 5.4% to 5.2%. The North Central (4.1%), Hampton Roads (4.5%), Eastern (4.7%), and Northern (5.0%) areas had dropout rates below the statewide average; the remaining areas had rates above the statewide average. Only the Southside area saw a slight increase (0.1%) in its high school dropout rate for the 2014-15 school year.

State Policy Standard: Agency Accountability and Strategic Planning

VDH is compliant with the Virginia Department of General Services accounting policies. All state agencies, including VDH, develop strategic plans and area service plans (operational plans) that are tied to their operating budgets.

Title V and Virginia's Plan for Well-Being

VDH has established a roadmap to achieve the Health Commissioner's goal for Virginia to "become the healthiest state in the nation." VDH has been working to prioritize health needs across the state, align all of our initiatives in accordance with the priorities, leverage resources and measure the improved health outcomes.

Virginia's Plan for Well-Being lays out the foundation for giving everyone a chance to live a healthy life: 1) factoring health into policy decisions related to education, employment, housing, transportation, land use, economic development, and public safety; (2) Investing in the health, education, and development of Virginia's children; (3) Promoting a culture of health through preventive actions; and (4) Creating a connected system of healthcare. The plan highlights specific goals and strategies on which communities can focus so the state can make measureable health improvement by 2020. Virginia's Plan for Well-Being is a call to action for all Virginians to work together to make Virginia the healthiest state in the nation. While all of the aims have a positive impact on the populations included in the Maternal and Child Health programs, the second aim details specific health strategies related to accomplishing Title V priorities including planned pregnancies, early childhood development and preparation for success in school, and improving birth outcomes particularly for African American Virginias who experience almost 3 times the infant mortality of White families (see state priorities).

The Plan clearly outlines the priorities for the health of all Virginians and identifies the importance of planning pregnancies and early childhood health and development which align with the Title V priorities. The Plan highlights the importance of Maternal/prenatal care as a foundation for population health. Also, early universal screening in early childhood is essential to identify children with special healthcare needs as early as possible and to support the child and family with appropriate direct and wrap-around services including care coordination. The emphasis placed on Maternal and Child Health in the Plan is a success of the Title V program raising awareness and gathering support among state leadership.

See Attachment 1 for the Plan.

II.B. Five Year Needs Assessment Summary and Updates

FY 2018 Application/FY 2016 Annual Report Update

Process

The two ongoing mechanisms that provide data and/or information that inform the Title V annual review are: (1) learning from the VDH Division of Population Health Data (DPHD)'s ongoing surveillance efforts, including local health district (LHD) Community Health Assessments (CHAs); and (2) staff participation on state and regional boards and councils.

Division of Population Health Data

DPHD provides expertise, consultation, and support to the maternal and child health (MCH) team on epidemiology, data collection, analysis, interpretation, and reporting.

DPHD also contributes to statewide MCH needs assessment efforts is their strategic implementation of CHAs and Community Health Improvement Plans (CHIPs) with the 35 LHDs throughout Virginia. These CHAs are community-led, with DPHD support, and provide grassroots perspectives on community health needs and assets. While these CHAs and CHIPs are much broader than Title V, results relevant to the MCH populations are used to inform program design.

Boards and Councils

MCH team members participate in advisory committees and councils that address health in Virginia. Some directly address Title V goals and objectives (e.g. CHIPAC), while others are broader in scope and provide opportunities to investigate and plan multi-level approaches to improving the health of MCH populations (e.g. Virginia Interagency Coordinating Council, VICC). Each serves as an ongoing resource for information on the six Title V population domains and, in turn, are provided with updates from the state MCH program. Selected groups that provide such information to the state Title V program are presented below.

Name of Group	State MCH Team Representative	Population Domain(s) and/or Issue Addressed
Children's Health Insurance Program Advisory Board (CHIPAC)	MCH/Title V Director	child and adolescent health, oral health, health coverage
Virginia Interagency Coordinating Council (VICC)	Early Childhood Health (ECH) Consultant	early childhood programs, screening and referrals
Early Impact Virginia	ECH Team	infant mortality, child health, maternal health, prenatal care (home visiting programs)
Virginia School Nurse Association	School and Adolescent Health (SAH) Coordinator	child and adolescent health, Bright Futures guidelines
Annual Meeting of	SAH Coordinator	child and adolescent health,

Virginia Chapter of the American Academy of Pediatrics (VA-AAP)		Bright Futures guidelines
March of Dimes Committee (MOD)	Maternal Infant Health (MIH) Coordinator	maternal and child health
5 Star Breastfeeding Program	MIH Coordinator	maternal and child health
Infant Mental Health Task Force	MCH/Title V Director	infant health
Long-Acting Reversible Contraceptives (LARC) Workgroup	MIH Coordinator, Comprehensive Reproductive Health (CRH) Supervisor	unintended pregnancy, birth spacing
Department of Education (DOE) Virginia Preschool Initiative +	MCH/Title V Director	school readiness for 4-year olds in high-risk communities
Virginia Neonatal Perinatal Collaborative (VNPC)	MIH Coordinator	maternal and infant health, and preterm birth
Neonatal Abstinence Syndrome (NAS) Taskforce	MIH Coordinator	maternal and infant health
Safe Sleep Initiative	MIH Coordinator	infant mortality (IM) and safe sleep
IM Collaborative Improvement and Innovation Network (CoIIN)	MIH Coordinator	safe sleep
Child Health CoIIN	Director, Division Prevention and Health Promotion (DPHP)	injury prevention

Findings

Through the two mechanisms above, the MCH team is kept abreast of changes in the state's MCH population and level of partnerships/collaborations. The MCH team meets monthly to share updates from these committees and boards.

MCH Population Needs

An example of a significant change in the needs of an MCH population since the five-year needs assessment was conducted is the growing opioid use among preconception and pregnant women. Interagency partnerships facilitated the realization that many agencies were mobilizing efforts to address opioid use and helped to coordinate efforts and leverage resources across the state.

Title V Program Capacity

A transition of the Virginia Title V grant and infrastructure towards a population health perspective and life course model for programs and data collection started in FY15. A key driver is the concept of working systematically and less programmatically. This includes focusing on all children and families. It also includes strategic balance between quality and quantity and strengthening linkages between tools (i.e. standards/evidence-based screening tools, curriculum, and assessments) and actions.

Organizational Structure

The Health and Human Service Secretariat oversees the state health and human services agencies (e.g. VDH; Department of Medical Assistance Services, DMAS; Department of Behavioral Health and Developmental Services, DBHDS; Department of Social Services, DSS).

Section 32.1-77 of the Code of Virginia authorizes VDH to prepare and submit to the state Title V plan. The Commissioner of Health is authorized to administer the plan and expend Title V funds. The Office of Family Health Services (OFHS) provides fiscal oversight; the Division of Child and Family Health (DCFH), led by the state Title V Director, manages the state Title V program, provides strategic direction, and ensures coordination with other state and federal MCH programs. See Attachment 2 for Organizational Chart.

The Health Commissioner recently established a new Deputy Commissioner of Population Health position. Vanessa Walker Harris, MD, has served as the OFHS Director in November 2015. She reports directly to the Deputy Commissioner for Population Health. Cornelia Deagle, PhD, MSPH, serves as the Title V Director and DCFH Director. In 2017, Carla Hegwood, MPH, assumed the MCH Title V and Special Projects Coordinator position. Two vacancies are under recruit and expected to be filled by late 2017: the Adolescent Health Specialist, who will focus on the emerging priority of adolescent health within the agency, and the lead MCH Epidemiologist. Designated staff will temporarily cover these positions until filled.

Agency Capacity

Title V funds are used to improve the health of several populations, including women, infants, children, and adolescents, within all communities in the Commonwealth. While programs are available to all women, infants, and children, emphasis is placed on women of child-bearing age, low-income populations, and those who do not have access to health care.

Virginia's MCH and CSHCN programs prioritize maintenance of a statewide system of services that reflects the principles of family-driven, data-informed, comprehensive, community-based, coordinated care. The programs interact with this system on three levels: state agencies and organizations (e.g. headquarters for statewide home visiting programs), regional partners (e.g. hospitals service areas and CSHCN centers), and local partners (e.g. local health departments, providers, community-based organizations, parent organizations, school divisions, etc.).

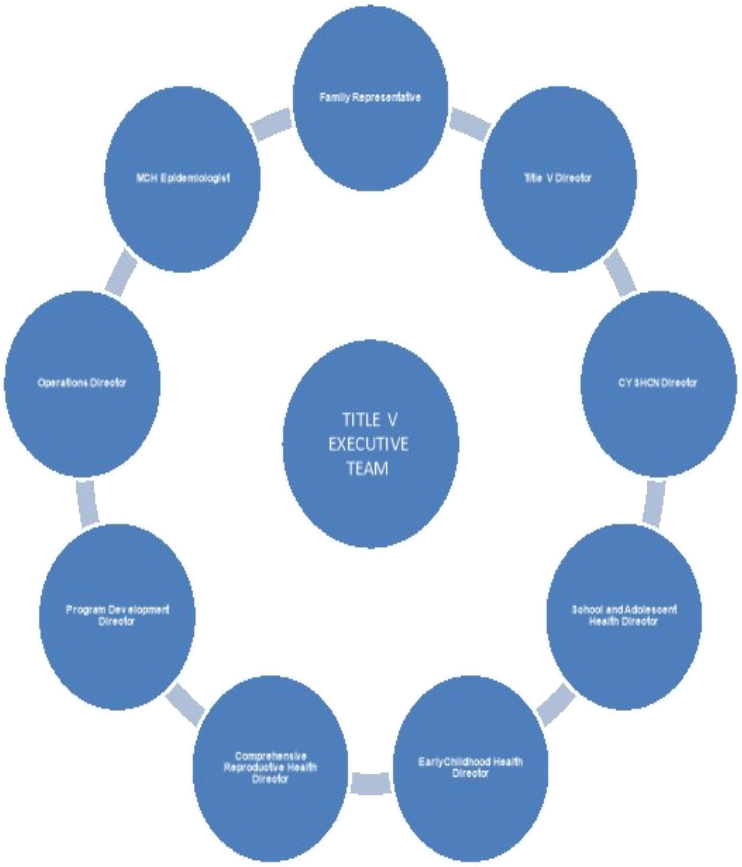
VDH's infrastructure includes 35 LHDs and 119 sites. Each LHD receives an allocation of state and federal Title V funds to address the MCH priorities that have been identified in their local community assessments.

VDH also maintains a statewide network of six Care Coordination for Children (CCC) Centers and five Child Development Centers (CDCs). The CCCs provide comprehensive care coordination and wrap-around services for CYSHCN and their families, and the CDCs provide a wide range of health and developmental screenings for children and youth up to age 21. Approximately half of the federal allocation for Virginia is dedicated to maintaining a

consistent workforce and high-quality programs and services for CYSCHN.

MCH Workforce Development and Capacity

The state Title V Executive team is comprised of 9 key staff who contribute to the state's planning, evaluation, and data analysis capabilities.



Family Representative Dana Yarbrough is the Executive Director of Parent to Parent of Virginia, the Family to Family (F2F) Network, and the Center for Family Involvement at Virginia Commonwealth University (VCU). Dana brings family wisdom and experience as the parent of a 22-year-old daughter with significant intellectual, physical, and sensory disabilities.

Title V Director Cornelia Deagle, PhD, MSPH, serves as DCFH Director and brings 25 years of public health research and practice expertise to leadership of the state Title V program.

CYSCHN Director Marcus Allen, MPH, oversees program implementation, fiscal accountability, and performance of CYSHCN initiatives. This is accomplished through site visits, quarterly meetings, videoconferencing, and technical assistance.

School and Adolescent Health Director Janet Wright, BSN, RN, NCSN, oversees school and adolescent health

initiatives. Janet is a National Certified School Nurse and serves as the school nurse consultant.

ECH Director Mary Beth Cox, MSW, MPH, serves as the Early Childhood Health Unit Supervisor and is Principal Investigator for the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant.

CRH Director Emily Yeatts, MSW, MPH, serves as Principal Investigator for the Title X grant and provides oversight for family planning and abstinence programs.

Program Development Director Shannon Pursell, MPH, serves as the MIH Coordinator and provides subject matter expertise and technical assistance to all 35 LHDs on Title V initiatives.

Operations Director Carla Hegwood, MPH, serves as the Title V Coordinator and Special Projects Director. She coordinates day-to-day grant operations and works with OFHS Administrative Deputy on fiscal oversight.

MPH Epidemiologist This position is currently vacant. Leslie Hoglund, PhD, serves as the Director of the Division of Population Health Data and currently provides coverage.

C. Partnerships, Collaboration, and Coordination

VDH maintains a number of organizational relationships which serve the legislatively-defined MCH populations and contribute to the capacity and reach of the state Title V MCH and CSHCN programs.

No individual organization, program, or profession can accomplish the transformation to population health without collaboration, pooled resources, and effective partnerships. Virginia is finding new ways to apply a strength-based, protective factor approach in our work, focusing efforts on providing care coordination for children with special health care needs and their families (e.g., medical neighborhood initiative).

MCH efforts in Virginia demonstrate a multidisciplinary partnership approach to health care by including traditional and non-traditional partners. This practice is reflected in our advisory committees (e.g. early hearing detection), strategic planning (e.g. VDH Population Health Plan), and ongoing MCH programs (e.g. CYSHCN). MCH partnerships include representatives from medicine, nursing, social work, public health, behavioral health, education, social services, academia, community-based organizations, and most importantly, families and individuals served by our programs. Program staff continue to conduct outreach to public and private primary care providers as well as public and private insurers. Input from each of these stakeholders informs the planning, implementation, and evaluation of MCH efforts. The MCH team also remains committed to increasing the level of engagement of insurance companies and the state Medicaid agency in strategic planning efforts. In addition, specialists and professionals from across the state and from academic medical centers, hospitals, and community-based services are engaged in VDH program development and oversight (i.e. universal newborn screening programs, CYSHCN programs).

MCHB Investments

Most VDH efforts to serve MCH populations are housed within OFHS. This includes: State System Development Initiative (SSDI) Grants, CSHCN State Implementation Grants, MIECHV Grants, Healthy Start Grants, MCH workforce development projects, and National Governor's Association MCH workforce development projects. In addition, any VDH-MCHB efforts relating to injury prevention, adolescent health, workforce development, and oral

health are also housed within OFHS.

Autism, developmental disabilities, and early intervention efforts are spearheaded by DBHDS. Title V staff work hand-in-hand with DBHDS staff to ensure a streamlined and family-friendly referral process.

Other Federal Investments

A number of federal investments are awarded to VDH but administered outside of the state Title V Director's scope.

Federal investments (e.g. CDC, USDA) awarded to VDH include:

- DPHP: chronic disease (e.g. 1305 and 1422), injury prevention, violence, substance abuse, nutrition, physical activity, cancer
- DPHD: data and surveillance (e.g. SSDI)
- Division of Community Nutrition: WIC, Child and Adult Care Food Program (CACFP)
- Office of Epidemiology: immunizations, HIV/AIDS (e.g. Ryan White)

The MCH team works closely with external partners who receive federal funds. This includes working with partners that provide prenatal care and family planning services.

VDH is a decentralized agency with a single Central Office and 35 LHDs. All LHDs participate in Title V activities and receive state and federal Title V funds.

Other Governmental Agencies

The Medical Neighborhood project, a joint effort of Title V, VA-AAP, and DMAS, aims to promote evidence-based, culturally competent approaches to service delivery using Bright Futures as the standard of practice. See CSHCN program narrative for details.

Tribes, Tribal Organizations, and Urban Indian Organizations

There are 11 state-recognized tribes in Virginia, eight of which are in the process of seeking federal recognition. This is important because these communities do not quality for Indian Health Service resources. Anecdotally, the Title V team is aware that these communities experience significant health disparities as well as major risks associated with social determinants of health (e.g. poverty, access to care, access to healthy foods). Building relationships with each unique tribal community and working jointly to develop and provide culturally appropriate interventions and services is a high priority.

Family/consumer partnership and leadership programs

The range of Virginia's family/consumer partnership efforts includes providing the community with information about evidence-based and promising practices, family involvement, and family partnership to paid family staff positions.

Virginia's F2F Health Information Center is housed within the Partnership for People with Disabilities at VCU. CYSHCN staff work closely with the F2F Network; F2F provides education, outreach, and support to families (including culturally and linguistically diverse families of CYSHCN) through the employment of parents serving as liaisons through regional CCC centers throughout the state.

The F2F director, Dana Yarbrough, was actively involved in several initiatives and trainings as a core member of the

Title V/MCH team.

FY 2017 Application/FY 2015 Annual Report Update

2015-2016 update on Title V Needs Assessment

The 5-year comprehensive needs assessment was completed and informed the original grant submission (2015) for the new grant cycle. The 2016 proposal was based upon those findings; however, there were some additional health topics and questions that have arisen since the formal needs assessment. The three key health topics that continued to be raised in meetings and discussions with stakeholders over the past year were Maternal Mental Health, teen pregnancy prevention and infant mortality reduction specifically related to the inequities between the African American and white communities. These questions reinforced the selection of these topics for the state Title V priorities. In addition, two general themes emerged from our continued collaborations . These themes were the violence experienced by adolescents in Virginia and uncertainty regarding the health priorities on the locality level. The following steps are underway to address these updates to the needs assessment:

1. The MCH team explored the existing data and current gaps in programs and services. Regarding mental health, VDH is partnering with the Virginia Department of Behavioral Health and Developmental Services in a multidisciplinary effort to understand and plan programs for Substance Exposed Mothers and Infants and another program to address Maternal Depression. In addition, the Virginia changed a state performance measure from Well Woman Check-ups to Maternal Mental Health.
2. The VDH explored the options available to address violence among adolescent populations. Two programs will be included in the Title V activities moving forward. First, the suicide prevention program will ensure adolescents are included in the target audience and programs are adapted to meet the adolescent perspective. Second, the injury prevention program will incorporate gun safety education and training into current programs.
3. Regarding health priorities at the locality level, all 35 health districts in Virginia have been mandated to conduct community needs assessments. In addition, 9 contractors have been hired by the agency to assist the districts in conducting these needs assessments. After the assessments are completed, a Community Health Improvement Plan will be designed for each district. Maternal and Child Health issues will be included in the needs assessments and improvement plans and the MCH team will be included in meetings/communications and planning interventions. The Title V Annual Reports will include Progress Reports regarding these assessments and Plans at the locality level.

During the course of FY16, the MCH core leadership team continued to work with a multi-disciplinary team to further define the priority areas and align with the existing agency strategic plan and Virginia's Statewide Plan for Well-being. Through this process, the following state priorities were focused on areas with high risks and adverse health outcomes:

2016 Identified Priority	**2017 Priority Focus Area**
Mental Health	Maternal mental health screening and intervention
Intended Pregnancy	Teen pregnancy prevention (particularly ages 15-19)
Infant Mortality Reduction	Racial disparity between non-white vs white infants

State performance measures and outcome measures were developed for each FY17 priority focus area for the purpose of monitoring outcomes of implemented strategies and to improve overall population health.

Five-Year Needs Assessment Summary
(as submitted with the FY 2016 Application/FY 2014 Annual Report)

II.B.1. Process

Beginning in April 2014, the Virginia Department of Health (VDH) Office of Family Health Services (OFHS), convened a Maternal and Child Health General Subcommittee (MCHGS) under the guidance of the Title V Director Dr. Laurie Kalanges M.D. MPH. The MCHGS consisted of Virginia's Title V Director, Title V Grant Coordinator/Consultant, Lead Maternal and Child Health Epidemiologist, Director of the OFHS Division of Policy and Evaluation and Subject Matter Experts (SME) from each of the three MCH populations [Women & Infants, Children & Adolescent, and Children and Youth with Special Health Care Needs](see MCH Committee Schematic 05/13/15).

The MCHGS was charged with coordinating the ongoing Title V Need Assessment process specifically to:

1. Gathering and compiling information from population workgroups;
2. Outlining and compiling Needs Assessment for the Steering Committee;
3. Draft the sections on methodology, partnerships, how priorities/performance measures were developed;
4. Developing surveys, focus groups, stakeholder meetings and implementing them upon approval by Steering Committee;
5. Updating Steering Committee at regular meetings;
6. Arranging for and supervising any contractor(s) hired for the Needs Assessment.

Additionally, population specific workgroups were convened chaired by SME. Each of these population workgroups were tasked with:

1. Reviewing existing reports & assessments related to their specific population;
2. Identifying trends and data related to their specific population;
3. Revising sections of the Needs Assessment relating to their specific population;
4. Identifying gaps that need to be addressed in the Needs Assessment related their specific population.

The population workgroups met biweekly between mid-May and mid-August 2014 to work through and complete their respective assignments. Each population workgroup compiled a population profile that summarized key findings about the health status and key issues facing the population, as well as existing programmatic areas of strength and weakness. The population workgroups submitted the population profiles along with a list of issues and health prioritized to the MCHGS in August 2014. The population specific work products were reviewed and used as the bedrock for gathering additional qualitative information.

Stakeholder Meeting Overview

As a first-step in developing the 2015 Maternal and Child Health Needs Assessment, the Virginia Department of Health (VDH), Office of Family Health Services (OFHS) convened a meeting on November 17, 2014 with members of the OFHS staff and 42 community stakeholders to identify and discuss critical health issues currently affecting women and children across the state. This was also an opportunity for VDH to hear what stakeholders hope to see addressed over the next five years and the type of resources that are currently needed and may be required in the future. Finally, OFHS wanted to gain

insight into how special populations are faring, the disparities that continue to exist and how community groups can collaborate with each other and VDH to move the needle forward and bring about positive change. To ensure a focused discussion, the three objectives for the meeting were to:
• Ensure that stakeholders understand Title V and components of the needs assessment
• Obtain insight into the public health challenges that Virginia's communities face,
particularly special populations.
• Discuss how MCH stakeholders may collaborate to leverage resources and achieve Virginia's state and national priorities over the next five years.

The participants represented a cross-section of individuals, such as physicians, clergy, representatives of non-profit organizations, health care agencies, academic institutions, and community based centers. They represented entities such as the Center for Family Involvement, ACOG, Virginia Commonwealth University Center for Health Disparities, Healthy Start, Breastfeeding Advisory Committee, Healthy Families/Prevent Child Abuse of VA, University of Virginia, Smart Beginnings and SIDS Mid-Atlantic. In addition, participants represented various regions, including Hampton Roads, Charlottesville, Richmond, Wise County, Chesterfield and Northern Neck. Prior to the meeting, a facilitator's guide was developed to ensure that the conversation aligned with the three thematic areas:

A Closer Look at Community Issues and Needs
This session covered ongoing pressing issues and emerging issues in communities throughout Virginia. This segment took a look at issues facing special populations:
communities of color, rural, military and immigrant populations.

A First Step to Setting Maternal and Child Health Priorities
Through this session we sought to identify state priorities for maternal and child health. This session addressed how each stakeholder can contribute to achieving state and national priorities.

Leveraging Resources: Creative Approaches to Addressing Community Needs
The final segment included a discussion about collaborating with state agencies and community-based organizations to address community needs by leveraging resources and sharing evidence-based approaches. Some of the questions that were posed to the group included:
• What are the current issues, as well as the emerging MCH issues facing Virginia
communities?
• How are the needs being addressed?
• How are you addressing the needs of special populations?
• What should the new MCH priorities be for Virginia?
• Where are resources most needed within communities?
• Where can Virginia make the most impact within MCH?
• What are the most successful community partnerships; and how would you like to
collaborate with the State in the future?

KEY INFORMANT INTERVIEWS

Overview

As part of the Virginia Department of Health's Maternal and Child Health Needs Assessment, Campbell & Company (C&C) conducted 22 interviews in December 2014 and January 2015 with key stakeholders throughout the Richmond, VA area. The group of individuals interviewed included non-profit executives and leaders of foundations, state and local government officials, and physicians. They are experts in diverse areas, including health care administration and social services, dentistry, children and youth with special needs, pediatrics, women's health and mental health. The majority of the stakeholders serve those in greatest need—specifically Virginia residents living in poverty or those considered low-income, those suffering from poor health, and those with little to no access to regular health services. The stakeholders were encouraged to be candid in their responses as they spoke about the most critical health issues impacting Virginia families, specific health needs for individual population groups, and barriers and gaps to improving health among the community.

The stakeholders also were asked to share their perspective on what VDH does well with special population groups, as well as provide recommendations to strengthen the role of VDH and other sectors that would improve collaboration, data collection and sharing.

This final report builds on the topline report provided by C&C in early January. Presented are an overview of the consistent themes, the pressing health concerns, as well as the recommendations and strategies offered to address the commonwealth's critical health issues. As mentioned in the topline report, there was a great deal of similarity in responses from individual to individual. This report aims to capture not only the key findings from the interviews but also provide, in more detail, the most relevant responses from the participants.

Consistent Themes

There were several themes that were repeated across all interviews, but one specifically was provided by an overwhelming majority of the individuals—Medicaid expansion. For many respondents, expanding Medicaid was the most critical current health issue that also could have the most profound impact on families and children over the next five years. After the need for Medicaid expansion, the next most recurring theme among the interviewees was a call for additional and improved mental health services for both children and adults. Additional repeated themes included the need to increase access to dental care across all age ranges, the importance of addressing poor nutrition and the growing obesity epidemic. In addition, themes similar to those expressed during the November 2014 stakeholder meeting emerged in many of the interviews. This included the need to reduce infant mortality overall and specifically reduce disparities among African American and Latino populations as it relates to infant deaths. Other similarities presented during the interviews and the November stakeholder meeting included the need to better coordinate care for children and youth with special health care needs, and address the unique needs of undocumented immigrants.

FOCUS GROUP

I. **STUDY BACKGROUND AND PURPOSE**

As the third step in developing the 2015 Maternal and Child Health Needs Assessment, the Virginia Department of Health (VDH), Office of Family Health Services (OFHS), convened six focus groups throughout January 2015 to explore critical health issues currently affecting women and children across the commonwealth. VDH is required to conduct this assessment every five years in order to receive funding from the federal Title V – Maternal & Child Health Block Grant. VDH will use the findings from its assessment to identify priorities and to guide resource allocation, as well as program planning. Thus, these groups are a critical element to this process. Of the six focus groups, four included consumers, in general, and the other two included parents of children and youth with special health care needs.

1. **Research Objectives**

Focus groups provide a level of insight that is rarely achieved through less interactional methods such as surveys and observations. Further, this type of research is recognized as a valuable tool for gauging attitudes, perceptions and motivations. They typically encourage more honest and in-depth responses from participants than other methods. As such, these focus groups were undertaken with consumers to:

- Explore behaviors that contribute to healthy lifestyles
- Identify health issues that facing women and children that are most important to participants
- Identify barriers to care
- Discuss how participants' health care needs have changed and are anticipated to change further
- Determine preferred communication channels and key influencers

2. **Methodology**

Between January 8 and January 27, 2015, six focus groups were held in key regions across Virginia. The locations and dates for the focus groups were:

- Johnston-Willis Hospital in Richmond, located in the Central Region (Thursday, January 8)
- Johnston Memorial Hospital in Abingdon, located in the Far Southwest Region (Monday, January 12)
- Inova Fair Oaks Hospital in Falls Church, located in the Northern Region (Monday, January 12)
- CB Hale Community Service Building in Bristol, located in the Far Southwest Region (Tuesday, January 13)
- Sentara Princess Anne Hospital in Virginia Beach, located in the Eastern Region (Tuesday, January 20)
- Shenandoah Valley Child Development Clinic in Harrisonburg, located in the Northwestern Region (Tuesday, January 27)
- To help facilitate the discussions, two separate moderator guides were developed—one for the general consumer group (Guide A), and the second for parents of children and young adults with special health care needs (Guide B). Both guides asked a series of questions about health beliefs and behaviors. Guide A, however, also asked participants to prioritize health issues that are of greatest concern to them. Guide B asked parents to describe their experiences with programs and services for children with special needs,through which VDH hoped to gain better insight into how these parents are faring, the disparities in care that continue to exist and how they will approach/manage health care as adults with special needs. Each discussion lasted approximately 90 minutes.

The cities for the focus groups were selected to ensure that the groups adequately represented both urban and rural communities and all regions of the state. Five of the groups were held in local hospitals or clinics, and one group was conducted in a community-based organization. As requested in the statement of work, note takers were used to capture participant responses in four of the groups; however, due to illness, a digital recorder was used in both Abingdon and Bristol. The recorded sessions were transcribed by the moderator to produce written notes. As an incentive for participants, individuals who attended the focus groups received a $25 Wal-Mart gift card at the conclusion of his/her group.

Participant Recruitment

VDH facilitated the initial contact with the health professionals coordinating the focus groups. VDH contacted each site representative via email to explain the goals of the focus groups and secure logistical support. Each representative/site coordinator was asked to identify and provide a local site and recruit participants. Representatives were also asked to consider providing refreshments to further incentivize participants to attend.

To facilitate recruitment, each site coordinator received a screener outlining inclusion and exclusion criteria to guide the identification of appropriate participants. Campbell & Company drafted the screeners and worked with VDH to finalize the appropriate criteria. As modifications were needed, VDH worked with site coordinators to ensure participant recruitment goals were achieved. While the screener sought to preclude participation of health care workers, some focus groups included those who do work in the health field. Their participation is noted in the individual focus group notes. In addition, VDH invited regional health directors to attend and observe focus groups, as they were able. Their attendance is noted in individual focus group notes, as well.

In wrapping up the discussion, parents were asked how they would spend $1 million dollars to address healthcare needs similar to those facing their children. Several participants said that they would use this funding to train teachers to better interact with children with special needs. Others said that more research is needed to identify the root causes of conditions like ADHJD. Other parents would create spaces where children would be among other children like themselves. Going back to the importance of counseling, other parents said they would increase the number of in-house counselor.

II.B.2. Findings

II.B.2.a. MCH Population Needs

General Findings and Themes from Stakeholder Meeting

The stakeholder meeting was an open forum, allowing for a rich, interactive exchange among participants about what is happening with women, children and families in Virginia's communities. The stakeholders were vocal about the issues facing their constituents and the resources (or lack thereof) available to help address their needs. They also described the challenges they're facing to meet their community's needs while oftentimes struggling with limited resources. While a wide variety of health issues were raised by the group, recurring topics and themes emerged throughout the morning discussion, including:

• Reducing infant mortality, with a particular emphasis on African Americans
• Increasing the availability of and access to mental health services
• Improving access and coordination of services for all children, including children and youth with special health care needs
• Ensuring the successful transition of special needs children and youth into adulthood

Other issues that arose focused on unintentional injuries and suicide among adolescents, substance abuse, dental health care (e.g., during pregnancy), home visitation, and the overall needs of special populations such as undocumented immigrants and racial and ethnic minorities.

General Findings and Themes from the Key Informant Interviews

Overall Health Environment and Pressing Health Issues

When asking respondents to identify the health-related changes that have had the greatest impact on families over the past five years, the responses varied greatly. However, individuals repeatedly cited the following: the introduction of the Affordable Care Act (ACA) to assist in providing coverage to those previously uninsured; the impact that the increase in poverty and unemployment has had on the health of families; and the increased rate of obesity and poor nutrition especially among children. Other responses, not listed in any particular order, included:

- Patients are sicker and respondents are seeing more children with multiple medical diagnosis. One explanation: technological advancements are "saving" children that would not have previously survived
- Food allergies
- Breakdown of the family structure
- Increase of tobacco use and smoking during pregnancy
- Dental health, especially in rural areas
- Growing identification of autism spectrum disorder
- Impact of late, pre-term birth
- Fetal alcohol syndrome and the increase of alcohol use during pregnancy
- The need to educate parents on immunizations
- Impact of the environment, especially on the health of children as it relates to conditions such as asthma

When asked to describe emerging health issues that will have the greatest impact on families and children over the next five years, the majority of respondents again emphasized the need for more robust mental and behavioral health services for all populations. They also cited a need to address the health concerns for the growing population of undocumented immigrants. Further, individuals stated a need to pay continued attention to the large health disparities that exist among residents living in the northern part of Virginia compared to those living in the southern and southwestern regions. One stakeholder summarized this by stating, "*There really are two Virginias*." Additional emerging health issues that were

expressed by many of the respondents included the following:

- Rising rate of obesity, Type 2 diabetes and mental health issues occurring at younger ages
- Co-morbidities that exist with obesity
- Growing substance use and abuse problem with prescription and illicit drugs (e.g., “meth”), particularly among pregnant women
- Using mobile health units and telemedicine to improve access in rural areas (e.g., lack of specialists, traveling long distances for care)
- Inadequate number of providers overall; dentists in particular
- Severe shortage of medical and dental providers that serve children with special needs
- Other health issues in no particular order, were identified within the interviews:

- Changing focus to preventive rather than tertiary care
- Access and eligibility of health care services among undocumented pregnant women.
- Toxic stress and trauma (e.g., child abuse and neglect)
- Genetics and reproductive rights
- Increase of autism diagnosis in children
- Tobacco use and the legislation of e-cigarettes
- Increased rate of opioid use among pregnant women

Respondents were then asked to pinpoint one or two most pressing health issues and how they might be addressed. The most common responses included the following:

Health Issue	Strategies to Address the Issue
• Access to care	• Medicaid expansion • Focus on early interventions; “we get to problems too late” • Obtain data on these individuals from every VDH agency • Enroll 71,000 eligible children into FAMIS
• Lack of providers, particularly among certain specialties (e.g., pediatric dentists and pediatric psychiatrists) and in rural areas	• Use mobile health and telemedicine to access rural areas. • Increase funding to rural areas and expand Medicaid • Increase the number of medical residency spots in specialty areas such as pediatric dentistry and pediatrics overall • Recruit practitioners who will accept the uninsured, under-insured and Medicaid
• Obesity	• Start early introducing healthy routines in children • Increase access to healthy food options, i.e., farmer’s markets, summer food programs • Empower families to make healthy choices through campaigns such as “Rev Your Bev” • Use breastfeeding as a tool to teach moms to identify hunger cues early on in children and prevent later issues with over-feeding
• Lack of public transportation	• Increase funding for transportation services • Partner with non-traditional partners to provide

Health Issue	Strategies to Address the Issue
	transportation
• Substance abuse	• Educate medical providers on the need to routinely screen women for substance abuse, mental health and domestic violence issues
• Lack of medical homes	• Ensure adequate insurance coverage and providers • Be innovative and use tele-medicine
• Mental and behavioral health	• Decrease unemployment by providing low-income populations with “decent jobs” and decent salaries • Create a pipeline for producing behavioral health professionals, specifically psychiatric nurse practitioners • Need to look at social systems and community-based supports (e.g., families, churches, parenting classes, other available services)
• Prenatal care/developmental disabilities and delays	• Early childhood providers and health practitioners to be trained on “Ages and Stages” curriculum to screen for delays and disabilities • Ensure social emotional issues are addressed through assessment, treatment and referrals • Increase access to prenatal care and screenings • Make home visiting services available for at-risk families
• Breakdown of the family	• Engage faith-based communities to support families
• Limited English proficiency	• Provide cultural sensitivity resources for health care and social service providers.
• Poor nutrition	• Increase access to fresh and healthy foods through nutrition education, farmer’s markets and federal nutrition programs such as school lunch programs • Enhance the coordination of services by having multiple partners join the health department to sustain the infrastructure of the various nutrition programs
• Rural maternal and child health	• Increase number of hospitals with quality labor and delivery services
• Appropriate use of health care services	• Promote health education about preventive care (i.e., move away from “ER care”) and help families conduct ongoing care of themselves, not just when they are sick

Subgroups Who are of Most Concern

Not surprisingly, many of the subgroups mentioned throughout the interviews are disproportionately affected by some of the most serious diseases and conditions. One participant said they worry most about “people on the fringes,” such as minorities, low-income populations and those lower to middle-income individuals who have been hardest hit by the

recession. Other stakeholders named specific groups:

- African Americans
- Undocumented immigrants
- Individuals with chronic diseases who require frequent medical interventions
- Residents in the southern tier of Virginia
- Children with special needs
- Young children and young women
- Veterans
- Adolescents
- Children and youth in foster care
- Medicaid recipients

Significant Barriers or Gaps

The barriers and gaps in services heard during the November 2014 stakeholder meeting were reiterated by the key informants interviewed during this phase of the research. Most frequently-mentioned barriers were: lack of transportation, language, and being uninsured coupled with the inability to pay for services out of pocket, including the co-pay. Stakeholders repeated how the lack of insurance and limited financial resources is particularly problematic in rural parts of the state. Additional barriers and gaps mentioned included the following:

- Socio-economic issues:unable to take time off from work to address health needs
- Poverty and the lack of access to quality living environments (housing, food, health care)
- Unfamiliar with how their "new" insurance works and what is covered
- Cultural competency of providers
- Funding for certain health programs
- Can't pay: lack of adequate or any health insurance
- Subsidies and cost sharing insufficient for people who must frequent doctors
- Annual physicals are not required after 6th grade, so adolescents have coverage, but rarely see a physician
- Distrust of the government's ability to manage a large social programs
- Little to no access to healthy food choices
- Individuals' perceptions of what it means to be healthy
- Trusting health care providers and the health care system
- Adequate resources for a robust healthcare workforce (i.e., need more specialists, nurse practitioners, etc.)
- Community service boards only provide case management and crisis stabilization
- Lack of or limited health education and health literacy
- Attitudes of health care providers
- Two Virginias – the North receives better access and quality of services; the South receives the exact opposite

General Findings from the Focus Groups

1. **FINDINGS FOR GROUPS WITH GENERAL CONSUMERS**
    1. **General Health Perceptions and Behaviors**
    When participants were asked to define a healthy person, three common themes emerged: 1) individuals who remain physically active; 2) those who maintain a healthy weight; and 3) those who eat healthy foods and a balanced diet. A significant number of people also mentioned that healthy people take care of themselves, and typically don't have chronic diseases or conditions that require regular medical care. At least one participant challenged this view, stating that being healthy doesn't mean the absence of health issues, but that these medical conditions are carefully monitored through "regular checkups" and adhering to "doctors' orders." Verbatim responses to the question included:
        - *Educate themselves on diet and exercise*
        - *No high blood pressure or cholesterol*
        - *Can have medical needs but is tuned in and gets proper care*

- *Gets regular checkups*
- *Exercise and taking care of their body*

To stay healthy, participants also believed that individuals must strive for a work/life balance, which includes setting aside time for adequate sleep—6 to 8 hours each night. Additionally, healthy people avoid certain foods by reading food labels, buying organic foods and preparing their own foods, rather than eating out. Still others said that they schedule regular appointments with healthcare providers, work to eliminate the need for prescription medications and avoid fast food. Walking outdoors, yoga and minimizing stress by building in quiet time were other responses. Two participants said that a "clean home" is important to keeping themselves healthy. Verbatim responses included:

1. **FINDINGS FOR GROUPS WITH PARENTS OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS**

    1. **General Health Perceptions and Behaviors**
    The overwhelmingly majority of parents seemed to struggle to get an initial diagnosis. They described how schools and pediatricians suggested that they "wait and see", believing that some of their child's behaviors would simply "go away." However, even after a diagnosis was made, securing a treatment plan often took years after symptoms, such as anger, fighting, violent behavior appeared. In one situation, a parent who was diagnosed as an adult with ADHD, diagnosed her own child, pushing for a treatment plan. At least two parents home-school their children and, as a result, did not get an early diagnosis and remain without a treatment plan. Approximately half of the participants have a current treatment plan; others feel abandoned by the system and have turned to websites that cater to parents of children with special needs. Other responses:

        - *There's some kind of block [with doctors]—think it will go away. Gave suggestions, but no treatment plan.*
        - *No treatment plan, feel like it's a dead end…*
        - *Son goes through moods, bad anger issues since about 13 [currently 17]…diagnosed as bi-polar, meds not working.No treatment plan.*
        - *She was having fighting problems with other children. She's now on medication and diagnosed.*

Preschool and primary school teachers initially suggested that some of the children be tested. One parent said that his son was diagnosed in Head Start after having temper tantrums and difficulty focusing. Other parents said that Pre-K teachers recommended specific assessments and still another parents said that his child's kindergarten teacher approached him, suggesting that his child be tested. Additional responses included.

1. **CONCLUSIONS**
2. *Conscious in selecting healthy foods in grocery stores*

- *Drink less alcohol and beer*
- *Try to cook your own foods*
- *Doing preventive things like going to the doctor and dentist annually for checkups*
- *Being able to get off of some of the meds being taken*
  For the most part, participants reported that they take steps to keep themselves in good shape and subsequently, view themselves as healthy. One participant described how she stopped smoking decades before; in another instance, individuals mentioned how they follow a daily exercise regimen. Additional responses included:

- *Try to do what is right for self*
- *Yes. I can complete tasks with no issues, no problems*
- *Age causes health changes, but not bad ones at this time*
- *Work to keep any ailments in check*
- *My doctor says I'm healthy.Everything checked out.*
  Almost all of the participants said that they are responsible for the family's health or that the responsibility is shared. "It's a partnership," they said. Their role includes scheduling doctor appointments, keeping a job that provides insurance and buying making healthy selections when buying groceries. They stated:

- *Yes.I am a female; wife and mother—have that responsibility.*
- *I am the keeper for my family's health.*

- *I pay attention to my husband's health.He has a medical condition, so I do feel responsible for him.*
- *It's a partnership. Should be looking out for each other and being supportive.*

2.1 Important Health Issues and Needs - Women

During the November 2014 VDH Stakeholder's meeting, participants were asked to rank maternal and child health issues that were most important to their communities. To determine how this information would align with consumers, we conducted a similar exercise during the four consumer focus groups. Using information gleaned from the Stakeholder meeting, we created a document that identified 19 women's health issues; these were not put in rank order. The four consumer groups were first asked to select the top ten issues that they believe to be most important. This list was then narrowed to reflect their top three concerns. An asterisk indicates where disparate health issues were tied in the rankings. The top 10 women's health issues across the four focus groups were:

1. Mental Health
2. Nutrition
3. Cancer and Breast Cancer *
4. Substance Abuse and Tobacco Use and Reproductive Health*
5. Prenatal Care and Diabetes*
6. Violence and High Blood Pressure*
7. Accidental Injury; Obesity and Toxic Stress*
8. Infant Mortality and SIDS and Oral Health*
9. Suicide Prevention
10. Breastfeeding

**Indicates a tie or equal ranking*

Overwhelmingly, the issues that repeatedly received the highest rankings were: Mental Health, Nutrition and a tie between Cancer and Breast Health, specifically breast cancer.

Mental Health

Participants unanimously agreed that "good" mental health has a direct impact on every aspect of life. They also expressed how poor mental health is linked to the other conditions, such as suicide, substance abuse, obesity and toxic stress. Some felt that facilities typically offer medication (e.g., "pills or shots") as the first approach to treatment but are not "fixing the root cause" or offering "real care."

Participants were also disturbed about the lack of resources for people with mental health issues and their families. This included support for caregivers and gaps in insurance coverage for treatment. Focus groups participants stated:

- *Mental issues can be hidden and not detected because you are unhappy or not pleased with yourself*
- *[People are] In and out of facilities without solutions or real care.You are only given medicine or shots for depression, shots for anxiety, just giving people pills instead of fixing the root cause*
- *There are not a lot of resources or education on mental health.It has a huge impact on people's lives*
- *Puts lots of stress on care givers, insurance doesn't support mental health as much as diabetes or cancer or heart conditions*

Nutrition

A consistent belief was that nutrition is the foundation of disease prevention. Participants stated that without proper nutrition, the likelihood of developing chronic diseases or conditions is high. Worthy of mention was feedback from new mothers who called for more education on post-pregnancy nutrition. These women said:

- *Seems to be the bedrock that underlies all of the issues like diabetes and heart disease and other issues in discussion. Bad nutrition leads to the other conditions listed – cancer, diabetes, obesity etc.It impacts other areas of life.*
- *You can have some control over nutrition.Understanding food labels is important.*
- *I got a lot of information from the doctor while my wife was pregnant but there was not a lot of information on how to produce milk or post-pregnancy nutrition.That should have been brought up.*

- *Without proper nutrition physical health is compromised.Eating right and exercising are the main ways to stay healthy.*

Breast Cancer

Although the document distributed during the focus groups listed breast health and not breast cancer, the conversation quickly shifted to a discussion about breast cancer. Participants were concerned about how prevalent it has become and that "everyone has been affected by it."

Most participants, especially women, described how they had some personal connection to the disease. While participants were alarmed about its frequency, they did believe that "you can do something about it, if caught in time." Others stated that developing breast cancer is outside of their control and that it could be inherited because of genetics or just an unfortunate life development. Responses included:

- *It's out there and most prevalent.Everyone has been affected by it.It's a disease that has no cure so it's on everyone's mind.*
- *This issue is personal for me.I have friends dealing with breast cancer.Seems like it's just a matter of time before it's my turn.*
- *Everyone is dying from cancer [women & children].Statistics are high.It's very concerning.It doesn't matter how healthy you are, it just happens.*
- *It's a rude awakening when cancer is diagnosed, but you can do something if caught in time.*

The moderator offered participants the opportunity to expand the list. Individuals suggested heart health, eye/vision health and post-partum depression. **Children's Health Issues**

- The participants were asked to repeat the same activity with a different focus – health issues affecting children. The top 10 issues were:

1. Mental Health
2. Nutrition
3. Obesity and Physical Inactivity*
4. Immunizations; Accidental Injury; Developmental disabilities or delays*
5. Oral Health and Violence*
6. Autism; Substance Abuse and Tobacco Use*
7. Asthma
8. Infant Mortality and SIDS; Suicide Prevention*
9. Diabetes
10. Toxic Stress

**Indicates a tie or equal ranking*

Participants repeated the same exercise and the top three children's health issues were Mental Health, Nutrition and Obesity and Physical Inactivity. The top two were identical to the women's health issues. Although immunization, accidental injury and developmental disabilities or delays were not officially in the top three, they were separated by only a few votes.

Mental Health

All participants provided similar feedback about the benefits of good mental health for children, specifically, that children without mental health issues typically become mentally stable adults. Participants expressed surprise over how common depression and anger has become among children, and called for more education on the issue, coupled with better diagnosis and treatment. Participants generally agreed that mental health issues are linked to other items on the list, namely toxic stress, violence, substance abuse and tobacco use. Some continued by stressing that peer pressure, bullying and violence in the home are often root causes of poor mental health among children. Participants stated:

- *There is so much depression and anger in kids nowadays.Without a positive, healthy brain, a child may have more detrimental long-term effects.*
- *It's just as important for a child to have a stable mental capacity as it is for adults.*

- *It's difficult for children to identify that they need help in this area.Children and teenagers have a hard time pinpointing their emotions.*
- *It ties into toxic stress and even bullying through social media.Peer pressure leads to mental health issues which lead to substance abuse.*

Nutrition

- All participants acknowledged that proper nutrition has numerous benefits, especially for children. While there was widespread agreement of the need, there were differing views about why families often choose less healthy options. Some participants mentioned how poverty often forces low-income families to over indulge in fast foods and other items with limited nutritional value because they're cheaper and more convenient. Others stated that the lack of time to prepare healthy meals is yet another factor. Still others said that even though schools are offering healthier options, peer pressure often influences food choices. Participants stated:

- *Proper nutrition and education will set the child's entire life on a path of healthy habits and in turn healthy adults and parents.*
- *Children don't make healthy choices.We have to find ways to teach kids to keep healthy.It sets the stage for obesity if not monitored.*
- *Parents don't teach kids to eat right.And kids see teachers eating unhealthy even though they teach kids [in theory] healthy eating habits.They will follow the teacher.*
- *Peer pressure influences food choices.*
- *There are lots of fast food and poverty makes people unable to purchase healthier foods.*

Obesity and Physical Inactivity

Participants stated that in this "*nation of obese people*" this is a growing problem among children. Some of the causes stated were lack of proper nutritional guidance from parents and sedentary lifestyles, which discourage children from playing outside. Verbatim responses included:

- *It's a growing problem among children.Parents feed their kids McDonald's, then allow them to play video games all day.*
- *They are trying to make changes [regarding school lunches], but parents need to make better choices for their children.*
- *There's peer pressure, too.Some kids feel that it's not cool to eat the school lunch.*
- *It's the current lifestyle.Kids going on two years old know how to operate a tablet.Tablets, texting, TV, video games, [Apple] Face Time – all keep them from going outside to play and run around.*
- *Parents don't teach kids to eat right.Physically obese children result in obese and unhealthy adults, which increases the demand on health care.*

The participants were also asked about additional heath issues that should be added to the list. At least one participant thought that breastfeeding should be included because it affects both women and children. Bullying, eating disorders, cancer and prenatal care were other issues that participants felt should be added.

2.2 Barriers/Access to Care

With the exception of two people, all stated that they have primary care providers and dentists for themselves and their children. However, when asked about the ease of getting an appointment, there were definitely mixed reactions. A significant number of participants agreed that office visits are generally available when needed, especially for primary care physicians. In contrast, several participants expressed frustration with the length of time it often takes to see dentists and specialists. One participant explained how it took six months to see a specialist for her child.

Participants volunteered that these delays may, in part, be based on the type of insurance one has. An additional comment was that the delay—especially for dentists—may be due to the popularity of after school appointments—which are preferred by both the school and parents. Individuals noted:

- *Easy to get an appointment? Yes.*
- *Not hard to get an appointment, but the doctor's are never on time.*
- *Month-long wait or longer.*
- *The doctor's office was very accommodating, even when the doctor was not available.*

Overall, participants indicated that they are satisfied with the quality of their care. The concerns that were expressed focused on infrastructural and systemic issues, such as inaccurate billing, 3 to 5 hour waits during doctor appointments and finding doctors to accept new patients. These responses included:

- *So difficult to access. They make it hard on purpose. Have to call all the time and go through an automated prompt.*
- Aging was the leading reason individuals said that their health care needs had changed over the past two to three years. Closely following was "becoming a mom," or developing a condition that requires ongoing treatment for a child, family member or themselves. These individuals stated:
- *Health issues increase with age.I know about 10 doctors—eyes, hearing, prostate, etc.*
- *There have been major illnesses with my son and my daughter.My daughter is going through eye surgery at 6 years old.*
- *I utilize the healthcare system more because of the change in age and responsibility for my husband.*
- *After pregnancy, my thyroid levels needed to be checked regularly.*

In determining what their health needs would be five years from now, many of the answers were similar to those provided for the previous question. Once again, aging emerged as a leading issue, along with being diagnosed with conditions like cancer, diabetes and osteoporosis. One person said that they purchased long-term care insurance to help address future issues. Individuals stated:

- *More of the same because of age.*
- *I'm going to be hitting 40 soon, which calls for more exams.*
- *Will likely have double the appointments, a lot more specialists due to additional issues.I have a cardiologist, surgeon and oncologist.*
- *Keeping an eye on heart health.My dad had a heart attack at 44.*
- *I plan to have another baby, so women's health is important to me.*
- *Was healthy but as I got older started getting sick with ailments such as diabetes, bad eyesight, hearing goes, need oxygen sometimes….*

Some of the changes that have affected participants' ability to get health care include the loss of insurance, fewer general practice providers and higher deductibles. At least one person said the increase in options—specifically urgent care centers—makes receiving care more convenient.

2.3 Communication Channels/Influencer

With the exception of a few participants, Facebook is the most popular social media site. Only a few people reported using Instagram or Twitter.

Physicians are the most trusted source of information, followed by "credible" sites on the Internet. Additional responses were Dr. Oz, friends who work in the medical field and people who have had similar conditions.

Finally, participants were asked if they had one minute to speak with the Governor of Virginia about the health of their community, what they would discuss. There was a wide range of responses, many of which strayed from health care. The most common themes focused on the need to make health care more accessible, lower the cost of insurance and co-pays, continue to advocate for the expansion of Medicaid and make Medicaid more flexible. Others would encourage the Governor to enhance support for individuals with mental health issues; recruit more specialists to rural areas; and provide additional assistance to families with special health care needs children. Seniors, the homeless and medical students were also mentioned. Specific responses for the Governor included:

- *Need Medicaid, but keep being dropped whenever we have a few dollars more during any given month.*
- *Sick of insurance company deciding that medication prescribed is not necessary.*
- *Should not to be fired from job for taking time off with special needs kids.*
- *More funding for special needs kids in public schools.Children that can't walk need more slides, fund equipment to get down on their level.*
- *More choices for the elderly and the homeless.*
- *More drug awareness programs.*

- *Advancing educational opportunities for medical students.More people to teach equals more students, equals more healthcare professionals.*
- *Health insurance should be more affordable for young families.It's still kind of easy for me because I'm still on my Mom's insurance.I'd be in the hole every month otherwise.*
- *Lack of central care for the elderly, so many have to choose between necessary medications or essential food….*
- *Taking too long to see a specialist and getting more specialists in rural areas.*

Some of the non-health related comments included: poverty, and the need to increase job opportunities in rural communities and among low-income populations through improved transportation systems. Individuals stated:

- *Compassion for the needy.The shelters are crowded and people die.*
- *Lower income areas needs lots of help… stigma of the areas as lazy, hillbillies not doing anything useful.*
- *Need to expand job opportunities.*
- *Lack of transportation for getting back and forth to work.*

- *Kindergarten teacher asked if she had been tested…thought she had Asperger's.Came to clinic to get diagnosis, but can't get diagnosis.*
- *Was hard for my son, he was in Head Start. Couldn't focus, temper tantrums.Couldn't figure out why he was upset.Diagnosed by pediatrician, then tested.*

Participants were asked to remember a time when their child's medical needs weren't being met, and what type of assistance would have been helpful. The most popular response was more counseling, both in and out-of-home. Another frequent response was the need to improve medications, because of the side effects, or finding the right medication earlier. One parent described how her child has recently benefited from occupational therapy, but she previously hadn't heard of it. Other parents stated:

- *Crossroads got him in-home counseling, a tremendous help.*

- *Would want more counseling.*
- *Improving meds, they stunt your growth.*
- *Wished I had known about OT.*
- *More information about nutrition.*
- *Need assistance reading and writing…right now she feels dumb.*

In general, participants could have benefited from having more access to relevant information.

- *More clarity. I don't understand it myself.*
- *Need simple answers. This is what it is. This is how to fix it. Is this really going to work?*

While most parents have plans in place in case of emergencies, they admitted that it wasn't formal and only addressed specific needs as they arose. Most participants only have family members and/or friends who can assist if needed. Other responses included:

- *We know what to do in case of fire.*
- *We have a plan loosely—not written down or formal.*
- *We've lost power, heat and figured it out. We can figure something out.*
- *…we have the basics: flashlights, batteries and food.*

Several parents mentioned being disappointed that educators have limited knowledge about special needs children, and more important, are often "insensitive" to their children's challenges.

- *It's [the program] right downtown, a 15-minute drive.*
- *They taught her life skills…making the bed, how to take care of herself, cooking.*
- *I figured the college should have something.*
- *Not too familiar, except Kluge Center. I happened to be there for something else.*

Parents agreed that having a child with special needs makes them eligible for appropriate services. However, several indicated that many of the programs are income-based and specifically for Medicaid beneficiaries.

- *Having a child with special needs makes you eligible.*
- *Some programs are income-based. If you don't have Medicaid then you're not accepted.*
  For several parents, losing their Medicaid benefits is a constant concern. Without this insurance, they would be unable to afford certain services.
- *If I didn't have Medicaid, I wouldn't have been able to have him tested.*
- *If we lose Medicaid, we're going to have to stop OT.*

Participants were not familiar with the CCC or other health districts. Only a few mentioned "hearing about" the CDC or knew about 211. While almost all participants acknowledge problems along the way, their overall experience with programs and resources is "good." Several described how their children have improved through counseling by learning coping skills and making changes to their medication.

- *Counseling has been good.*
- *Meds were not good at first, but now it's ok.*
- *New meds helped.*
  However, when asked to identify current difficulties, participants said they are continuously frustrated with the inability to see specialists in a timely manner, the cost of medications and the lack of support from educators.
- *They didn't know coping mechanisms for a kid in kindergarten…counting to 10.*
- *I was told that "it's not a disability" by educators.*
- *Schools need to be more educated.*

Family members and friends provide respite to parents who need to take time away from their children. In some instances, older children take care of younger children. One single mother with six kids said that she doesn't have family and desperately needs support. Others stated:

- *The kids help one another…we rely on one another.*
- *They're at an age where we don't need support.But he's not mentally 16 so we have to be careful.*
- *Family and friends…don't have an issue finding somebody.*
- *I could use any help…a reputable company that offers on-call child care—so that you're not rolling the dice.I might just need one hour on Saturday.*
- *A 211 for babysitters…*

Most of the focus group participants have children in elementary or middle school, and were not familiar with a transition plan. Unfortunately, parents with high school-age children were also unfamiliar with transition plans. These parents, however, were concerned about the next steps for their children and their inability to live independently. One parent mentioned that his 17 year old son was already a father and in "trouble with the law," but he doesn't know where to get assistance. Though parents of younger children have years before they're facing this issue, the conversations have begun.

- *It scares me to know that he's almost there.I feel that I have to help him in some way.*
- *We don't think she'll ever leave the house.We worry about her ability to be independent…to function on her own.*
- *Don't know if he'll be able to be independent…live on his own.Will need life coaching throughout his life.*
  None of the families indicated that they're prepared for their child to transition to adulthood. When asked who should make the referral, the overwhelming majority said either their child's pediatrician or school counselor. Other suggestions included the IEP team, school psychologist.
- *Schools and counselors should be able to make the referrals.They're in school 5 to six hours a day, 5 days a week.*
- *Pediatrician.*
- *If my child was in the public school system, it should come from the school counselor.*
- *Counselor or School Psychologist.*
- *Your child's IEP team.*
  Parents were not familiar with the website "Got Transition," although several parents said that a website about transitioning would enable them to "educate themselves."

- **The importance of mental health and the perceived inadequacies of mental health services in Virginia was a consistent theme across all four consumer groups, ranking as the most important health issue for both women and children.** This may be due, in part, to the 2013 tragedy involving State Senator Creigh Deeds and other high-profile violent acts that were linked to mental illness. It should be noted that none of these situations were specifically mentioned during the focus groups.
- **Of the top ten health issues selected as the most critical for women and children, nutrition was ranked second for both groups.** This aligns with individual beliefs that proper nutrition is essential not only for good health, but also for chronic disease prevention. Participants strongly recommend educating parents about making healthier food choices, while acknowledging some of the limitations of lower-income parents (e.g. time, money). Women were concerned about the prevalence of breast cancer, which contributed to its ranking as the third most important health issue. For children, obesity ranked third, which participants view as an outgrowth of poor nutrition.
- **The expansion of Medicaid is viewed as an important safety net to help families stay healthy.** Participants mentioned how slight increases in their income force them off the Medicaid rolls, jeopardizing their ability to purchase medications for themselves and family members and to continue occupational and other therapies needed by their children with special needs. Participants in more affluent areas, such as Northern Virginia, expressed concern about the impact of not expanding Medicaid on the poor.
- **Participants have a clear understanding of activities and behaviors that contribute to healthy lifestyles and disease prevention.** Many have taken specific steps to improve their health, such as exercising, avoiding tobacco and reducing the stress in their lives. However, almost half of the respondents report that external factors, such as environmental contaminants, genetics and simple misfortune have a greater influence over one's overall health.
- **Parents of children and youth with special needs struggle to navigate the system.** Participants reported frustration in getting an initial diagnosis and follow up treatment plans. They also had difficulty identifying local programs and services, resorting to placing cold-calls to universities and school systems for assistance. Though once services began, they were satisfied with both the services and overall experience.
- **Parents have not had conversations with anyone about transition plans for their child.** Parents with high school-age children are unaware of what the next steps should be once their child turns eighteen. They are deeply concerned about the type of support available and whether their children will every able to live independently. Participants with younger children have had conversations among themselves about their child's future needs, but have not spoken to a professional. Parents reported that the most appropriate person to broach the subject should be someone with an ongoing history with their child, namely their pediatrician, school counselor, school psychologist or someone from their IEP team.
- **Participants find that appointments with primary care physicians are readily available; however, difficulties arise when scheduling appointments dentists and medical specialist.** Not surprisingly, more difficulties arise in rural communities where there are fewer dentists and specialists. Parents of children with special needs often wait months to see and specialists, then once on site, often wait for hours.

II.B.2.b Title V Program Capacity

II.B.2.b.i. Organizational Structure

The Virginia Title V program is housed within the Virginia Department of Health (VDH), one of twelve agencies within the cabinet level Health and Human Resources Secretariat. In January 2014, the newly elected Governor, Terence McAuliffe, reappointed Bill Hazel, MD as the Secretary of Health and Human Resources. Marissa Levine, MD, MPH, FAAFP was appointed as the State Health Commissioner. The Virginia Department of Health includes three deputy commissioners who provide oversight for Community Health Services; Public Health and Preparedness; and Administration.

VDH is mandated by the Code of Virginia to "administer and provide a comprehensive program of preventive, curative,

restorative and environmental health services, educate the citizenry in health and environmental matters, develop and implement health resource plans, collect and preserve vital records and health statistics, assist in research, and abate hazards and nuisances to the health and environment, both emergency and otherwise, thereby improving the quality of life in the Commonwealth." In carrying out these responsibilities, VDH, in Conjunction with the Board of Health, promulgates and enforces over 60 sets of regulations and manages over 70 federal and state grants.

In 1947, the Virginia General Assembly passed legislation requiring "each county and city to establish and maintain a local health department." Then in 1954, the Virginia General Assembly passed legislation that permitted the Department to organize the local health departments into 35 health districts which now include 119 local health department. The code allows local governments to enter into agreement with VDH to operate the local health department for them. All local governments except two, and operate under a cooperative agreement that delineates the mandated basic health services that each must provide and any additional services based on need and available funds. Arlington and Fairfax have a contractual agreement with VDH.

Section 32.1-77 of the *Code of Virginia* specifically addresses VDH's authorization to prepare and submit to HRSA the state Title V plan for maternal and child health services and services for children with special health care needs. The Commissioner of Health is authorized to administer the plan and expend the Title V funds.

Within VDH's central office, the Title V Block Grant is managed by the Office of Family Health Services (OFHS). Lilian Peake, MD, MPH serves as the OFHS director as well as Virginia's Title V Director. She reports directly to the Deputy Commissioner for Community Health Services, Robert Hicks who also oversees the 35 health districts.

The divisions within OFHS have specific responsibility for carrying out Title V funded programs. These include the divisions of Child and Family Health, Prevention and Health Promotion, Community Nutrition, Policy and Evaluation, and Administration. The majority of federal Title V funding supports programs and staff within the Division of Child and Family Health's Children and Youth with Special Health Care Needs Program. In addition to Children and Youth with Special Health Care Needs, the Division's program areas include child health, reproductive health, perinatal/infant health, and newborn screening. The Division staff work closely with the Prevention and Health Promotion Division on issues relating to dental health, breast cancer screening, injury and violence prevention, tobacco use and physical activity; and the Community Nutrition Division on issues relating to nutrition and breastfeeding. The Policy and Evaluation Division provides the Title V funded programs as well as other grant funded programs with policy, statistical and evaluation support. The Administration Division provides budgeting, accounting, contracting, grants management, procurement and human resource functions.

In addition to funding programs within the Central Office, Title V funds are provided annually to the 35 health districts to support maternal and child health services. The district funding levels are based on an estimate of the proportion of low income (200% FPL) births within each of the districts. A total of approximately $3.4 million is annually provided to the districts. Currently, district Title V funding addresses the following areas: breastfeeding, child health, dental services, injury/violence prevention, perinatal/infant health and teen pregnancy prevention.

Organizational charts for the Virginia Department of Health and the Office of Family Health Services are attached.

II.B.2.b.ii. Agency Capacity

The Office of Family Health Services within the VA Department of Health conducted and assisted throughout the five year needs assessment process.

II.B.2.b.iii. MCH Workforce Development and Capacity

The Office of Family Health Services (OFHS) within the Virginia Department of Health has responsibility for the development and implementation of the MCH Block Grant. The director of the OFHS is Lilian Peake, MD, MPH. She was appointed effective April, 2014. Jennifer O'Brien was hired as the MCH Consultant to work with the MCH Director in October 2014. During the past year, Lauri Kalanges, MD, MPH, was the Deputy Director of the OFHS and Maternal and Child Health until her resignation in February 2015. Lilian Peake, MD, MPH is the current MCH Director. Marcus Allen, MPH became the director of the CSHCN program in November 2014.

II.B.2.c. Partnerships, Collaboration, and Coordination

All partnerships, collaboration, and coordination are detailed in the MCH Needs Assessment, as well as detailed attendance sign-in sheets are attached in the MCH Needs Assessment document under attachments. Collaboration list contains too many characters to include in this section.

II.C. State Selected Priorities

No.	Priority Need
1	Safe Sleep: Increase safe sleep practices.
2	Tobacco: Decrease smoking among pregnant women and in households with children.
3	Medical Home: Promote the importance of medical home among providers and families.
4	Transition: Promote independence and transition of young adults with and without special healthcare needs.
5	Child/Adolescent Injury: Reduce injuries, violence, and suicide among Title V populations.
6	Woman/Maternal Health: Support the physical and emotional well-being of women and their children.
7	Developmental Screening: Support optimal mental health and social-emotional development of all children.
8	Oral Health: Increase access to oral health services.

In keeping with the national Title V transformation, the DCFH has prioritized annual review of the results of the five-year needs assessment and all ongoing programmatic needs assessment efforts (e.g. environmental scans, surveys, focus groups, formal and informal input from families and stakeholders). This annual review informs efforts to adjust and realign to the direction of the statewide MCH program with shifting population and resource needs. Within Virginia's MCH program, Title V funding serves as the canopy under which a number of complementary federal and state MCH investments and initiatives are administered by the state Title V director (e.g. MIECHV, Title X, Abstinence Grant, Zika).

In FY17, Virginia's three state priorities were refined to better reflect critical needs identified during the annual review. The translation of these priorities into action plan activities is described below.

Revised State Priority: Infant Mortality Disparities
Previous State Priority: Infant Mortality

This is a slight modification to the FY17 focus on infant mortality to more specifically reflect efforts to reduce disparities between African-American and White infant mortality rates in Virginia.

Revised State Priority: Unintended Pregnancy
Previous State Priority: Teen Pregnancy

This is a modification to the FY17 focus on teen pregnancy. Activities will be broadened to include unintended pregnancies among all women of child-bearing age. This reflects efforts to align Title V priorities and metrics with the goals and objectives of the Title X Family Planning Program. Shared priorities with Title X include having a child when a woman is ready, ensuring access to timely medical care, and promoting healthy birth spacing.

Unintended pregnancy is a critical public health issue that may affect the health, social, and economic future of the family. Unintended pregnancies may result in delayed entry into prenatal care and delayed adoption of appropriate pregnancy-related behavior modifications, such as quitting smoking.

Revised State Priority: Maternal Mental Health Screening
Previous State Priority: Maternal Mental Health

This is a slight modification to the FY17 focus on maternal mental health. Research shows that the typical place where women are screened for mental health is at their 6-week postpartum visit. About 42% of women currently return for their 6 week follow-up appointment. Research also shows increasing trends of depression and anxiety among women during pregnancy and the postpartum period (e.g. the American College of Obstetrics and Gynecology, ACOG, position statements on maternal mental health).

Maternal depression impacts not only the health and well-being of pregnant and postpartum women but also that of their children, partners, and other family members. According to 2012-2013 Pregnancy Risk Assessment Monitoring System (PRAMS) data, 10.2% of women delivering a baby in Virginia reported symptoms of postpartum depression. With proper awareness, education, intervention, and access to resources, perinatal mood and anxiety disorders are highly treatable. Increasing adoption of "Screening, Brief Intervention and Referral to Treatment" (SBIRT) models among providers has been identified as a strategic priority.

II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

- NPM 2 - Percent of cesarean deliveries among low-risk first births
- NPM 5 - Percent of infants placed to sleep on their backs
- NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool
- NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19
- NPM 11 - Percent of children with and without special health care needs having a medical home
- NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care
- NPM 13 - A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year
- NPM 14 - A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

During the development of the 2016 Title V application, VDH leadership selected eight of the 15 national performance measures (NPMs) for inclusion in the state Title V plan. Per federal guidance, selection was informed by the FY16-20 priority needs identified during the five-year MCH population needs assessment. Each of the six population domains has at least one corresponding NPM selected. See the state action plan table for a list of national outcome measures (NOMs) associated with each NPM.

During the development of the 2017 Title V application, the state Title V team created one or more evidence-based or evidence-informed strategy measures (ESMs) aligned with each selected NPM. These measures were designed to facilitate tracking the annual impact of VDH programmatic efforts on each NPM.

A review of the ongoing needs assessment efforts is conducted annually. The list of selected NPMs and state-created ESMs is also reviewed and updated during this time to ensure the state Title V plan addresses shifts in MCH population needs.

The eight NPMs selected are presented by priority need and population domain below:

FY16 and FY18 Linkages: NPMs by State Priority and Population Domain

Needs Assessment Priority Area	Selected National Performance Measures	Title V Population Domains	Title V Legislatively-Defined Services
Women/Maternal Health	NPM 2 - Low-Risk Cesarean Delivery: Percent of cesarean deliveries among low-risk first births	Women/Maternal	preventive & primary care services for pregnant women, mothers, and infants up to age one
Breastfeeding **EXPIRES FY18**	NPM 4 – Breastfeeding: A - Percent of infants who are ever breastfed B - Percent of infants breastfed exclusively through 6 months	Perinatal/Infant	
Safe Sleep	NPM 5 - Safe Sleep: Percent of infants placed to sleep on their backs		
Developmental Screening **NEW in FY18**	NPM 6 - Developmental Screening: Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool	Child	preventive and primary care services for children
Physical Activity **EXPIRES FY18**	NPM 8 - Physical Activity: Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day	Child Adolescent	
Child/Adolescent Injury	NPM 7 - Injury Hospitalization: Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19		
Medical Home	NPM 11 - Medical Home: Percent of children with and without special health care needs having a medical home	Children with Special Healthcare Needs	services for children with special healthcare needs
Transition	NPM 12 – Transition: Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care		
Tobacco	NPM 14 – Smoking: A - Percent of women who smoke during pregnancy B - Percent of children who live in households where someone smokes	Life Course / Cross-Cutting	all of above
Oral Health **NEW in FY18**	NPM 13 - Oral Health: A - Percent of women who had a dental visit during pregnancy B - Percent of infants and children, ages 1 through 17 years, who had a preventive dental visit in the last year		

The corresponding ESMs for each NPM are presented by priority need:

FY18 Linkages: NPMs and ESMs by State Priority		
Priority	**NPM**	**ESM**
Women/ Maternal Health	NPM 2 - Low-Risk Cesarean Delivery: Percent of cesarean deliveries among low-risk first births	ESM 2.2 - Completion of a report identifying NTSV data/rates for all Virginia delivering hospitals to identify facilities for C/S reduction/QI interventions
Safe Sleep	NPM 5 - Safe Sleep: Percent of infants placed to sleep on their backs	ESM 5.2 - Number of visits to the SafeSleepVA.com website Active ESM 5.3 - Number of partners who have implemented a quality improvement plan for standardization of safe sleep messaging in their organization
Child/ Adolescent Injury	NPM 7 - Injury Hospitalization: Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19	ESM 7.1 - Proportion of maternity centers with prenatal courses including Virginia's injury prevention curriculum ESM 7.2 - Number of Family Assessment and Planning Teams (FAPT) teams that have incorporated suicide prevention practices into their workflow and/or policies
Developmental Screening	NPM 6 - Developmental Screening: Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool	ESM 6.1 - Number of LHDs, community partners, and providers receiving developmental screening resources, training, and TA ESM 6.2 - Number of individuals (families, providers, community members) accessing social media messaging about the importance of regular developmental screening
Medical Home	NPM 11 - Medical Home: Percent of children with and without special health care needs having a medical home	ESM 11.1 - Number of providers in Virginia who have completed the medical home training module ESM 11.2 - Percentage of VDH CYSHCN who report a primary care provider ESM 11.3 - Percentage of children enrolled in public schools who report a primary care provider
Transition	NPM 12 – Transition: Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care	ESM 12.1 - Number of providers in Virginia who have completed the transition training module
Oral Health	NPM 13 - Oral Health: A - Percent of women who had a dental visit during pregnancy B - Percent of infants and children, ages 1 through 17 years, who had a preventive dental visit in the last year	ESM 13.1 - Completion of action plan identifying strategies and partners for addressing top 3 MCH population oral health needs in Virginia
Tobacco	NPM 14 – Smoking: A - Percent of women who smoke during pregnancy B - Percent of children who live in households where someone smokes	ESM 14.1 - Number of pregnant women who initiate a call to the Quitline ESM 14.2 - Number of pregnant women who complete the Quitline cessation program (10 counseling calls)

II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

- SPM 3 - Infant Mortality Disparity: Infant Mortality Disparity Ratio
- SPM 4 - Unintended Pregnancy: Proportion of females ages 15-44 using Tier 1 (most effective) contraceptive methods
- SPM 5 - Maternal Mental Health Screening: Proportion of women who attend a postpartum visit with a healthcare provider within 6 weeks after giving birth and are screened using an SBIRT tool

To track measures of particular importance to Virginia's MCH priority, the state Title V team created three state performance measures (SPMs). A corresponding state outcome measure (SOM) was created for each SPM.

These measures were included in the annual MCH populations needs review. Minor revisions were made for FY18. See state priorities section for additional details.

Virginia's three SPMs are presented by priority need and population domain below:

FY16 and FY18 Linkages: NPMs by State Priority and Population Domain			
Needs Assessment Priority Area	**Selected National and State Performance Measures**	**Title V Population Domains**	**Title V Legislatively-Defined Services**
Women/Maternal Health	SPM 4 – Unintended Pregnancy: Proportion of women aged 15-44 years using Tier 1 (most effective) method of contraceptive	Women/Maternal	preventive & primary care services for pregnant women, mothers, and infants up to age one
	SPM 5 – Maternal Mental Health Screening: Proportion of women who attend a postpartum visit with a health care provider within 6 weeks after giving birth and are screened using a SBIRT tool		
	SPM 3 – Infant Mortality Disparity Ratio: Ratio of non-white infant mortality rate to white infant mortality rate	Perinatal/Infant	

The corresponding SOMs for each SPM are presented by priority need:

FY18 Linkages: State Priority Needs, SPMs, and SOMs		
Priority	SPM	SOM
Unintended Pregnancy	SPM 4 - Proportion of women aged 15-44 years using Tier 1 (most effective) method of contraceptive	SOM 4 - Rate of unintended pregnancy among all women of child-bearing age
Maternal Mental Health Screening	SPM 5 - Proportion of women who attend a postpartum visit with a health care provider within 6 weeks after giving birth and are screened using a SBIRT tool	SOM 3 - Proportion of women who are educated and/or screened during pregnancy or after delivery about depression by a health care worker
Infant Mortality Disparities	SPM 3 - Ratio of non-white infant mortality rate to white infant mortality rate	SOM 2 - Infant mortality rate

II.F. Five Year State Action Plan

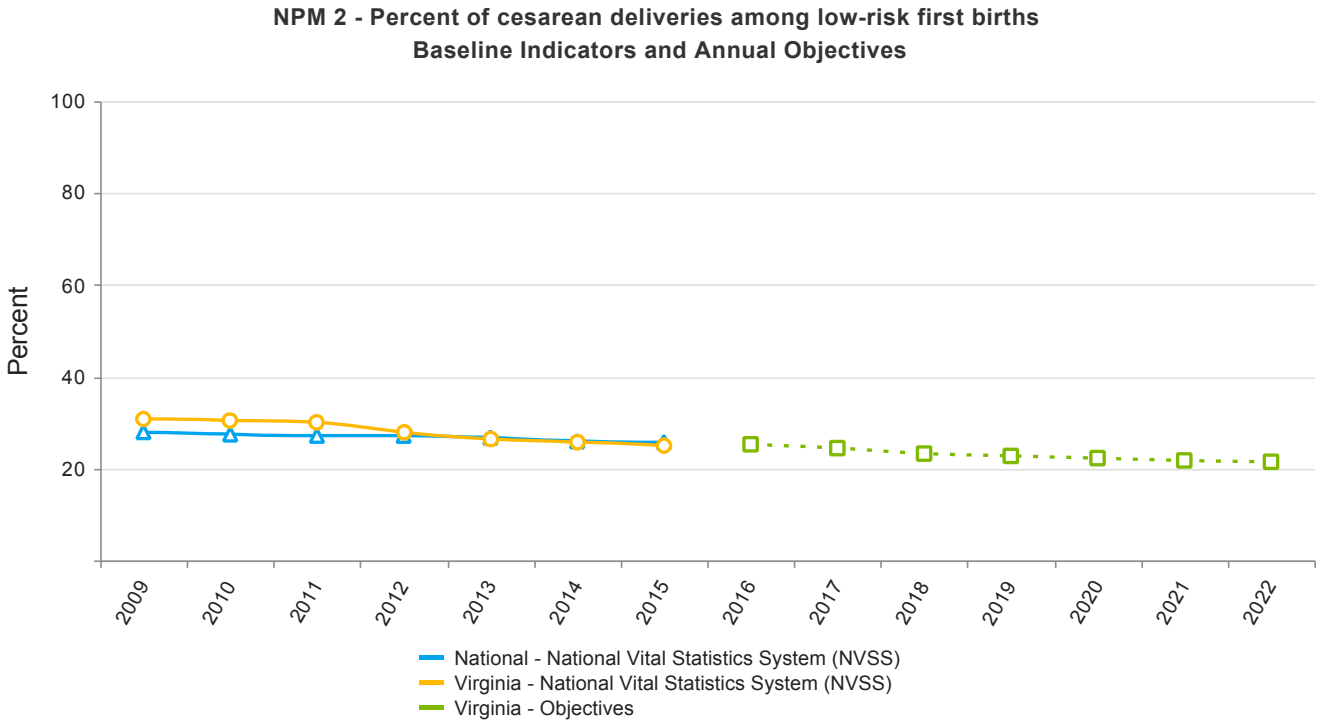
II.F.1 State Action Plan and Strategies by MCH Population Domain

Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2014	155.3	NPM 2
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS	Data Not Available	NPM 2

National Performance Measures



Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2016
Annual Objective	25.3
Annual Indicator	25.1
Numerator	5,664
Denominator	22,588
Data Source	NVSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	24.5	23.3	22.8	22.3	21.8	21.5

Evidence-Based or –Informed Strategy Measures

ESM 2.1 - Proportion of birthing hospitals who have adopted a policy to reduce low risk cesarean deliveries

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	100
Numerator	57
Denominator	57
Data Source	Virginia Healthcare and Hospital Association
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	50.0	65.0	80.0	95.0	100.0	100.0

ESM 2.2 - Completion of a report identifying primary cesarean data/rates for all Virginia delivering hospitals to identify facilities for C/S reduction/QI interventions

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	No	No	No	No	No	Yes

State Performance Measures

SPM 1 - Teen Pregnancy Prevention: Rate of females age 15-19 using most effective contraceptive methods

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	21.7
Numerator	11,662
Denominator	538,332
Data Source	APCD
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	22.0	22.7	23.4	23.9	24.3	25.0

SPM 2 - Maternal Mental Health: Proportion of women who attend a postpartum visit with a health care worker within 6 weeks after getting birth

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	90
Numerator	
Denominator	
Data Source	PRAMS
Data Source Year	2014
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	91.0	91.5	91.9	92.3	92.8	93.0

SPM 4 - Unintended Pregnancy: Proportion of females ages 15-44 using Tier 1 (most effective) contraceptive methods

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	2.6	3.0	3.3	3.5	3.8	4.0

SPM 5 - Maternal Mental Health Screening: Proportion of women who attend a postpartum visit with a healthcare provider within 6 weeks after giving birth and are screened using an SBIRT tool

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	80.0	80.5	81.0	81.5	82.0	82.5

State Action Plan Table

State Action Plan Table (Virginia) - Women/Maternal Health - Entry 1

Priority Need
Woman/Maternal Health: Support the physical and emotional well-being of women and their children.

NPM
Percent of cesarean deliveries among low-risk first births

Objectives
Objective 1: Reduce primary cesarean births by 5% (2020).

Strategies
1. Partner with VHHA to adopt best practices and provide education to labor and delivery hospitals and OB providers.
2. Partner with the Virginia Neonatal Perinatal Collaborative (VNPC) to develop a quality improvement program through safe reduction of primary cesarean births.
3. Partner with insurance companies and DMAS to reduce primary cesarean deliveries by implementing policies supporting a culture that values, promotes, and supports spontaneous onset and progress of labor and vaginal birth and understands the risks for current and future pregnancies of cesarean birth without medical indication.
4. Develop and promote (through organizations such as, ACOG, VHHA, and the VNPC) provider education and training techniques that develop knowledge and skills on approaches which maximize the likelihood of vaginal birth, including assessment of labor, methods to promote labor progress, labor support, pain management, and shared decision making.
5. Continue collaboration with VHHA to maintain low rates of early elective delivery in Virginia.

ESMs	Status
ESM 2.1 - Proportion of birthing hospitals who have adopted a policy to reduce low risk cesarean deliveries	Inactive
ESM 2.2 - Completion of a report identifying primary cesarean data/rates for all Virginia delivering hospitals to identify facilities for C/S reduction/QI interventions	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

State Action Plan Table (Virginia) - Women/Maternal Health - Entry 2

Priority Need

Woman/Maternal Health: Support the physical and emotional well-being of women and their children.

SPM

Maternal Mental Health Screening: Proportion of women who attend a postpartum visit with a healthcare provider within 6 weeks after giving birth and are screened using an SBIRT tool

Objectives

Objective 2: Increase the percentage of postpartum women attending a postpartum visit within 6 weeks by 5% (2020).

Strategies

1. Partner with ACOG, VHHA, AWOHNN, DBHDS, and VNPC to increase use of the SBIRT process to screen for maternal mental health, with special emphasis on education and counseling (e.g. outpatient OB clinics and inpatient facilities).

2. Explore SBIRT as an approach to the delivery of early intervention and treatment for pregnant women with substance use disorders and those at risk of developing these disorders within local health departments.

3. Collaborate with local health departments and community partners to educate women about signs and symptoms of postpartum depression through the use of social media.

4. Partner with DBHDS and other partners to provide training to local health department staff on SBIRT approaches, including referrals to treatment.

State Action Plan Table (Virginia) - Women/Maternal Health - Entry 3

Priority Need

Woman/Maternal Health: Support the physical and emotional well-being of women and their children.

SPM

Unintended Pregnancy: Proportion of females ages 15-44 using Tier 1 (most effective) contraceptive methods

Objectives

Objective 3: Reduce the rate of unintended pregnancies for all women of child-bearing age by 10%.

Strategies

1. Partner with local health districts, healthcare providers, and community partners to increase access to quality family planning services for all women of childbearing age.

2. Collaborate community partners to expand safety net services.

3. Partner with local health districts and community partners to deliver abstinence programs to adolescents.

Women/Maternal Health - Plan for the Application Year

The Division of Child and Family Services' Maternal and Infant Health (MIH) Unit administers a number of programs and initiatives serving women and infants. These programs are managed by the MIH Coordinator (Shannon Pursell, MPH). The unit has a spoke-and-wheel structure consisting of a centralized subject matter expert housed within VDH's Central Office, who works closely with 35 local health districts (LHDs) and an array of state and local community partners.

Maternal and Infant Health Unit

Current Title V MIH priorities include access to prenatal care, tobacco cessation for pregnant women, and addressing the opioid crisis for MCH populations.

Approximately one-quarter of the federal Title V funds is allocated to the 35 LHDs to address locally-identified priorities; each LHD maintains a workplan and reports annually on successes, challenges, and emerging needs. Each LHD is also charged with conducting a community health assessment (CHA) every 5 years. This process includes identifying priorities for MCH populations at the local level. The MIH Coordinator provides technical assistance (TA) to the LHDs to address these priorities and identify appropriate strategies and activities to address them.

In FY17, a statewide survey was conducted asking the LHDs to identify their top five MCH priorities. At this time, the data are being analyzed in preparation for the upcoming five-year grant cycle. This is the first phase of a multidimensional statewide needs assessment.

The MIH Coordinator provides leadership and subject matter expertise to the Virginia Neonatal Perinatal Collaborative (VNPC). The VNPC will be working closely with our regional coordinator at AIM, the Virginia ACOG chapter, and Virginia Hospital and Healthcare Association (VHHA) to implement this project and bring maternal mortality and morbidity to the forefront and address these rising numbers. See Other Programmatic Activities for more detail.

OBJECTIVE 1: Reduce primary cesarean births by 5% (2020).

In FY17, efforts centered on reducing low-risk cesarean births. In February 2017, Virginia was nationally recognized for decreasing early elective deliveries to a rate of 1.3% by late 2016, down from a rate of 8% in late 2012. VDH understands that we must continue our collaboration with March of Dimes (MOD) and VHHA to sustain low rates of early elective delivery.

In FY18, the focus will shift to reducing primary cesarean births that are non-medically indicated. Rates vary across the Commonwealth, but some hospitals have cesarean rates as high as 40%. Research shows that cesarean births result in higher mortality and morbidity rates for both mothers and neonates. Collaborators will include the VNPC, MOD, and VHHA.

OBJECTIVE 2: Increase the percentage of postpartum women attending a postpartum visit within 6 weeks and who are screened using an SBIRT tool by 5% (2020).

Increasing the number of providers providing screenings using a "Screening, Brief Intervention and Referral to Treatment" (SBIRT) approach has been identified as a key strategic priority in Virginia. See State Priorities for

additional detail.

For FY18, six of the 35 LHDs have selected improving post-partum visits as a district priority. Staff will maintain a partnership with March of Dimes, supporting several Centering Pregnancy and Baby Basic sites statewide in promoting the importance of attending a post-partum visit and working with training providers to screen for mental health using a SBIRT approach.

OBJECTIVE 3: Reduce rate of unintended pregnancies for all women of child-bearing age.

Seventeen LHDs identified unintended pregnancy as one of their MCH priorities for FY18. By identifying this priority, they have committed to working with healthcare providers and community partners to promote use of the CDC Reproductive Health Plan to encourage women to think about and plan when a family is right for them. In addition, LHDs will provide abstinence education programs.

VDH will collaborate with FQHCs and LHDs to expand safety net services within their communities and promote through social media and professional organizations (ACOG, VNPC, VHHA, MOD) about available family planning services and the importance of a reproductive health plan to identify when she would like to have a child.

Due to the unbundling of LARCs on January 1, 2017, for all Medicaid patients, the state workgroup has identified additional barriers to improve access to LARCs immediately postpartum. The state workgroup plans to work with private payers to unbundle their codes.

In FY16, the state Title V director established and filled the Maternal and Infant Health (MIH) Coordinator position. This enabled resources to be focused in the area of maternal health, including building partnerships, conducting an environmental scan of maternal clinical services, overseeing statewide communications campaigns, and laying the foundation for the maternal health unit to meet Title V objectives. This position also manages agreements with and provides technical assistance to 35 LHDs throughout the state. The MIH Coordinator also serves on the Maternal Health Advisory Committee, which is chaired by the VDH Medical Director.

NPM 2 - Low-Risk Cesarean Delivery: Percent of cesarean deliveries among low-risk first births

Program Activities/Partnerships

In FY16, the MIH Coordinator collaborated with MOD and VHHA on efforts to decrease low-risk cesarean deliveries.

ESM 2.1 - Proportion of birthing hospitals who have adopted a policy to reduce low risk cesarean deliveries

VHHA completed review of 100% of Virginia's 57 birthing hospitals to ensure that an early elective delivery policy was in place, thus resulting in a decrease of early elective delivery rates 8% in late 2012 to 1.3% by late 2016. The 2020 national goal for early elective delivery is 2%; Virginia received national recognition for decreasing early elective deliveries in February of 2017. In light of this success, this ESM was removed for FY16.

SPM 1 - Proportion of women aged 15-44 years using Tier 1 (most effective) method of contraceptive
SOM 1 - Rate of unintended pregnancy among all women of child-bearing age

These measures were changed from addressing only teen pregnancy (15-19) to include women of all childbearing age.

Program Activities/Partnerships

In FY16, in partnership with VHHA, MOD, DMAS, academic universities, and other community partners, a task force was created based on the need to address the low access rate to most effective contraceptive methods such as long-acting reversible contraceptives (LARCs). The group submitted a white paper addressing needs and recommendations. The low-hanging fruit that was identified was the bundled code among both commercial and Medicaid payers. Thus, providers were not recommending LARCs for immediate postpartum insertion. The group began working with both payers to address unbundling.

SPM 2 - Proportion of women who attend a postpartum visit with a health care provider within 6 weeks after giving birth and are screened using a SBIRT tool
SOM 2 - Proportion of women who are educated and/or screened during pregnancy or after delivery about depression by a health care worker

Program Activities/Partnerships

The MIH Coordinator partnered with MOD to train LHD staff to implement Baby Basics and Centering Pregnancy.

The curricula for both programs include education about postpartum depression. LHDs also worked with community partners to increase awareness of opportunities to participate in Baby Basics.

Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	5.7	NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	1.9	NPM 5
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2014	101.7	NPM 5

National Performance Measures

NPM 5 - Percent of infants placed to sleep on their backs
Baseline Indicators and Annual Objectives

FAD for this measure is not available for the State.

State Provided Data	
	2016
Annual Objective	78.5
Annual Indicator	80.2
Numerator	
Denominator	
Data Source	PRAMS
Data Source Year	2013
Provisional or Final ?	Final

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	81.0	82.0	83.0	84.0	85.0	86.0

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - Proportion of partnering hospitals who have implemented a standardized safe sleep curriculum

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	7
Numerator	4
Denominator	57
Data Source	Office of Family Health Services, VDH
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	10.0	15.0	20.0	25.0	30.0	35.0

ESM 5.2 - Number of visits to the SafeSleepVA.com website

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	150.0	200.0	250.0	300.0	350.0	400.0

ESM 5.3 - Number of partners who have implemented a quality improvement plan for standardization of safe sleep messaging in their organization

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	5.0	7.0	10.0	12.0	15.0	25.0

State Performance Measures

SPM 1 - Teen Pregnancy Prevention: Rate of females age 15-19 using most effective contraceptive methods

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	21.7
Numerator	11,662
Denominator	538,332
Data Source	APCD
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	22.0	22.7	23.4	23.9	24.3	25.0

SPM 2 - Maternal Mental Health: Proportion of women who attend a postpartum visit with a health care worker within 6 weeks after getting birth

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	90
Numerator	
Denominator	
Data Source	PRAMS
Data Source Year	2014
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	91.0	91.5	91.9	92.3	92.8	93.0

SPM 3 - Infant Mortality Disparity: Infant Mortality Disparity Ratio

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	1.7
Numerator	7.8
Denominator	4.7
Data Source	Virginia Department of Health
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.6	1.5	1.4	1.3	1.2	1.0

State Action Plan Table

State Action Plan Table (Virginia) - Perinatal/Infant Health - Entry 1

Priority Need

Safe Sleep: Increase safe sleep practices.

NPM

Percent of infants placed to sleep on their backs

Objectives

Objective 1: Increase the percentage of infants placed in a safe environment to sleep by 10% (2020).

Strategies

1. Partner with Virginia Home Visiting Consortium, local health districts, March of Dimes, and community partners to provide standard messaging through promotion of SafeSleepVA.com, technical assistance, and resources to reduce sleep related deaths among infants.

2. In partnership with the Division of Population Health Data, conduct an internal and external programmatic environmental scan of current safe sleep activities statewide and ensure all activities are consistent with evidence-based safe sleep messages.

3. Develop a quality improvement plan based on a framework of Plan-Do-Study-Act (PDSA) cycle models, in the standardization of safe sleep messaging among partners listed above.

ESMs	Status
ESM 5.1 - Proportion of partnering hospitals who have implemented a standardized safe sleep curriculum	Inactive
ESM 5.2 - Number of visits to the SafeSleepVA.com website	Active
ESM 5.3 - Number of partners who have implemented a quality improvement plan for standardization of safe sleep messaging in their organization	Active

NOMs

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

State Action Plan Table (Virginia) - Perinatal/Infant Health - Entry 2

Priority Need

Woman/Maternal Health: Support the physical and emotional well-being of women and their children.

SPM

Infant Mortality Disparity: Infant Mortality Disparity Ratio

Objectives

Objective 2: Eliminate the racial/ethnic disparities in Virginia's infant mortality rates (2020).

Strategies

1. Collaborate with community partners (e.g. Virginia Commonwealth University) to expand the number of safety net providers for maternity care services to vulnerable populations.

2. Partner with MIECHV and Healthy Start to increase utilization of evidence-based home visiting models in Virginia to support optimal pregnancy outcomes and infant health.

3. Continue to partner with the Office of the Chief Medical Examiner to identify strategies to address infant mortality.

4. Partner with the VNPC to promote healthy pregnancies, improve access to care and improve birth outcomes for both moms and babies through the support of all birth hospitals across Virginia, March of Dimes, ACOG, AAP, and several other community partners and professional organizations.

5. Continue to work with other safety net providers to promote breastfeeding, smoking cessation, and utilization of most effective contraceptive methods.

Perinatal/Infant Health - Plan for the Application Year

The Division of Child and Family Services' Maternal and Infant Health (MIH) Unit administers a number of programs and initiatives serving women and infants. These programs are managed by the MIH Coordinator (Shannon Pursell, MPH). The unit has a spoke-and-wheel structure consisting of a centralized subject matter expert housed within VDH's Central Office, who works closely with 35 local health districts (LHDs) and an array of state and local community partners.

Maternal and Infant Health Unit

Current Title V priorities for maternal and infant health include access to prenatal care, tobacco cessation for pregnant women (also a priority for the Cross-Cutting domain), and addressing the opioid crisis for MCH populations.

Approximately one-quarter of the federal Title V funds is allocated to the 35 LHDs to address locally-identified priorities; each LHD maintains a workplan and reports annually on successes, challenges, and emerging needs. Each LHD is also charged with conducting a community health assessment (CHA) every 5 years. This process includes identifying priorities for MCH populations at the local level. The MIH Coordinator provides guidance and technical assistance (TA) to the LHDs to address these priorities and craft appropriate strategies and activities to address them.

In FY17, a statewide survey was conducted asking the LHDs to identify their top five MCH priorities. At this time, the data are being analyzed in preparation for the upcoming five-year grant cycle. This is the first phase of a multidimensional statewide needs assessment.

OBJECTIVE 1: Increase the percentage of infants placed in a safe environment to sleep by 10% (2020).

In FY18, the MIH Coordinator will provide TA to LHDs that have identified safe sleep as one of their top five local priorities. Activities will include staff education, community outreach, and capacity-building to promote safe sleep practices.

The MIH Coordinator will continue to partner with Virginia Home Visiting Consortium, local health districts, March of Dimes, and community partners to standardize safe sleep messaging through SafeSleepVA.com (a statewide website featuring resources for reducing sleep-related deaths) as well as implement other health communications strategies (e.g. online newsletters, conferences, meetings).

In addition, MIH staff will coordinate with the MIECHV-funded Early Childhood Unit (ECH) to conduct an internal and external programmatic environmental scan of current safe sleep activities statewide and ensure all activities are consistent with evidence-based safe sleep messages.

Continuous quality improvement (CQI) is an important component of all of Virginia's MCH programs. The ECH Unit has a dedicated CQI subject matter expert who will assist Title V staff with developing a quality improvement plan based on a Plan-Do-Study-Act cycle model to improve the safe sleep initiative.

In FY17, two new ESMs were developed to reflect input received from partners and stakeholders on this objective:

- ESM 5.1 - Number of visits to the SafeSleepVA.com website
- ESM 5.2 - Proportion of partners who have implemented a quality improvement plan for standardization of

safe sleep messaging in their organization

OBJECTIVE 2: Eliminate the racial/ethnic disparities in Virginia's infant mortality rates by 2020.

FY17 activities related to infant mortality reduction, particularly concerning disparities in African-American infant mortality when compared to the White infant mortality rate, will continue in FY18 due to the high level of interest from partners and stakeholders and ongoing family engagement in the strategies outlined in the action plan. These efforts are aligned with the Virginia Plan for Well-Being.

The MIH Coordinator will collaborate with community partners to expand the number of safety net providers of prenatal care services to vulnerable populations. For example, VDH will partner with VCU to facilitate referrals for maternity care in central Virginia. The coordinator will partner with the VNPC to promote healthy pregnancies, improve access to care and improve birth outcomes for both moms and babies through the support of all birth hospitals across Virginia, March of Dimes, ACOG, AAP, and several other community partners and professional organizations.

VDH MCH staff will partner with MIECHV and Healthy Start to increase utilization of evidence-based home visiting models in Virginia to support optimal pregnancy outcomes and infant health. VDH’s ongoing partnership with OCME and the Infant Mortality Review Committee to monitor infant mortality, examine leading causes of infant deaths, and determine statewide strategies for infant mortality reduction will continue.

Perinatal/Infant Health - Annual Report

In FY16, the state Title V director established and filled the Maternal and Infant Health (MIH) Coordinator position. This enabled resources to be focused in the area of perinatal health, including building partnerships, conducting an environmental scan of prenatal clinical services, overseeing statewide communications campaigns, and laying the foundation for the perinatal health unit to meet Title V objectives. This position also manages agreements with and provides technical assistance to 35 LHDs throughout the state. The MIH Coordinator also serves on the Maternal Health Advisory Committee, which is chaired by the VDH Medical Director.

NPM 5 - Safe Sleep: Percent of infants placed to sleep on their backs

Program Activities/Partnerships

A large network of diverse partners, including LHDs, collaborated to determine best practices regarding education and outreach for providers and families on safe sleep practices. This network included hospitals, AAP, home visiting programs, community-based organizations, and family representatives.

Almost half of Virginia's LHDs identified safe sleep as a local MCH priority and were engaged in community outreach and education. For example, AAP materials were distributed to pediatricians and licensed daycare providers across the state.

ESM 5.1 - Proportion of partnering hospitals who have implemented a standardized safe sleep curriculum

VDH staff partnered with VHHA for this effort. Of the 57 birthing hospitals in Virginia, 4 have adopted a standardized safe sleep curriculum to date. These 4 hospitals were members of a single health system. Other health systems in the state have their own educational materials already developed and were resistant to changing curricula. For this reason, this ESM has been discontinued for FY17.

NPM 4 - Breastfeeding: A - Percent of infants who are ever breastfed, B - Percent of infants breastfed exclusively through 6 months

Program Activities/Partnerships

Most of VDH's breastfeeding efforts were coordinated through the Virginia Maternity Quality Improvement Collaborative, which included representatives from the major health systems as well as lactation consultants and OB/GYNs.

VDH also maintained an online breastfeeding training module for providers through the University of Virginia and offered continuing education credits (CEUs) for Virginia providers at no cost. Providers from other states were able to take the course but paid a fee per CEU. The module was promoted to Virginia providers through avenues such as online newsletters and other professional education channels.

ESM 4.1 - Proportion of hospital based maternity centers with Virginia Breastfeeding Friendly designation

In FY16, the committee met twice to review very comprehensive applications from approximately a dozen individual hospitals (i.e. some hospitals were independent, while others were associated with larger hospital systems). At least

six hospitals received at least one star for recognition of hospital breastfeeding best practices, including patient education and support, availability of lactation consultants, nursing education, etc.

ESM 4.2 - Proportion of Virginia WIC breastfeeding coordinators certified as IBCLC/CLCs

In FY16, VDH's Division of Community Nutrition underwent staffing and leadership transitions, resulting in competing strategic priorities for the WIC breastfeeding program. The WIC Breastfeeding Coordinator position was vacant for much of the grant year. As a result, this ESM was discontinued. In FY17, the Title V team assumed leadership of breastfeeding promotion efforts, as reflected in the updated state action plan.

SPM 3 - Ratio of non-white infant mortality rate to white infant mortality rate
SOM 3 - Infant mortality rate

Title V funds supported MCH surveillance related to improving maternal and birth outcomes, including infant mortality disparities.

Program Activities/Partnerships

In FY16, the General Assembly requested an infant mortality study and environmental scan of current and ongoing efforts across the state related to infant mortality. This study highlighted areas to be strengthened through partnerships with academic universities and other community partners significant to moving the needle. It also identified regions of the state with poorer outcomes and recommendations were made specific to those regions to improve maternal and infant health.

Based on these findings, changes were made throughout the FY18 action plan to align the recommendations from the study. For example, VDH efforts to promote smoking cessation, early prenatal care, and other best practices.

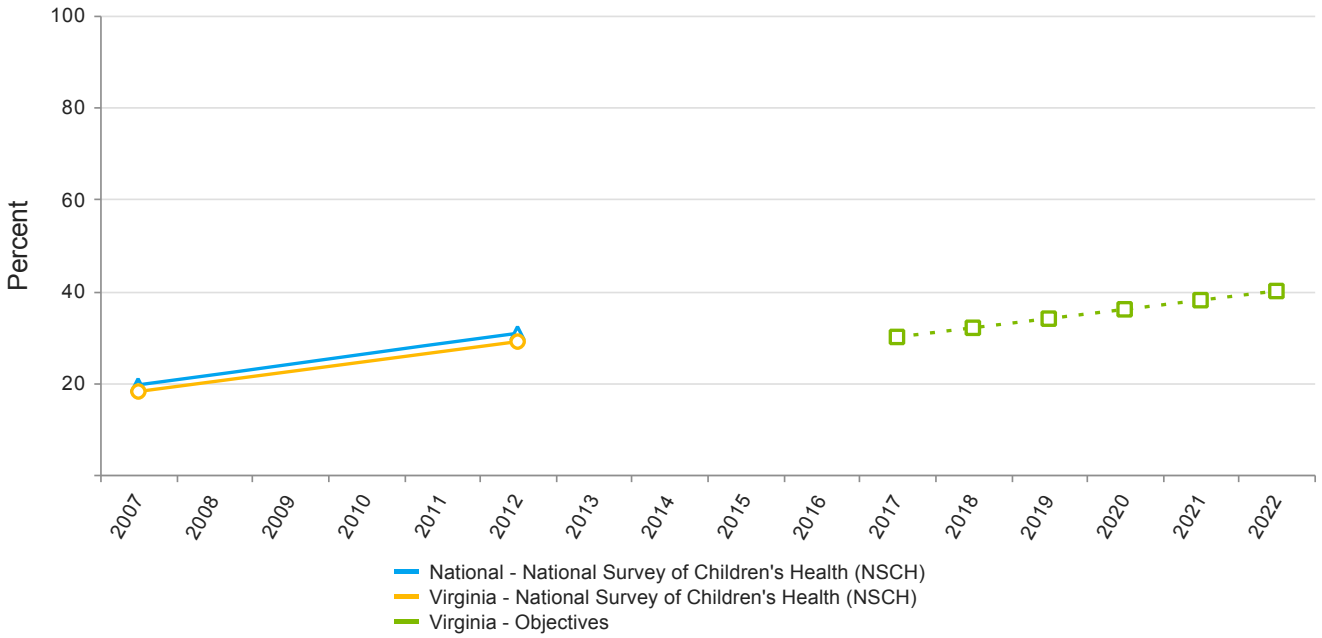
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available	NPM 6
NOM 15 - Child Mortality rate, ages 1 through 9 per 100,000	NVSS-2015	17.5	NPM 7
NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000	NVSS-2015	29.5	NPM 7
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000	NVSS-2013_2015	9.8	NPM 7
NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000	NVSS-2013_2015	9.1	NPM 7
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	89.2 %	NPM 6

National Performance Measures

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool
Baseline Indicators and Annual Objectives



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	
Annual Indicator	29.1
Numerator	143,283
Denominator	491,741
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	30.0	32.0	34.0	36.0	38.0	40.0

Evidence-Based or –Informed Strategy Measures

ESM 6.1 - Number of LHDs, community partners, and providers receiving developmental screening resources, training, and TA

Measure Status:	Active

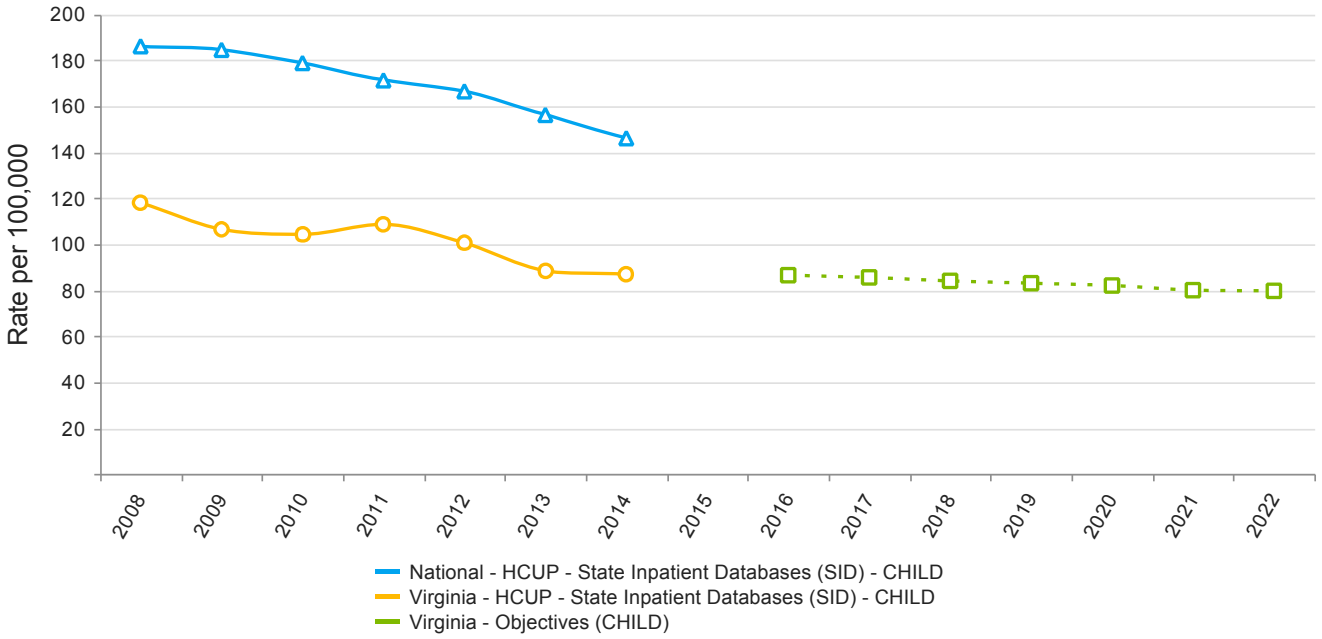
Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	7.0	15.0	20.0	25.0	35.0	50.0

ESM 6.2 - Number of individuals (families, providers, community members) accessing social media messaging about the importance of regular developmental screening

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	100.0	125.0	200.0	250.0	300.0	350.0

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19
Baseline Indicators and Annual Objectives



NPM 7 - Child Health

Federally Available Data	
Data Source: HCUP - State Inpatient Databases (SID) - CHILD	
	2016
Annual Objective	86.5
Annual Indicator	87.0
Numerator	899
Denominator	1,033,738
Data Source	SID-CHILD
Data Source Year	2014

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	85.5	84.0	83.0	82.0	80.0	79.7

Evidence-Based or –Informed Strategy Measures

ESM 7.1 - Proportion of maternity centers with prenatal courses including Virginia's injury prevention curriculum

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Office of Family Health Services, VDH
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	15.0	20.0	25.0	30.0	35.0

ESM 7.2 - Number of Family Assessment and Planning Teams (FAPT) teams that have incorporated suicide prevention practices into their workflow and/or policies

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	10.0	25.0	50.0	75.0	90.0	100.0

State Action Plan Table

State Action Plan Table (Virginia) - Child Health - Entry 1

Priority Need

Child/Adolescent Injury: Reduce injuries, violence, and suicide among Title V populations.

NPM

Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Objectives

Objective 1: Develop and disseminate a childhood injury prevention curriculum for use in prenatal education courses conducted by maternity hospitals, birthing centers, and comprehensive case management programs for vulnerable populations (2020).

Strategies

1. Collaborate with state and local partners to develop an injury prevention curriculum for use in prenatal education courses conducted by maternity hospitals, birthing centers, and comprehensive case management programs for vulnerable populations.

2. Conduct ongoing surveillance of hospitalizations among children ages 0 to 9.

ESMs	Status
ESM 7.1 - Proportion of maternity centers with prenatal courses including Virginia's injury prevention curriculum	Active
ESM 7.2 - Number of Family Assessment and Planning Teams (FAPT) teams that have incorporated suicide prevention practices into their workflow and/or policies	Active

NOMs

NOM 15 - Child Mortality rate, ages 1 through 9 per 100,000

NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

State Action Plan Table (Virginia) - Child Health - Entry 2

Priority Need

Developmental Screening: Support optimal mental health and social-emotional development of all children.

NPM

Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Objectives

Objective 2: Increase the number of children screened with a parent administered tool by 10% (2020).

Strategies

1. Explore training and support needs for developmental screening tools and referrals for Virginia's 35 local health districts.

2. Conduct asset mapping to identify a subset of a high risk population to develop a pilot screening project site (e.g. Native American community, churches).

3. Provide messages for families and the community about the importance of ongoing screening and monitoring of child development using social media.

4. Develop a report on current Virginia developmental screening practices with recommendations for provider, family, and community needs for evidence-based services.

ESMs	Status
ESM 6.1 - Number of LHDs, community partners, and providers receiving developmental screening resources, training, and TA	Active
ESM 6.2 - Number of individuals (families, providers, community members) accessing social media messaging about the importance of regular developmental screening	Active

NOMs

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

NOM 19 - Percent of children in excellent or very good health

Child Health - Plan for the Application Year

The Division of Child and Family Services' Early Childhood Health (ECH) Unit administers an array of programs and initiatives serving children ages 0 to 9. The Division of Prevention and Health Promotion's Injury and Violence Prevention (IVP) Program is a strong Title V collaborator.

OBJECTIVE 1: Develop and disseminate a childhood injury prevention curriculum for use in prenatal education courses conducted by maternity hospitals, birthing centers, and comprehensive case management programs for vulnerable populations (2020).

Injury and Violence Prevention Program

The IVP Program supports promising and best practice activities at the local level that address leading or emerging injury issues. In FY18, the IVP Program Supervisor will continue to support efforts to address broad child injury mechanisms and to implement the strategies noted in the action plan. Efforts will focus on capacity-building (particularly regarding staffing), sustaining and expanding service delivery, and policy. All activities were selected based on insight from stakeholder meetings.

Unintentional injuries continue to be a leading cause of death in the US and Virginia. Although death is the most severe result of injury, it represents only part of the problem. The majority of those who incur injuries survive, and often endure life-long mental, physical, and financial problems as a result of prolonged rehabilitation, hospitalization, loss of productivity, or stress to victim, family, and other caregivers. Despite its immense burden, injuries are largely preventable. Per the socioecological model, the IVP will aim to implement multi-level interventions (e.g. individual, relationship, community, societal) in order to effectively move the needle.

Parents and caregivers of newborns and infants are readily engaged to receive injury prevention education and represent an opportunity to make lasting improvement in the safety behaviors and practices that impact a child's environment.

The misuse of prescription opiates among women of childbearing age is a major concern. Rates of Neonatal Abstinence Syndrome (NAS) have increased 2.8-fold since 2005, corresponding with increases in maternal opioid use. Marked by hypersensitivity to stimuli and autonomic hyperfunction, NAS-effected infants can display physical manifestations, such as excessive crying and the inability to be consoled. Such symptoms often present challenges to the substance-abusing or recovering parent or caregiver. A caregiver that does not practice positive parenting techniques may place their infant at significant risk for child maltreatment and intentional injury (e.g. Shaken Baby Syndrome). In addition, unintentional injuries can occur while caregivers are under the influence of substances. The Virginia Child Fatality Review Team reported that 15% of mothers of an infant who died in 2009 from a sleep-related death while co-sleeping were prescribed a Schedule II or III narcotic post-birth and showed evidence of substance abuse during pregnancy.

In FY18, the Injury and Violence Prevention Program will continue efforts on Project Patience, an initiative supporting statewide delivery of prenatal and postpartum education on child maltreatment and infant injury prevention. Project Patience focuses on providing technical assistance to maternity hospitals and community comprehensive maternity case management programs. Priority populations include mothers of NAS infants and pregnant women at risk for or with a history of addiction. The goals are to engage, inform, and educate key stakeholders and to leverage infrastructure partnerships to address child maltreatment and injury prevention among substance-exposed infants.

A key planned activity is the dissemination of a childhood injury prevention curriculum designed for use during prenatal classes at maternity centers. The curriculum was designed in FY16 and informed by insights from stakeholder meetings. The content is inclusive of children with special health care needs and newborns exposed to controlled, illicit, or legal altering substances. This activity will leverage existing partnerships to improve access to injury prevention education and promote workforce competency in injury prevention best practices.

OBJECTIVE 2: Increase the number of children screened with a parent-administered tool by 10% (2020).

Developmental screening represents an emerging priority for the state Title V program. Two ESMs have been developed to reflect planned FY18 efforts aligned with this priority, as discussed under the *Program Activities/Partnerships* heading below. These efforts are jointly expected to support implementation of the Bright Futures guidelines and to encourage a more comprehensive, coordinated approach to providing pediatric care at the community level.

Developmental Screening as a State Priority

VDH's Plan for Well-Being prioritizes investing in the health, education, and development of Virginia's children. Among the key strategies outlined in the Plan for giving children a strong start are: (1) increasing developmental screening for childhood milestones and delays; and (2) expanding programs that help families affected by ACEs, toxic stress, domestic violence, mental illness, and substance abuse to create safe, stable, nurturing environments.

According to a report by the University of Virginia's Curry School of Education, one in three children in Virginia is not prepared to succeed in the areas of self-regulation, social skills, literacy, and/or math at the beginning of kindergarten. Being developmentally ready to learn and participate in classroom activities not only sets the stage for successful school entry but can have lifelong influence on well-being. The report found that "children who enter kindergarten behind their peers rarely catch up; instead, the achievement gap widens over time." Investing in programs that prepare children to succeed in school and facilitate early intervention for those requiring additional support helps to prevent them from falling behind and experiencing poor educational outcomes, such as dropping out of high school.

The earliest years of life represent vulnerability as well as promise. From the time they are born and until the time they enter school, children's brains undergo dramatic development. They acquire the ability to think, speak, learn, and reason. Early experiences form the foundation and the scaffold upon which to build additional skills throughout life. Positive, nurturing relationships with parents and other key caregivers during this period are critical for healthy growth and development.

Violence, neglect, social and economic hardships, negative family and community environments, and other sources of trauma negatively impact the mental and physical health of children and have lasting effects into adulthood. Toxic stress can trigger hormones that wreak havoc on the brains and bodies of children, increasing their lifetime risk for disease, homelessness, and early death. Seven out of ten leading causes of death are linked to adverse childhood experiences (ACEs).

The Plan for Well-Being recognizes the importance of supporting children's social and emotional health and prioritizes working with healthcare providers, social services, community organizations, childcare providers, and other partners to increase the number of providers and educators who screen for adverse childhood events (ACEs) and are trained in using a trauma-informed approach to care.

Program Activities/Partnerships

ESM 6.1 – Number of LHDs, community partners, and providers receiving developmental screening resources, training, and TA

At the local level, LHDs serve as a safety net for providing child health physicals and developmental screenings and play a key role in linking families to community resources to ensure continuity of care. In FY18, ECH staff will provide statewide training, technical assistance, and resources to LHD nurses that provide such services. Efforts will focus on sustaining and expanding the number of LHD staff that have up-to-date knowledge and skills to provide developmental screenings using the revised ASQ3 and ASQSE2.

In FY17, each LHD was provided with copies of the fourth edition of the Bright Futures Guidelines and accompanying reference materials. ECH staff have also conducted trainings on Bright Futures and ASQ tools for LHD staff. Sustaining the number of trained LHD staff is a priority. Ongoing FY18 trainings will not only allow for continued technical assistance and support but also help to prevent loss of staff knowledge and capacity due to turnover.

Future activities may include: exploring billing practices for developmental screening reimbursement; exploring the feasibility of allotting a minimum thirty minutes of clinic time to working with each family to complete, score, and review results of screening tools; and ensuring LHD staff are equipped to link families to community resources for follow-up and referrals, as needed.

VDH ECH staff will also continue to participate in critical interagency initiatives related to developmental screening. For example, the Early Childhood Mental Health Advisory Board is a statewide multi-agency, multidisciplinary stakeholder group tasked with addressing infant and child mental health issues in Virginia. All key state agencies serving infants and children are represented, with multiple staff participating on behalf of each agency's various programs. Since its inception, the number of agencies represented has grown from four agencies to 24 agencies. Among the interests represented are advocacy, social services, health, education, behavioral health, early intervention, and parents/families. Early childhood special education professionals and clinical providers also offer input, including a psychologist, a pediatrician, and various rehabilitation associates (e.g. occupational, speech, and physical therapists).

ESM 6.2 – Number of individuals (families, providers, community-at-large) accessing social media messaging about the importance of regular developmental screening

To date, VDH efforts have focused on providing messaging and education to providers. Family-focused efforts have been largely limited to families of CSHCN. However, a number of partners are currently working together to educate parents on the importance of well-child visits. In FY18, ECH staff will work to expand engagement and education efforts to families of children with and without special healthcare needs.

Promotion of the *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents* to LHD staff and external providers will continue. Efforts will include development and dissemination of messaging to providers via channels such as electronic newsletters and the VDH website. In addition, ECH staff will develop and disseminate social media messaging targeting families and community members on the importance of regular developmental screening. The OFHS Communications team will provide support and expertise.

The Division of Child and Family Services' Early Childhood Health (ECH) Unit administers an array of programs and initiatives serving children ages 0 to 9.

In FY16, the Division of Prevention and Health Promotion's Injury and Violence Prevention (IVP) Program and Chronic Disease Unit (CDU) were strong Title V collaborators. Each utilized Title V funds to complement other federal and state funding streams to serve MCH populations.

NPM 7 - Injury Hospitalization: Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Program Activities/Partnerships

The IVP Program Supervisor leveraged Title V funds, along with state revenue funds and other federal funds, to oversee the development, implementation, and evaluation of various statewide injury prevention programs.

The proper use of child safety seats and booster seats is required for all children under the age of eight by Virginia Code 46.2-1095. Pursuant to VA code 46.2-1098, VDH coordinated the Low-Income Safety Seat Distribution and Education Program (LISSDEP) to provide safety seats through a network of 152 dissemination sites statewide to indigent families through revenue derived from fines collected from violations of the CPS law. LISSDEP helps to remove financial barriers and increase access to safety devices and proper education for reducing motor vehicle-related injuries. In FY16, local health departments operating as LISSDEP distribution leveraged funding from the *Child Restraint Special Device Fund* and *Federal Highway Safety Fund* with Title V funds to support program coordination. Child safety seats and booster seats were provided to income-eligible families that were on LISSDEP waitlists. Through a combination of federal, state, and Title V funds, a total of 9,412 safety seats were distributed. In addition, child passenger safety education was provided to indigent families that addressed the proper usage and installation of safety seats.

The Injury and Violence Epidemiologist worked in partnership with Title V-supported epidemiologists and evaluators to maintain the Virginia Online Injury Reporting System (VOIRS), which provides the public with data on deaths and hospitalizations attributable to injury. VOIRS allows quick and easy access to basic injury data and enables users to customize data reports on various types of injury hospitalizations and deaths. Data are available for both intentional and unintentional injuries, and some demographic and geographic information is included to allow for more detailed analysis. The Injury and Violence Epidemiologist routinely responded to data requests from constituents that could not be addressed through the VOIRS system.

ESM 7.1 - Proportion of maternity centers with prenatal courses including Virginia's injury prevention curriculum

In FY16, the IVP program leveraged Title V funds to enhance *Preventive Health and Health Services Block Grant*-funded efforts to design a hospital prenatal curriculum. This effort was developed as part of a planned injury prevention education and technical assistance package for maternity hospitals. The curriculum is designed for expectant parents, new parents, and caregivers. The content addresses critical injury mechanisms and includes strategies for reducing injuries and deaths related to sleep, motor vehicles, falls, drowning, products, and fires.

NPM 8 - Physical Activity: Percent of children ages 6 through 11 who are physically active at least 60

minutes per day

Program Activities/Partnerships

Efforts to promote healthy eating and active living among children and adolescents are housed within the VDH CDU. The Child and Adolescent Wellness Coordinator (Kate Alie, MS, RDN, Pn1) serves as the subject matter expert for these efforts. The program is managed by the Chronic Disease Manager (Kathy Rocco, MPH, RDN) and the Healthy Communities Supervisor (Melicent R. Miller, MSPH).

ESM 8.1 - Number of students enrolled in targeted public schools where staff received professional development or technical assistance in physical activity

In FY16, VDH CDU staff provided professional development and technical assistance (TA) to 172 staff from early care and education (ECE) programs and K-12 schools. These staff represent over 86,000 enrolled students across 9 targeted school divisions.

ECE Programs: Through funding provided by the Centers for Disease Control and Prevention's 1305 Cooperative Agreement, VDH worked with key partners, including Child Care Aware of Virginia and Virginia Early Childhood Foundation, to recruit 124 ECE programs into the Go NAP SACC program. Go NAP SACC is an online platform designed to build healthy eating and physical activity habits in children. Of the 124 ECE programs recruited, 107 programs completed online pre- and -post self-assessments and created goals and action plans related to "Infant & Child Physical Activity" or "Outdoor Play & Learning." These 107 programs represent 4,635 children. Additionally, 65 of the 124 ECE programs completed pre- and post-self-assessments and created goals and actions plans related to "Screen Time," representing 2,622 children impacted.

Partnership results included:

- A 14.2% increase in best practice scores among those programs completing both pre- and post- physical activity assessments;
- Fifty-two (52) ECE programs participated in four (4) hours of professional development focusing on obesity prevention and nutrition and physical activity best practices; and
- The 107 programs who completed both online pre- and post-self-assessments and created goals and action plans also received consistent TA throughout the fiscal year, totaling 321 hours of TA provided, or 3 TA hours per ECE.

K-12 Schools: VDH also provided professional development and TA to nine (9) Local Education Agencies (LEAs) on wellness policy updates, the creation of School Health Advisory Boards, and the promotion of physical education and physical activity in schools.

Partnering organizations included the Virginia Department of Education, Virginia Cooperative Extension Family Nutrition Program/SNAP-Ed, Virginia Foundation for Healthy Youth, Focused Fitness, Alliance for a Healthier Generation, and Action for Healthy Kids. Through the creation of updated policies and programs, VDH worked with its partners to create sustainable improvements to the physical activity environments in LEAs.

These partnerships resulted in:

- Virginia Cooperative Extension Family Nutrition Program/SNAP-Ed agents providing 62.5 hours of professional development and TA related to physical education and physical activity, or approximately 4.5 hours per LEA;

- Focused Fitness providing 15 hours of professional development to health and physical education teachers from six (6) LEAs.

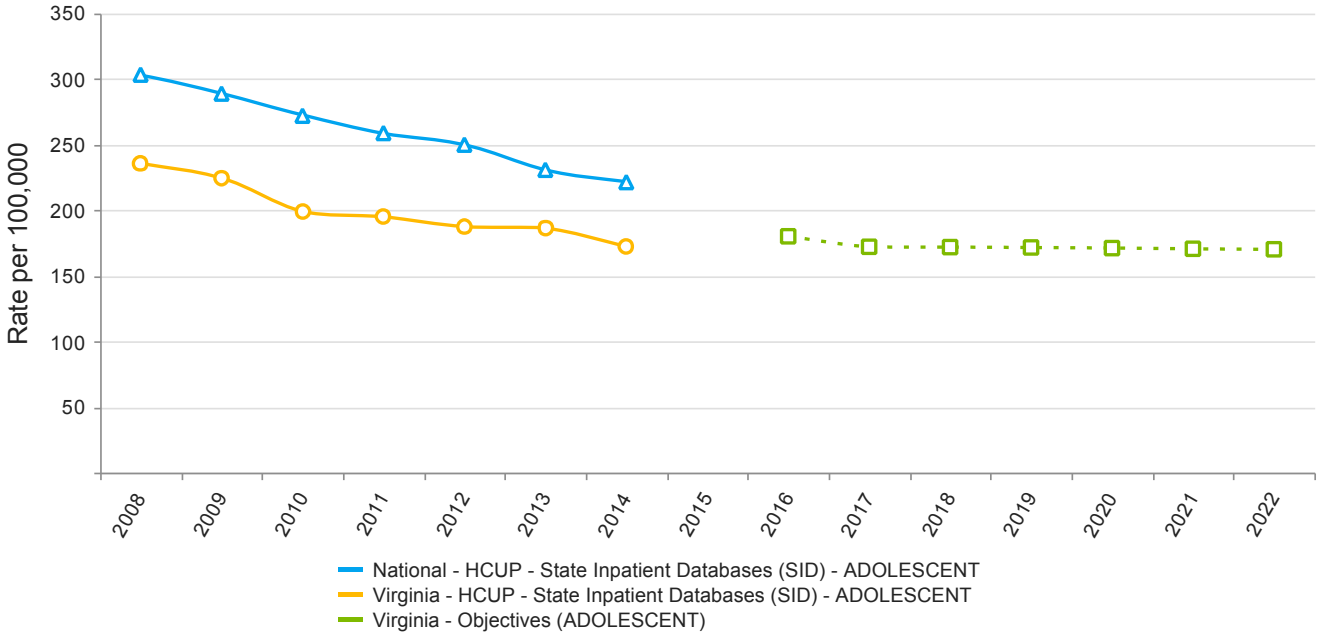
Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 15 - Child Mortality rate, ages 1 through 9 per 100,000	NVSS-2015	17.5	NPM 7
NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000	NVSS-2015	29.5	NPM 7
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000	NVSS-2013_2015	9.8	NPM 7
NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000	NVSS-2013_2015	9.1	NPM 7

National Performance Measures

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19
Baseline Indicators and Annual Objectives



NPM 7 - Adolescent Health

Federally Available Data	
Data Source: HCUP - State Inpatient Databases (SID) - ADOLESCENT	
	2016
Annual Objective	180
Annual Indicator	172.4
Numerator	1,826
Denominator	1,059,470
Data Source	SID-ADOLESCENT
Data Source Year	2014

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	172.0	171.8	171.5	171.1	170.5	170.1

Evidence-Based or –Informed Strategy Measures

ESM 7.1 - Proportion of maternity centers with prenatal courses including Virginia's injury prevention curriculum

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Office of Family Health Services, VDH
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	15.0	20.0	25.0	30.0	35.0

ESM 7.2 - Number of Family Assessment and Planning Teams (FAPT) teams that have incorporated suicide prevention practices into their workflow and/or policies

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	10.0	25.0	50.0	75.0	90.0	100.0

State Performance Measures

SPM 1 - Teen Pregnancy Prevention: Rate of females age 15-19 using most effective contraceptive methods

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	21.7
Numerator	11,662
Denominator	538,332
Data Source	APCD
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	22.0	22.7	23.4	23.9	24.3	25.0

State Action Plan Table

State Action Plan Table (Virginia) - Adolescent Health - Entry 1

Priority Need

Child/Adolescent Injury: Reduce injuries, violence, and suicide among Title V populations.

NPM

Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Objectives

Objective 1: Sustain and expand statewide capacity for injury prevention and surveillance for adolescents ages 10 to 19 (2020).

Strategies

1. Train and provide technical assistance to Comprehensive Services Act for At-Risk Youth (CSA) Family Assessment and Planning Teams (FAPT) to incorporate suicide prevention practices into their workflow and policies.

2. Conduct ongoing surveillance of hospitalizations due to injuries among adolescents ages 10 to 19.

ESMs	Status
ESM 7.1 - Proportion of maternity centers with prenatal courses including Virginia's injury prevention curriculum	Active
ESM 7.2 - Number of Family Assessment and Planning Teams (FAPT) teams that have incorporated suicide prevention practices into their workflow and/or policies	Active

NOMs

NOM 15 - Child Mortality rate, ages 1 through 9 per 100,000

NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

Adolescent Health - Plan for the Application Year

The Division of Child and Family Services' Early Childhood Health (ECH) Unit administers an array of programs and initiatives serving children ages 0 to 9. The Division of Prevention and Health Promotion's Injury and Violence Prevention (IVP) Program is a strong Title V collaborator.

OBJECTIVE 1: Sustain and expand statewide capacity for injury prevention and surveillance for adolescents ages 10 to 19 (2020).

Injury and Violence Prevention Program

The IVP Program supports promising and best practice activities at the local level that address leading or emerging injury issues. In FY18, the IVP Program Supervisor will continue to support efforts to address broad child injury mechanisms and to implement the strategies noted in the action plan. Efforts will focus on capacity-building, sustaining and expanding service delivery, and policy.

Unintentional injuries continue to be a leading cause of death in the US and Virginia. Although death is the most severe result of injury, it represents only part of the problem. The majority of those who incur injuries survive, and often endure life-long mental, physical, and financial problems as a result of prolonged rehabilitation, hospitalization, loss of productivity, or stress to victim, family, and other caregivers. Despite its immense burden, injuries are largely preventable. Per the socioecological model, the IVP will aim to implement multi-level interventions (e.g. individual, relationship, community, societal) in order to effectively move the needle.

Parents, caregivers, community, coaches, and school personnel mentoring adolescents are readily engaged to receive injury prevention education and represent an opportunity to make environmental changes that promote and support safe behavior and practices.

In FY18, IVP efforts will include collaborating with Safe Kids Virginia, local health districts, Department of Education, school nurses, and other community partners to educate school age adolescents and families regarding safety. Staff will collaborate with three school divisions in high risk areas across the Commonwealth to pilot the implementation of the *Smart Moves, Smart Choices* strategic toolkit in order to ensure best practice approach in the screening for, reporting, and raising awareness of prescription drug abuse. Efforts will target students, administration, school nurses, guidance, peer mentors, and Parent Teacher Association members. This activity was selected based on both insight gained in stakeholder meetings and a FY15 evaluation of practices employed by school nurses for providing prescription drug misuse education to school age youth.

Reduction of suicide deaths is a continuing priority. In FY18, efforts will include continuing assistance to the statewide Campus Suicide Prevention Center, which is designed to provide technical assistance to university and college campuses through cohort infrastructure and address risk and protective factors for acts of suicide specific to college age adolescents and young adults. This activity will leverage existing partnerships to improve access to injury prevention education and promote workforce competency in injury prevention best practices.

In FY16, the Division of Prevention and Health Promotion's Injury and Violence Prevention (IVP) Program and Chronic Disease Unit (CDU) were strong Title V collaborators. Each utilized Title V funds to complement other federal and state funding streams to serve MCH populations.

NPM 7 - Injury Hospitalization: Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Program Activities/Partnerships

The IVP Program Supervisor leveraged Title V funds, along with state revenue funds and other federal funds, to oversee the development, implementation, and evaluation of various statewide injury prevention programs.

The Injury and Violence Epidemiologist worked in partnership with Title V-supported epidemiologists and evaluators to maintain the Virginia Online Injury Reporting System (VOIRS), which provides the public with data on deaths and hospitalizations attributable to injury. VOIRS allows quick and easy access to basic injury data and enables users to customize data reports on various types of injury hospitalizations and deaths. Data are available for both intentional and unintentional injuries, and some demographic and geographic information is included to allow for more detailed analysis. The Injury and Violence Epidemiologist routinely responded to data requests from constituents that could not be addressed through the VOIRS system.

NPM 8 - Physical Activity: Percent of adolescents 12 through 17 who are physically active at least 60 minutes per day

Program Activities/Partnerships

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ESM 8.1 - Number of students enrolled in targeted public schools where staff received professional development or technical assistance in physical activity

In FY16, VDH CDU staff provided professional development and technical assistance (TA) to 172 staff from early care and education programs and K-12 schools. These staff represent over 86,000 enrolled students across 9 targeted school divisions.

K-12 Schools: VDH provided professional development and TA to nine (9) Local Education Agencies (LEAs) on wellness policy updates, the creation of School Health Advisory Boards, and the promotion of physical education and physical activity in schools.

Partnering organizations included the Virginia Department of Education, Virginia Cooperative Extension Family Nutrition Program/SNAP-Ed, Virginia Foundation for Healthy Youth, Focused Fitness, Alliance for a Healthier Generation, and Action for Healthy Kids. Through the creation of updated policies and programs, VDH worked with

its partners to create sustainable improvements to the physical activity environments in LEAs.

These partnerships resulted in:

- Virginia Cooperative Extension Family Nutrition Program/SNAP-Ed agents providing 62.5 hours of professional development and TA related to physical education and physical activity, or approximately 4.5 hours per LEA;
- Focused Fitness providing 15 hours of professional development to health and physical education teachers from six (6) LEAs.

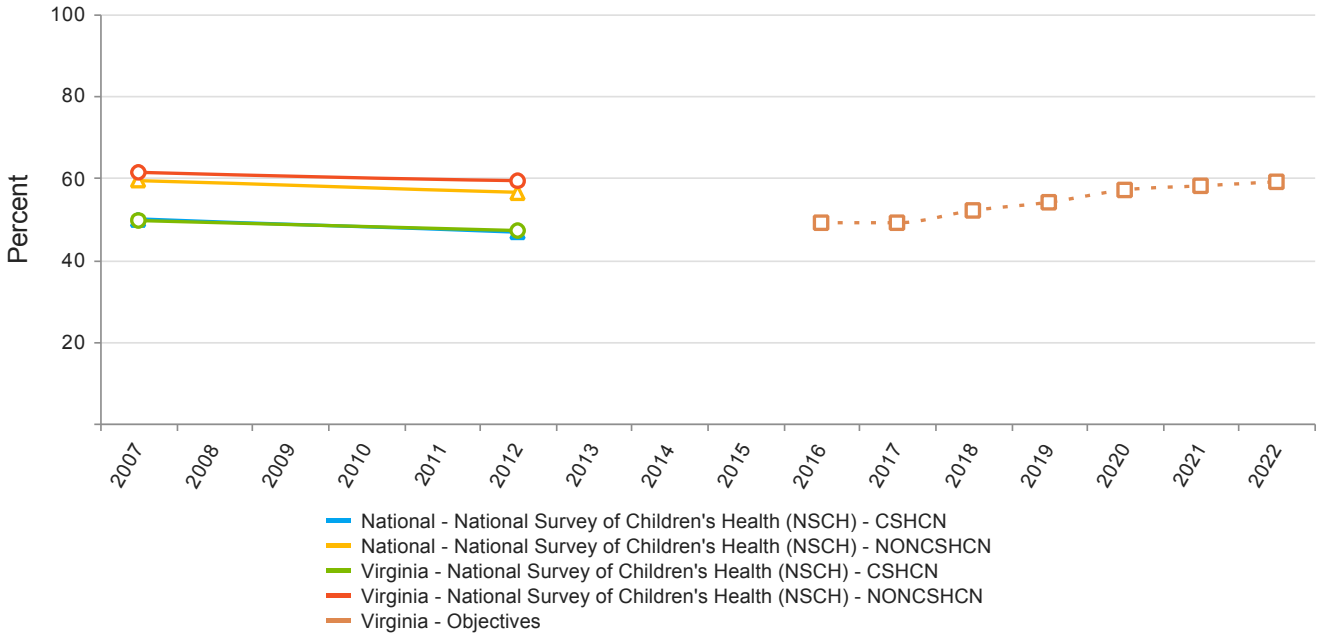
Children with Special Health Care Needs

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system	NS-CSHCN-2009_2010	19.6 %	NPM 11 NPM 12
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	89.2 %	NPM 11 NPM 12
NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)	NIS-2015	64.4 %	NPM 11
NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza	NIS-2015_2016	62.4 %	NPM 11
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISF-2015	61.2 %	NPM 11
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISM-2015	40.1 %	NPM 11
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2015	82.2 %	NPM 11
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2015	66.8 %	NPM 11

National Performance Measures

NPM 11 - Percent of children with and without special health care needs having a medical home
Baseline Indicators and Annual Objectives



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2016
Annual Objective	49
Annual Indicator	47.3
Numerator	173,295
Denominator	366,760
Data Source	NSCH-CSHCN
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	49.0	52.0	54.0	57.0	58.0	59.0

Evidence-Based or –Informed Strategy Measures

ESM 11.1 - Number of providers in Virginia who have completed the medical home training module

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Division of Child and Family Health
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	25.0	100.0	250.0	400.0	500.0	525.0

ESM 11.2 - Percentage of VDH CYSHCN who report a primary care provider

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	89.2
Numerator	4,061
Denominator	4,555
Data Source	Office of Family Health Services, VDH
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	90.0	91.5	93.0	94.5	96.0	97.5

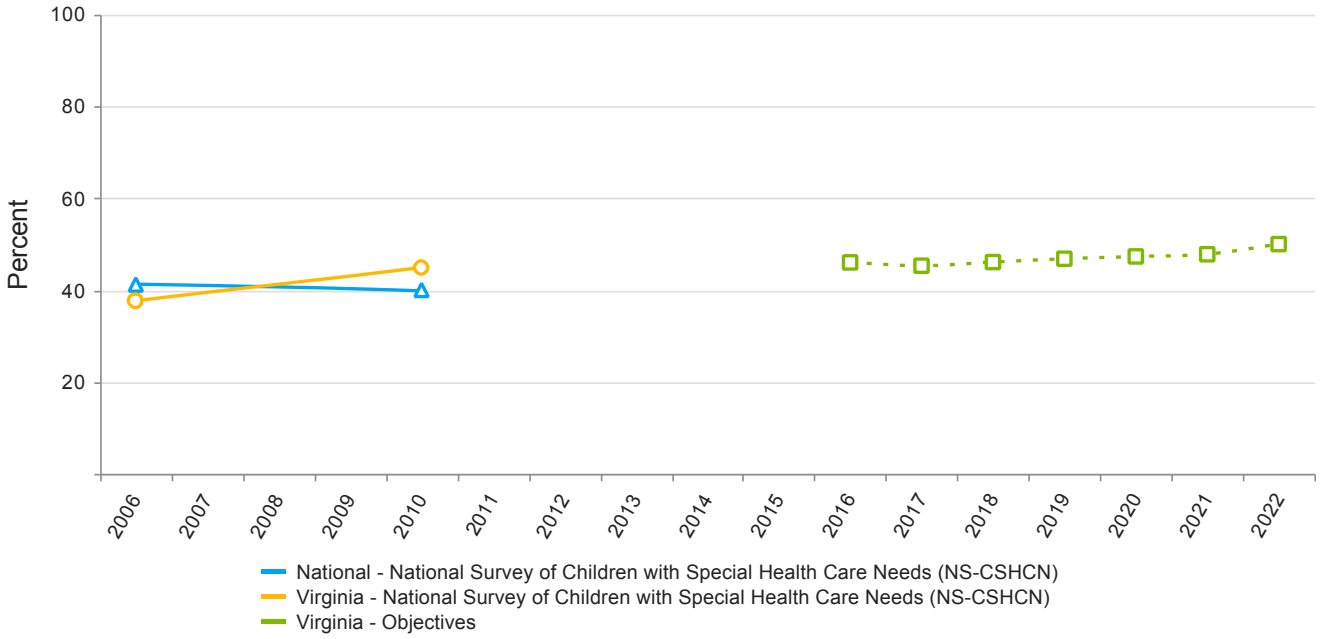
ESM 11.3 - Percentage of children enrolled in public schools who report a primary care provider

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	30.6
Numerator	200,000
Denominator	653,103
Data Source	Virginia Department of Education
Data Source Year	2015-2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	40.0	42.5	45.0	47.5	50.0	53.0

NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care
Baseline Indicators and Annual Objectives



Federally Available Data	
Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)	
	2016
Annual Objective	46
Annual Indicator	44.9
Numerator	50,747
Denominator	113,089
Data Source	NS-CSHCN
Data Source Year	2009_2010

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	45.3	46.1	46.8	47.3	47.8	50.0

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Number of providers in Virginia who have completed the transition training module.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Division of Child and Family Health
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	25.0	100.0	250.0	400.0	500.0	525.0

State Action Plan Table

State Action Plan Table (Virginia) - Children with Special Health Care Needs - Entry 1

Priority Need

Medical Home: Promote the importance of medical home among providers and families.

NPM

Percent of children with and without special health care needs having a medical home

Objectives

Objective 1: Increase the percentage of typical and children with special health care needs who can identify a primary care provider as a medical home by 10% (2020).

Strategies

1. Partner with VA Chapter of the American Academy of Pediatrics (VA-AAP), community partners, and Virginia's CYSHCN centers (i.e. Care Coordination for Children centers, Child Development Centers, Virginia Bleeding Disorders Program sites, Sickle Cell Program sites) to develop a training module for health care providers to educate on a comprehensive care approach to provide a medical home for children (including those with special health care needs) as a component of the emerging Virginia Medical Neighborhood model.

2. Collaborate with Department of Education (DOE), VA-AAP, Head Start, Virginia Preschool Initiative programs, and community partners to educate families, health care providers, community partners, school personnel, and the public on the importance of children and families establishing a medical home, obtaining recommended physical examinations, developmental screenings, and appropriate immunizations needed to promote optimal health through early screening, detection, and referral.

ESMs	Status
ESM 11.1 - Number of providers in Virginia who have completed the medical home training module	Active
ESM 11.2 - Percentage of VDH CYSHCN who report a primary care provider	Active
ESM 11.3 - Percentage of children enrolled in public schools who report a primary care provider	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM 19 - Percent of children in excellent or very good health

NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

State Action Plan Table (Virginia) - Children with Special Health Care Needs - Entry 2

Priority Need

Transition: Promote independence and transition of young adults with and without special healthcare needs.

NPM

Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Objectives

Objective 2: Increase the proportion of children ages 10-24 engaged in transition services to adult health care by 10% (2020)

Strategies

1. Collaborate with VA-AAP, community partners, and Virginia's regional CYSHCN centers (i.e. Care Coordination for Children centers, Child Development Centers, Virginia Bleeding Disorders Program sites, Sickle Cell Program sites) to develop training modules for health care providers, school personnel, families, and adolescents to educate on best practices regarding the delivery of transition services, the provision of transition tools, the importance of the transition process, and self-advocacy, to achieve optimal health.

2. Partner with child care, medical providers, CYSHCN resources/organizations, schools, and early childhood serving state agencies to educate and provide support to children (and their families). Include the provision of individualized health care plans and training on transitioning children and adolescents to child care, elementary/middle/high school entry, and into adulthood.

ESMs	Status
ESM 12.1 - Number of providers in Virginia who have completed the transition training module.	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM 19 - Percent of children in excellent or very good health

Children with Special Health Care Needs - Plan for the Application Year

Title V-funded programs for children and youth with special health care needs (CYSHCN) include Care Connection for Children (CCC), Child Development Centers (CDC), the Virginia Bleeding Disorders Program (VBDP), and the Sickle Cell Program (SCP). These programs are housed within the VDH Division of Child and Family Services and are managed by the CYSHCN Director (Marcus Allen, MPH).

The VDH School and Adolescent Health (SAH) program serves as a resource to Virginia public, private, and parochial schools and school nurses. The program is managed by the SAH Specialist (Janet B. Wright, BSN, RN, NCSN), who serves as the state school nurse consultant and the state adolescent health coordinator for Title V.

OBJECTIVE 1: Increase the percentage of typical and children with special health care needs who can identify a primary care provider as a medical home by 10% (2020).

OBJECTIVE 2: Increase the proportion of children ages 10-24 engaged in transition services to adult health care by 10% (2020).

CYSCHN Programs

During FY17, VDH made great strides towards implementing strategies to improve outcomes for the medical home and transition national performance measures. Staff continued to build on technical assistance that received from the 2015 MCH Workforce Development Program by attending the MCH Skills Institute training in the summer of 2016. The core initiative developed as a result of the training and technical assistance received was the Medical Neighborhood initiative.

The purpose of the project is to bring together government, non-profit, and family leaders to focus on initiatives that improve outcomes for CYSHCN, and eventually, all children in Virginia. Partners include the state Family to Family director, University of Virginia Health System (UVA) staff in various capacities, the state Medicaid agency, local pediatricians (including the Virginia chapter of the American Academy of Pediatrics, VA-AAP), and others. Three meetings have been held. Partners are committed to the work and agree that it is appropriate for the initial focus to be on creating medical home and transition modules. It is recognized that other modules exist, but what makes this project unique is its dual focus on families and service providers. The group has created a framework for the modules and is ready to move forward with implementation.

In FY18, VDH plans to partner with UVA's Department of Continuing Education to negotiate a cost, design, and implementation plan for the modules. Once draft modules have been created, VDH and UVA will present them to our partners for feedback and constructive criticism. Simultaneously, we will work with partners to try to secure funding for the long-term sustainability of the modules. If successful, the team will collaborate with the OFHS Communications team to develop a marketing plan targeting providers and families. All CYSHCN programs will promote the importance of a medical home by encouraging families to establish a relationship with a primary care provider and to prepare adolescents for transition to adult care and life.

In addition to the above, several other initiatives and efforts will transpire. During the upcoming mosquito season, the CYSCHCN team will support its Newborn Screening sister unit by offering care coordination and behavioral and developmental assessments for infants impacted by Zika. This work will involve partnering with the CCCs and CDCs, most of which are already located within larger health systems and knowledgeable of services that are

available for impacted families. The Blood Disorders Coordinator will collaborate with community partners to revive the Virginia Sickle Cell Awareness Program, and all CYSHCN programs will be promoted on social media with support from the OFHS Communications team.

VDH CYSHCN staff continues to partner with the VA-LEND program. The CYSHCN Director serves on the selection committee for new LEND trainees and attends the poster presentations of LEND trainees to learn about their research. The Director recently disseminated LEND's training module on early identification of autism to the CCCs, CDCs, and other internal Title V partners, to include the VDH home visiting and early childhood program manager. VA-LEND is very interested in supporting the Medical Neighborhood project and will be working with VDH to promote the new training modules under development.

The CYSHCN Director attended a regional Learning Collaborative on Improving Quality and Access to Care in Maternal and Child Health in FY17. Additional attendees included the VDH Deputy Commissioner for Community Health Services, the MCH Director, one of the Deputy Directors from Virginia's Medicaid agency (DMAS), and three elected officials. Specific topics of discussion were improving systems of care for CYSHCN, Bright Futures, and improving quality and access to care for the MCH population as a whole. VDH is currently working with DMAS on formulating strategies to move this work forward through FY18.

Adolescent Health Program

Among other initiatives, the SAH Specialist supports efforts to (a) increase the percentage of school health personnel in Virginia schools who provide education on the importance of having a medical home to students and their families, and (b) increase the percentage of adolescents with and without special health care needs who receive services necessary to make transitions to adult health care.

For the past six years, the SAH Specialist has collaborated with the Virginia Department of Education (VDOE) and the Virginia Chapter of the American Academy of Pediatrics (VA-AAP) to provide professional development training for school nurses and VA-AAP pediatricians on school health topics impacting student health. This includes events such as the VA-AAP's Virginia Pediatric Health Care Conference, which was expanded in 2017 to include 86 school nurse coordinators as well as 15 pediatricians, 2 nurse practitioners, and 6 physician assistants. Efforts to provide professional development opportunities related to medical home and transition for Virginia school nurses, pediatricians, nurse practitioners, and physician assistants will continue in FY18.

She will also maintain VDH's partnership with the VDOE School Nurse Consultant in the administration of the annual National Association of School Nurses/National Association of State School Nurse Consultants (NASN/NASSNC) uniform data set survey, which includes a medical home component.

Virginia's Children and Youth with Special Health Care Needs (CYSHCN) Program, housed within the VDH Division of Child and Family Services, includes four components: Care Connection for Children (CCC), Child Development Centers (CDC), the Virginia Bleeding Disorders Program (VBDP), and the Sickle Cell Program (SCP). The program is managed by the CYSHCN Director (Marcus Allen, MPH).

In FY16, the program served approximately 7,894 children and families. Though the FY16 service level represents a slight decrease from FY15 (51 fewer clients than the 7,945 served in FY15), the program maintained most of the service level increase achieved in FY14 (increase of nearly 1,200 clients). The slight decrease in service level is mostly due to the loss of a pediatric psychologist in the southwest part of the state. This vacancy was recently filled, and the CYSHCN program anticipates being able to maintain or slightly increase service levels as long as funding remains stable. In addition to the loss of the pediatric psychologist, the VA CYSCHN program lost its Blood Disorders Program Coordinator to a promotion within the division. This position manages all state blood disorder program contracts, assures entry into care for children confirmed on the newborn screen with sickle cell disease, and assists with general CYSHCN program activities and projects. The VA CYSHCN Director was able to sustain program activities until Shamaree Cromartie was hired as the new Blood Disorders Program Coordinator in November 2016.

The School and Adolescent Health (SAH) Program, which promotes medical home and transition for children with and without special healthcare needs, served approximately 2,900 school nurses and school health personnel, who in turn serve approximately 1.2 million students at Virginia's public, private, and parochial schools.

NPM 11 - Medical Home: Percent of children with and without special health care needs having a medical home

National Data

All of the VDH CYSHCN programs monitor client medical home status and partner with families and medical homes to assure that children with special needs have access to the services they need. The latest National CYSHCN Survey indicates that 42.4% of Virginia's CYSHCN receive coordinated, ongoing, comprehensive care within a medical home. Although this figure is slightly lower than the 2005/2006 survey results (43.9%), the difference is not statistically significant. Racial/ethnic disparities persist across this measure, with White CYSHCN most likely to receive this level of care within a medical home (48.6%), versus Black/African-American CYSHCN (37.1%), or Hispanic CYSHN (33.1%). Low-income families were also the least likely to meet this outcome.

Program Activities/Partnerships

ESM 11.1 - Number of providers in Virginia who have completed the medical home training module

The Virginia MCH leadership team continued to focus on its Medical Neighborhood project. The purpose of this work is to bring partners together in the Blue Ridge region of the state to collaborate on issues that impact CYSCHN. Attendees at the meetings include representatives from the Virginia Chapter of the American Academy of Pediatrics, local pediatricians, care coordinators, the F2F Director for the state, Medicaid representatives, and others. VDH educated the group on the power of collective impact and began discussions on areas of focus. Medical home and transition were chosen as initial focus areas and representatives agreed that Virginia specific medical home and transition modules would be an appropriate first project. Virginia has been working with the group to create an outline for the modules and plans to work with the University of Virginia to design the modules, if

funding can be secured to sustain them long term.

ESM 11.2 - Percentage of VDH CYSHCN who report a primary care provider

The CCC program worked directly with primary care and specialty care providers to provide care coordination services for families and they help link them to primary care providers as needed.

The CDC program received about 79% of its client referrals from medical providers whom they subsequently worked with to assess youth suspected of having a developmental or behavioral disorder. In order to complete the assessments, the program worked closely with parents, referring clinical providers, and school systems.

At the end of quarter 4, the VBDP reported 81% of patients under 21 had a PCP and the program monitored applications quarterly in order to identify medical homes to assure that proper coordination was occurring. The SCP centers reported 77% of patients under 21 had a PCP. At comprehensive visits, the patients are asked about their last visit to the PCP. Families are educated on the importance of having a PCP for well visits and issues that are not related to sickle cell disease.

*ESM 11.3 - Percentage of children enrolled in public schools who report a primary care provide*r

The School and Adolescent (SAH) program served as a resource to approximately 2,900 school nurses and school health personnel from public, private, and parochial schools.

The SAH Specialist collaborated with the Virginia Department of Education (VDOE) state school nurse consultant (SSNC) to provide professional development training, resources, and technical assistance. Additional ongoing collaborators include: the School Nurse Institute Partnership (SNIP), a unique school nurse advisory board of practicing school nurses, university professors, and school nurse leaders; Virginia Asthma Coalition; Virginia Diabetes Council; Virginia Council of Private Education (VCPE); Virginia Association of School Nurses (VASN); and various VDH programs that contribute to the health and well-being of students.

The SAH Specialist integrated the Office of Adolescent Health's *Think, Act, Grow (TAG) 2015 Playbook and Call to Action* into statewide initiatives that seek to improve the health and well-being of adolescents via the promotion of the five essentials for healthy adolescents, which include establishing a medical home and managing transitions from pediatric to adult health care. To date, the *TAG 2015 Playbook* has been distributed to approximately 255 Virginia school nurses.

School nurses recognize the importance of each student having a medical home, as supported by the American Academy of Pediatrics *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents.* The SAH Specialist worked collaboratively with the VDOE SSNC who administers the annual National Association of School Nurses/National Association of State School Nurse Consultants (NASN/NASSNC) uniform data set survey. The survey began in 2014 and seeks to collect data on select chronic health conditions, school health personnel staffing, and student clinic visits and disposition data. This voluntary, non-mandated electronic survey is administered by VDOE to public, private, and parochial schools. During FY15/16, VDOE added a medical home component to the survey. Local school divisions provide a student health form for parents and guardians to complete at the beginning of each school year that provides the school with pertinent student health information. Sixty-seven of 132 local public school divisions reported that approximately 200,000 students had a medical home. Twenty-four private/parochial schools participating in the survey reported approximately 4,707 students have a medical home. This survey

represents the beginning of uniform data collection on SAH populations from Virginia schools and school nurses. The survey is an asset to ongoing SAH surveillance and needs assessment efforts. Inconsistent reporting of data (e.g. total student population) is a barrier to producing reportable rate data.

NPM 12 – Transition: Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

National Data

The 2009/2010 National Survey of CYSHCN indicated that 44.9% of Virginia youth with special health care needs received the services necessary to make transitions to all aspects of adult life, including healthcare, work, and independence. This was an increase from the 2005/2006 survey result of 37.8%. However, this difference was not statistically significant.

Program Activities/Partnerships

The CCC program continued to use the unique transition tool that it created. Care coordinators use the tool to help identify client needs and plan for their future. The tool focuses on all aspects of adult life, including education/vocation/employment, health and wellness, mobility/transportation/recreation, and legal/insurance/adult benefits/housing.

Virginia Commonwealth University (VCU), located in Richmond, VA, has the only robust adult centers for bleeding disorders and sickle cell. The VBDP required that each of its centers designate one employee to serve as a transition coordinator. The VBDP Program Manager has transition calls with each center to discuss the patients that will be transitioning to adult care.

Due to the lack of adult centers around the state for sickle cell, the centers have worked to locate hematologists in their respective areas that feel comfortable treating sickle cell patients. Only one center in the SCP has a dedicated transition coordinator on staff that works with patients 15-21 years of age; the other centers utilize social workers to coordinate transition activities. One center could not successfully transition patients to an adult center, so patients continued to receive care in the pediatric extension clinic. The other centers tried to identify an adult hematologist and worked with the provider to have an introductory meeting with patients prior to transition. One center was unsuccessful due to the Physician Assistant position being vacant.

All centers in the SCP provided patients assistance with identifying insurance options after age 18 and medical documentation for program eligibility such as SSI, college vocational training and disability services. Also, the centers provide educational materials or handouts specific to transition that addressed concerns of both patient and parents. If patients went to college outside of the local catchment area, the centers worked with the patient to find an adult hematologist in the area and provided a hard copy of their medical summary and encouraged them to sign up for the patient portal. One center held two overnight retreats for transition age patients. The retreats served as an opportunity for education and team building. They also invited adult sickle cell providers so that patients could meet potential providers in an informal setting. The center also held an annual Pediatric Hematology/Oncology Graduation ceremony and invited all graduating seniors. The center was fortunate enough to receive local monetary support from ASK and the local sickle cell association for each student who attended graduation.

As reported under ESM 11.3, the MCH Title V state adolescent coordinator employed the OAH 2015 TAG playbook

as a tool to educate over 250 school nurses on facilitating smooth transitions from adolescent to adult health care settings.

ESM 12.1 - Number of providers in Virginia who have completed the transition training module

During FY16, the CYSHCN programs continued to emphasize transition. As described in ESM 11.1, the program embarked on a project in the Blue Ridge Region of the state called Medical Neighborhood. Collectively, the Medical Neighborhood group agreed to create a module that centered on transition from the family and provider roles. The goal is to encourage providers to become more knowledgeable of transition and to affect policy change within practices across our state. As far as families are concerned, the group wants to educate them on the importance of transition and empower them to become advocates for their own needs.

Overall System Outcomes for CYSHCN

Virginia's CYSCHN program is informed by the AMCHP Standards for Systems of Care for Children and Youth with Special Health Care Needs. An overview of key FY16 system outcomes is presented below.

Family Professional Partnerships: Families of CYSHCN will partner in decision making at all levels and will be satisfied with the services that they received

National Data

During FY16, the CYSHCN programs continued to focus on involving families in decision-making regarding the care of their children. The 2009/2010 National CYSHCN Survey (which provides the most up-to-date data) indicates that 77.1% of Virginia families report that they partner in decision making and are satisfied with the services they receive. This outcome is not comparable to prior survey years. Virginia, however, was one of nine states that scored higher than the national rate of 70.3%.

Program Activities

The regional Care Connection for Children centers (CCC) continue to employ parent coordinators as staff and they actively engage families in order to offer resources and support. Most of the parent coordinators have a child with a special health care need so they understand the unique challenges families face. In addition to providing general support to families, parent coordinators in various regions across the Commonwealth work to: maintain center resource lists; create newsletters; lead educational activities and trainings; and work closely with families on overcoming barriers to care.

Another one of our core programs, the Child Development Centers (CDCs) also actively engage families. The CDCs provide assessments of children suspected of having developmental and/or behavior conditions. Families are an active part of the assessments that are done and they receive documentation regarding diagnoses. In addition, center staff members refer them to clinical and non-clinical resources for assistance and share the results of their assessments with other providers serving the family. In FY16, the CDC program was evaluated by an outside vendor (University of Virginia) and this evaluation looked at family centered care in the intake process. According to the evaluator, "across all of the CDCs, the family-centered, comprehensive, and timely intake,

evaluation, and diagnostic process were exemplary." Specifically, several exemplary practices were cited and they include:

- Family-centered engagement through parenting classes offered;
- Outreach to specialty and primary care physicians and nurses;
- Community outreach;
- Cross center connections (VCU Autlsm Spectrum Disorder project);
- Hand written thank you notes to those who refer patients;
- Resource coordination efforts through social work or other qualified personnel and;
- Follow up appointment to review written report.

The Virginia Bleeding Disorders Program (VBDP) and the Sickle Cell Program (SCP) continue to have a number of programs/events to support families in decision making at all levels. The VBDP educated families on home therapy management for those who infuse at home. The centers had educational sessions during clinic for families on various topics that included, but not limited to, safe summer activities for children with bleeding disorders and resources and support available. Monthly support groups for parents of children were started as well. One of the centers also partnered with the Virginia Hemophilia Foundation (VHF) to lead parent discussion groups for Family Weekend at Camp Holiday Trails. Families were invited to participate on the outreach and education committee.

The SCP centers offered genetic counseling to aide in future reproductive decision making. The regional centers provided events for families, including social gatherings and overnight camps with educational and group activities focusing on transition and self-advocacy. One center partnered with ASK Childhood Cancer Foundation to provide monthly discussion groups for patients and families, as well as held a program called "First Steps." The program provided basic information about SCD and a forum for families to discuss the challenges for caring for an infant with SCD. The social worker continued to send out pertinent information for families as topics arose pertaining to medical advances in SCD. Families with newborns diagnosed with SCD were given a copy of *Hope and Destiny: A Patient's and Parent's Guide to Sickle Cell Anemia* and patients entering the transition phase were given a copy of *Hope and Destiny Jr*.

Partnerships

During FY 16, the CYSHCN program maintained its partnerships with parent organizations, local/regional support groups, and the Virginia Department of Education Family Engagement Network. CYSHCN staff worked closely with the Family-to-Family Network (F2F) and F2F continued to provide education, outreach, and support to families (including culturally and linguistically diverse families of CYSHCN) through the employment of parents serving as liaisons. Specifically, the F2F director Dana Yarbrough was actively involved in several initiatives and trainings at the state level and is a core member of the VDH Title V/MCH Team. She attended the summer skills institute in Chicago with the Virginia team and is serving as one of the leaders of our medical neighborhood project.

Insurance and Financing: Families of CYSHCN have adequate private and/or public insurance and financing to pay for the services they need

National Data

The latest National Survey of CYSHCN indicated that 65.2% of CYSHCN families have adequate private and/or public insurance. This is a slight increase from the 63.7% reported in the 2005/2006 national survey. In FY16, Virginia's CYSHCN programs continued to refer all potentially eligible children to Medicaid, SCHIP, compassionate

use, and SSI programs, and followed-up with families regarding applications. This included support from trained social workers working with families to explore all insurance options (public and private).

Program Activities/Partnerships

The CCC and CDC programs continue to help families struggling with insurance issues by connecting them to public and private insurance options as needed. During FY16, the CCC program reported that 94% of CYSCHN served were insured and the CDC program reported that 97% were insured. As for the VBDP, 98% of patients served had adequate private or public insurance. The VBDP has a trained social worker who is very knowledgeable of health insurance options and works very closely with families to find the most cost effective insurance solutions that meet both family and client medical needs. One of the VBDP's most important partners in this process is Patient Services Incorporated (PSI). PSI continued to provide insurance case management and premium assistance to help eligible families maintain insurance coverage. All patients were entered into the REDCap database and reviewed by the VBDP team routinely. Based on the data reported from the centers, 74% of sickle cell patients served had adequate private or public insurance. One center had the Social Worker complete insurance assessments on all patients annually during appointments and upon request to ensure adequate coverage.

VDH also continued to manage a Pool of Funds (POF) for the CCC and VBDP. The POF is the payer of last resort, and helps families purchase needed medications when no other viable options are present, including insurance. The Hearing Aid Loan Bank is located at one of the regional CCC centers and continued to provide gap-filling services to families of children with hearing loss. In addition, the Care Coordination Notebook -- Financing and Managing Your Child's Health Care -- continued to be used, providing an overview of how health insurance works, how to understand and use deductibles and co-insurance, in addition to providing a summary of available public waiver programs and sample advocacy letters (e.g. appeal, claim reconsideration) for the family's use with insurers.

Easy-to-Use Services and Supports: Services for CYSHCN and their families will be organized in ways that families can use them easily and include access to patient and family-centered care coordination

National Data

The 2009/2010 National Survey of CYSHCN indicated that 67% of Virginia families of CYSHCN reported that the community-based service systems are organized in a manner such that they are easy to use. This percentage is not comparable to the previous 2005/2006 survey due to revisions in the question wording. During FY16, all Virginia CYSHCN programs continued to implement strategies to help families access necessary services. The CCC staff traveled to clinic appointments to meet with families to prevent them from needing to make an additional trip to the center. The CDC centers continue to consult with families over the phone prior to their visit to expedite the registration process. The purpose of these phone consultations is to confirm that families qualify for services. In some instances, families are not actually in need of an assessment, and may only need help understanding the resources available to their child.

Program Activities/Partnerships

Two of the SCP sites implemented satellite clinics in areas with geographic need for services in order to improve family access of care. They also addressed issues of family support, health insurance, and identified transportation barriers for patients getting to appointments and provided assistance in obtaining bus tickets, Medicaid cabs, gas vouchers, etc. The centers referred patients to the appropriate community-based organizations, such as the Sickle

Cell Association program, Catholic Charities, food bank, and other community resources. The centers partnered with the local sickle cell associations and encouraged staff and patients to participate in events, such as Camp Young, sickle cell walk, holiday party and the sickle cell ball.

The VBDP program manager worked with Virginia Hemophilia Foundation on education to families regarding ED/EMS dental services and education regarding schools. VBDP has also helped families fill out applications for children to participate in a summer camp for CYSHCN.

In addition to the above, families continued to have access to VDOE consultants and social workers who often work at program sites and function as part of a comprehensive team that strives to meet the needs of CYSHCN. Services provided in this manner help ameliorate barriers and assure that providers work together to most effectively serve families.

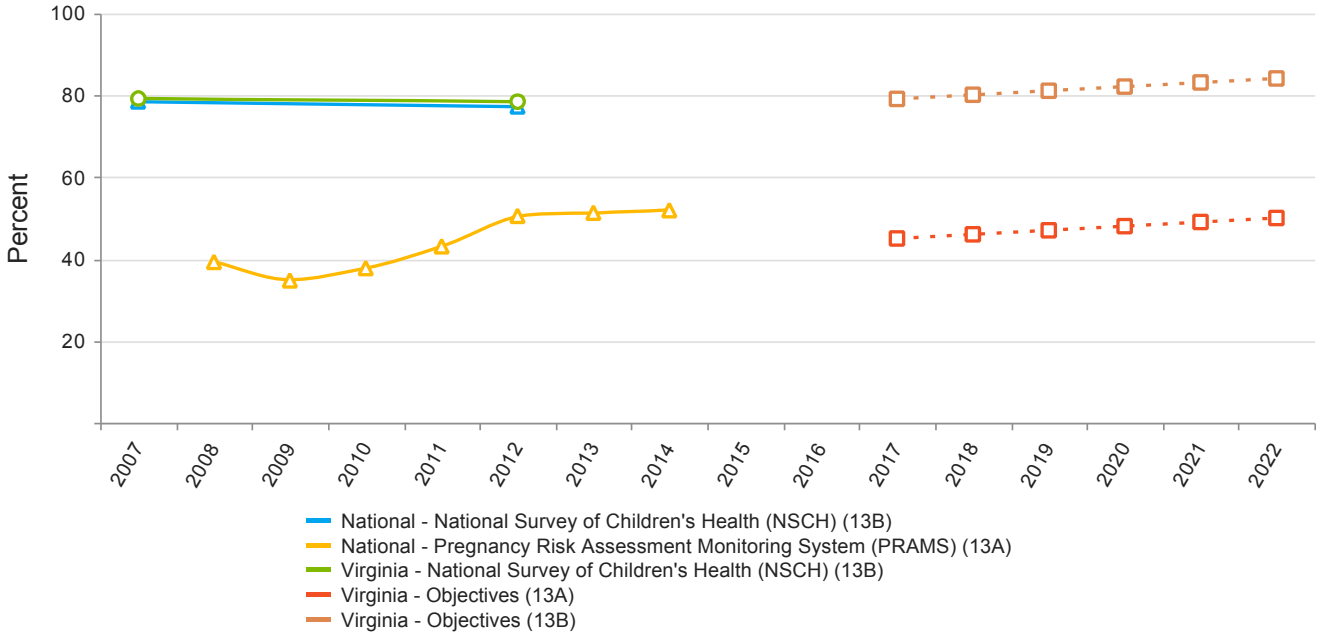
Cross-Cutting/Life Course

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2014	155.3	NPM 14
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS	Data Not Available	NPM 14
NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2015	7.9 %	NPM 14
NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)	NVSS-2015	1.5 %	NPM 14
NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)	NVSS-2015	6.4 %	NPM 14
NOM 5.1 - Percent of preterm births (<37 weeks)	NVSS-2015	9.3 %	NPM 14
NOM 5.2 - Percent of early preterm births (<34 weeks)	NVSS-2015	2.8 %	NPM 14
NOM 5.3 - Percent of late preterm births (34-36 weeks)	NVSS-2015	6.5 %	NPM 14
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2015	24.1 %	NPM 14
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2014	5.6	NPM 14
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	5.7	NPM 14
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2014	3.8	NPM 14
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	1.9	NPM 14
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2014	198.5	NPM 14
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2014	101.7	NPM 14
NOM 14 - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months	NSCH-2011_2012	15.5 %	NPM 13
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	89.2 %	NPM 13 NPM 14

National Performance Measures

NPM 13 - A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year
Baseline Indicators and Annual Objectives



NPM 13 - A) Percent of women who had a dental visit during pregnancy

FAD for this measure is not available for the State.

State Provided Data	
	2016
Annual Objective	
Annual Indicator	43.6
Numerator	
Denominator	
Data Source	PRAMS
Data Source Year	2010-2011
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	45.0	46.0	47.0	48.0	49.0	50.0

NPM 13 - B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	
Annual Indicator	78.5
Numerator	1,362,891
Denominator	1,735,196
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	79.0	80.0	81.0	82.0	83.0	84.0

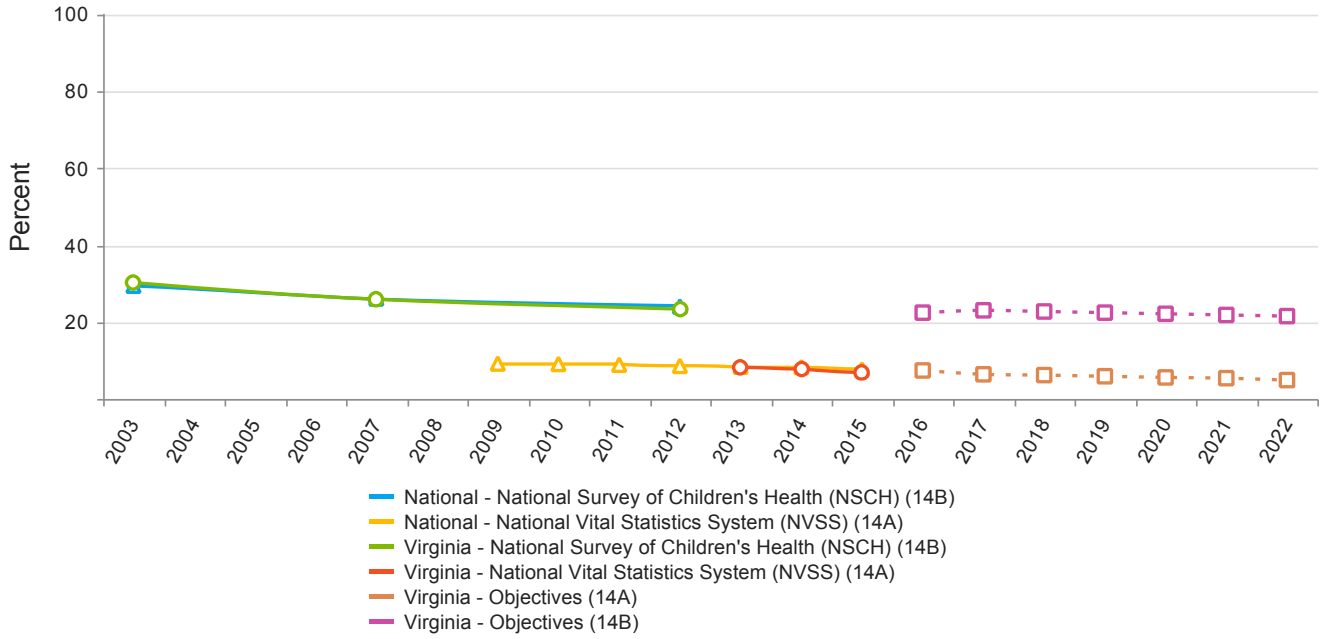
Evidence-Based or –Informed Strategy Measures

ESM 13.1 - Completion of action plan identifying strategies and partners for addressing top 3 MCH population oral health needs in Virginia

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	No	Yes	Yes	Yes	Yes	Yes

NPM 14 - A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes
Baseline Indicators and Annual Objectives



NPM 14 - A) Percent of women who smoke during pregnancy

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2016
Annual Objective	7.5
Annual Indicator	6.8
Numerator	6,167
Denominator	91,149
Data Source	NVSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	6.5	6.3	6.0	5.7	5.5	5.0

NPM 14 - B) Percent of children who live in households where someone smokes

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	22.5
Annual Indicator	23.4
Numerator	426,945
Denominator	1,824,329
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	23.1	22.8	22.5	22.2	21.9	21.6

Evidence-Based or –Informed Strategy Measures

ESM 14.1 - Number of pregnant women who initate a call to the Quitline

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	60
Numerator	
Denominator	
Data Source	Division of Prevention and Health Promotion
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	200.0	350.0	500.0	750.0	1,000.0	1,000.0

ESM 14.2 - Number of pregnant women who complete the Quitline cessation program (10 counseling calls)

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	3
Numerator	
Denominator	
Data Source	Division of Prevention and Health Promotion
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	25.0	35.0	50.0	75.0	100.0	100.0

State Performance Measures

SPM 1 - Teen Pregnancy Prevention: Rate of females age 15-19 using most effective contraceptive methods

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	21.7
Numerator	11,662
Denominator	538,332
Data Source	APCD
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	22.0	22.7	23.4	23.9	24.3	25.0

SPM 2 - Maternal Mental Health: Proportion of women who attend a postpartum visit with a health care worker within 6 weeks after getting birth

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	90
Numerator	
Denominator	
Data Source	PRAMS
Data Source Year	2014
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	91.0	91.5	91.9	92.3	92.8	93.0

State Action Plan Table

State Action Plan Table (Virginia) - Cross-Cutting/Life Course - Entry 1

Priority Need

Tobacco: Decrease smoking among pregnant women and in households with children.

NPM

A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Objectives

Objective 1: Increase the number of pregnant women who initiate a call to the Quitline by 50% (2020).

Strategies

1. Facilitate connections between local health districts and five regional tobacco coordinators (funded by the Tobacco Use Control Prevention Grant).

2. Through local health districts, educate women about smoking cessation while pregnant and track the number of pregnant women who initiate a call to the Quitline.

3. Partner with March of Dimes to provide resources and educational materials to pregnant moms enrolled in Baby Basic and Centering pregnancy programs.

ESMs	Status
ESM 14.1 - Number of pregnant women who initate a call to the Quitline	Active
ESM 14.2 - Number of pregnant women who complete the Quitline cessation program (10 counseling calls)	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

NOM 5.1 - Percent of preterm births (<37 weeks)

NOM 5.2 - Percent of early preterm births (<34 weeks)

NOM 5.3 - Percent of late preterm births (34-36 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

NOM 19 - Percent of children in excellent or very good health

State Action Plan Table (Virginia) - Cross-Cutting/Life Course - Entry 2

Priority Need

Oral Health: Increase access to oral health services.

NPM

A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Objectives

Objective 2: Develop action plan for reintegrating oral health into Virginia's Title V program.

Strategies

1. Collaborate with the Dental Health Unit and the Virginia Oral Health Coalition to identify top priorities for MCH populations.

ESMs	Status
ESM 13.1 - Completion of action plan identifying strategies and partners for addressing top 3 MCH population oral health needs in Virginia	Active

NOMs

NOM 14 - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months

NOM 19 - Percent of children in excellent or very good health

Cross-Cutting/Life Course - Plan for the Application Year

Efforts to reduce tobacco use statewide are housed within the Division of Prevention and Health Promotion. The Maternal and Infant Health Coordinator collaborated with the Tobacco Control Unit Program (TCUP).

The Dental Health Unit is housed by DPHP and managed by the Dental Health Programs Manager (Tonya McRae Adiches, RDH).

OBJECTIVE 1: Increase the number of pregnant women who initiate a call to the Quitline by 50% (2020).

Tobacco Control Unit Program

The MIH Coordinator will continue to provide technical assistance to all 35 LHDs on the importance of tobacco cessation among pregnant women and those who have a child in the home under age 8 regarding secondhand smoke, in partnership with March of Dimes (MOD) and the TUCP Regional Coordinators.

In FY18, the MIH Coordinator will collaborate with LHDs and the TUCP Regional Coordinators to continue promotion of the Quitline resource guide and posters statewide. Monitoring of the number of pregnant women who initiate a call to the Quitline will continue.

In addition, the MIH coordinator will lead efforts to promote the Quitline through social media, in partnership with MOD and VHHA. In partnership with the MOD grant, VDH will be given 10 slots for LHD staff to attend a SCRIPT train-the-trainer training. SCRIPT is an evidence-based motivational interviewing intervention that aims to decrease smoking among pregnant women. These 10 trainers will then be required to conduct additional train-the-trainer trainings within their communities, thus casting a wider net.

OBJECTIVE 2: Develop action plan for reintegrating oral health into Virginia's Title V program.

Dental Health Unit

Oral health was a priority in the 2010 – 2015 Title V grant cycle, particularly for children. While Virginia did not initially identify oral health as a national performance measure, two key MCH population changes have been noted in the last 3 years: (1) several communities have discontinued their community water fluoridation programs due to lack of staff or local funding; and (2) the Dental Health Unit noticed an increase in the number of 3rd graders with cavities while conducting our 3rd grade dental survey. For these reasons, the Title V team now recognizes the need to reprioritize oral health for children and pregnant women.

In FY18, the Title V team will collaborate with the Dental Health Unit and the Virginia Oral Health Coalition to identify top priorities for MCH populations.

Efforts to reduce tobacco use statewide are housed within the Division of Prevention and Health Promotion. The Maternal and Infant Health (MIH) Coordinator collaborated with the Tobacco Control Unit Program (TCUP).

NPM 14 – Smoking: A - Percent of women who smoke during pregnancy, B - Percent of children who live in households where someone smokes

Program Activities/Partnerships

In FY16, the MIH Coordinator provided technical assistance to all 35 LHDs on the importance of tobacco cessation among pregnant women and those who have a child in the home under age 8 regarding secondhand smoke. The Quitline was also promoted through a series of nine text4baby messages as well as posters placed within LHDs and community sites.

ESM 14.1 - Number of pregnant women who initiate a call to the Quitline

In FY16, a total of 80 pregnant women who were tobacco users initiated calls to the Quitline.

In July 2016, the General Assembly passed legislation making it a secondary offense if a parent is pulled over while smoking in a vehicle with a child under the age 8.

To increase call initiation, VDH promoted this legislation and created a Quitline resource guide for secondhand smoke and smoking during pregnancy. This guide was made available in both English and Spanish. Educational posters were also created and distributed throughout all 35 LHDs and to community partners and healthcare providers.

ESM 14.2 - Number of pregnant women who complete the Quitline cessation program (10 counseling calls)

Of the 80 pregnant women who initiated a call to the Quitline, a total 48 callers completed the 10 counseling calls. Retention rates were higher among women who received a mailed call attempt letter.

Through DMAS, pregnant women who are Medicaid-eligible and are enrolled in the Quitline cessation program are eligible for nicotine replacement therapy (NRT) at no cost so long as they are enrolled. This resource was promoted via the Quitline resource guide.

Other Programmatic Activities

Adolescent Health Program

The Title V SAH Coordinator is working to develop an Adolescent Health Unit with staff from across divisions. Capacity-building efforts are in progress. In FY2015, she began to address an identified gap in the population spectrum with an intentional public health focus on Virginia adolescents. During FY2015/16, Janet focused on building capacity to support adolescents through their growth, development, and transition into adulthood, as well as supporting the adults who espouse Virginia adolescents. Capacity building has included establishing a definition, mission, and vision for the adolescent health (AH) program. The AH program defines adolescence as “the period of life ranging from ages 10-24, during which individuals make the developmental transition from childhood to adulthood” (AMCHP & NNSAHC Conceptual Framework for Adolescent Health, 2015). The program’s vision is for all adolescents will be at their optimal health and wellness, and learn to their greatest potential. The program’s mission is to empower adolescents to achieve and maintain optimal health and to identify pillars of support and resources, providing the foundation for a healthy transition to adulthood.

Capacity-building activities also included conducting a brief needs assessment (NA) through a series of four focus groups representing internal VDH stakeholders and Virginia school nurses; analyzing NA data to determine AH priority needs and resources; and identifying internal and external AH partnerships and organizations. School nurses and school nurse coordinators that participated in the NA represented 53 out of 132 public school divisions (or 40%). Key program needs identified from the stakeholder needs assessment included: creation of a statewide depository (e.g. website) of AH best practices, resources, and training; and creation of a social media platform and AH-focused messaging. Priority AH content areas identified were nutrition, dental health, mental health, and sexual health.

Maternal and Infant Health Unit

The Virginia Neonatal Perinatal Collaborative (VNPC) is a newly established network of perinatal care providers, birth hospitals, and public health professionals working to improve pregnancy outcomes for women and newborns, and will use evidence-based strategies and quality improvement bundles established by Vermont Oxford Network (e.g. Neonatal Abstinence Syndrome (NAS) and Antibiotic Stewardship in the NICU) and the Alliance for Improving Maternal Health (AIM) (Obstetric Hemorrhage) to address these selected projects. In collaboration with MOD's road map, VDH maternity clinical guidance for local health departments and partnership with Virginia's ACOG chapter, the VNPC will identify and reduce barriers related to administering and prescribing of 17P. With the focus on these four projects, the VNPC's main goal is to eliminate health disparities within maternal and infant health and improve outcomes among all women and infants across Virginia.

The Substance Exposed Infant Task Force is a comprehensive group of perinatal care and neonatologists providers, public health professionals, professional organizations (e.g. ACOG, AAP, AWHONN, ACNM) multiple hospitals across the state experiencing high rates of NAS in their facilities, Medicaid and private payers, March of Dimes, VHHA, state agencies [e.g. Department of Social Services (DSS), Child Protective Services (CPS), Department of Behavioral Health and Disability Services (DBHDS), VDH] brought together to “review current policies and practices governing the identification and treatment of substance-exposed infants in the Commonwealth, identify barriers to treatment of substance-exposed infants in the Commonwealth, including barriers related to identification and reporting of such infants, data collection, interagency coordination and collaboration, service planning, service availability, and funding, and develop legislative, budgetary, and policy recommendations for the elimination of barriers to treatment of substance-exposed infants in the Commonwealth.” This report is due to the General Assembly in early December 2017.

The Maternal and Infant Health Coordinator represents Title V on the Maternal Mortality Review Team which meets every other month for the day to review cases, provide feedback and recommendations to the annual report, and identify common themes, limitations. She also attended the MMRIA (Maternal Mortality Review Information Application) training at CDC in Atlanta in February 21017. According to the CDC, the United States maternal mortality rate has not decreased since 1982. The death rate held steady in the range of seven or eight maternal deaths for every 100,000 live births. By 2003, the rate began to increase to 12.1 deaths for every 100,000 live births. These rates continued to increase over the next three years: 2004 – 13.1; 2005- 15.1; 2006 – 13.3 with a slight reduction in 2007 (12.7). Healthy People 2020 targeted a maternal death rate of 11.4 per every 100,000 live birth. In order to reduce the maternal mortality rate, the CDC recommends that state-level, systematic reviews of all maternal deaths be undertaken to identify prevention and intervention strategies. These review teams have identified risk factors associated with maternal death such as obesity and chronic illness as well as an association between pregnancy and homicide. Through the VNPC, Virginia's maternal mortality and morbidity rate will be addressed in partnership with AIM, with the first bundle selected being Maternal Hemorrhage. The VNPC will be working closely with our regional coordinator at AIM, the Virginia ACOG chapter and VHHA to implement this project and bring maternal mortality and morbidity to the forefront and address these rising numbers.

Although breastfeeding will no longer be a stated NPM in the Title V grant, it is still an important component of our MCH program. VDH will continue efforts around the 5-Star program to recognize breastfeeding-friendly hospitals; the Title V Director serves as the Chair, and the Maternal and Infant Health Coordinator is the coordinator. In addition, VDH will continue to support its Title V-funded breastfeeding collaborative training module through the University of Virginia and will continue to work with partners to promote education and support services for mothers and their babies. Virginia's breastfeeding rates have consistently been above the national average.
An annual breastfeeding conference is planned for early FY18, to include presentations from OBGYNs and pediatricians on the benefits of breastfeeding for both mothers and their infants as well as personal success stories from women who have successfully breastfed. Local health districts, the Virginia chapter of AAP, March of Dimes, maternity centers, and community partners are expected partners.

Newborn Screening

The Virginia Newborn Screening Program is composed of several service-programs including Dried Blood Spot Testing, Critical Congenital Heart Disease, Early Hearing Intervention and Detection, and VaCARES Birth Defects Surveillance. Every infant born in Virginia will receive testing, appropriate follow-up, and referrals as needed by VDH Central Office staff and partners to assist achieving optimal health through early diagnosis and treatment. Virginia is proud of our 98% screening rate for infants born in Virginia; only parents with religious objections are able to decline screening.

MIECHV

Virginia's MIECHV program supports pregnant women, families and at-risk parents of children (birth to age five) access resources and develop the skills needed to raise children who are physically, socially and emotionally healthy and ready to learn. The MIECHV Program develops and implements voluntary, evidence-based home visiting programs using models that are proven to improve child health and to be cost effective, including Parents as Teachers, Nurse Family Partnership, and Healthy Families.
Virginia's home visiting network also includes Healthy Start.

II.F.2 MCH Workforce Development and Capacity

The Virginia Department of Health has taken a leadership role in the development of the state population health plan. It highlights the importance of maternal and child health in Virginia. The state plan includes maternal and child health indicators, as well as health promotion, prevention, and when indicated, direct service delivery (e.g. safety net provider) which align with Title V priorities.

Current Capacity of Workforce

The actions taken to improve the current capacity of the workforce within the state to address the needs of the MCH population are linked to ongoing efforts within Virginia to use best practices to address policy and practice. MCH issues have been addressed through state-level bodies such as the Virginia's Children's Cabinet, the Commonwealth Council on Childhood Success, and the Commission on Youth's workgroup on adverse childhood experiences.

The Plan for Well-Being highlights the importance of maternal and child health and identifies strategies to improve the health and well-being of all MCH populations in the Commonwealth, including the development of the MCH workforce. VDH's MCH program has benefitted from workforce development efforts of other stakeholders, including Virginia Early Childhood Foundation's study of programs and services for children under five and advocacy work by the Virginia Poverty Law Center.

Changes to Improve Capacity

Virginia possesses strong leadership across the state's health and human services agencies. There is a collaborative vision across sectors (e.g., public health, education, social services, etc.) for early childhood development and the broader MCH population. There are many partnerships in the state, and many public and private organizations which are actively engaged to improve early childhood health, beginning in preconception. In addition, there is an emphasis on informatics, data systems development, and data sharing to improve the health of Virginians. These efforts create an optimal environment for the advancement of maternal and child health in Virginia.

A transition of the Virginia Title V grant and infrastructure towards a population health perspective and life course model for programs and data collection started in FY15. A key driver is the concept of working systematically and less programmatically. This includes focusing on all children and families. It also includes strategic balance between quality and quantity and strengthening linkages between tools (i.e. standards/evidence-based screening tools, curriculum, and assessments) and actions.

Organizational Structure

The Health and Human Service Secretariat oversees the state health and human services agencies (e.g. VDH; Department of Medical Assistance Services, DMAS; Department of Behavioral Health and Developmental Services, DBHDS; Department of Social Services, DSS).

Section 32.1-77 of the Code of Virginia authorizes VDH to prepare and submit to the state Title V plan. The Commissioner of Health is authorized to administer the plan and expend Title V funds. The Office of Family Health Services (OFHS) provides fiscal oversight; the Division of Child and Family Health (DCFH), led by the state Title V Director, manages the state Title V program, provides strategic direction, and ensures coordination with other state and federal MCH programs. See Attachment 2 for Organizational Chart.

The Health Commissioner recently established a new Deputy Commissioner of Population Health position. Vanessa Walker Harris, MD, has served as the OFHS Director since November 2015. She reports directly to the Deputy Commissioner for Population Health. Cornelia Deagle, PhD, MSPH, serves as the Title V Director and DCFH Director. In 2017, Carla Hegwood, MPH, assumed the MCH Title V and Special Projects Coordinator position. Two vacancies are under recruit and expected to be filled by late 2017: the Adolescent Health Specialist, who will focus on the emerging priority of adolescent health within the agency, and the lead MCH Epidemiologist. Designated staff will temporarily cover these positions until filled.

Workforce Development and Training Needs

The workforce development and training needs of the state Title V staff aligns closely with the Title V state plan. The needs include both training of new staff and sustaining skill or skill-building in current staff. Critical work force development includes content such as leadership development, implementation of Bright Futures, developmental screening and follow-up, SEI, maternal mental health and intergenerational service delivery, cultural competency, trauma-informed care, and continuous quality improvement. VDH partners with VA DBHDS for SEI, the Fortis group for leadership development, and cross-sector professional development for other content.

II.F.3. Family Consumer Partnership

The Office of Family Health Services (OFHS) provides a number of opportunities for family and consumer input into the MCH and CYSHCN programs. For example, a parent feedback survey is used to assess the services provided by the Care Connection for Children centers, Bleeding Disorders Program, and Child Development Clinics. In addition, a contract is in place with the state's federally-funded Family to Family (F2F) Health Information Center to employ parents as 1-3-6 family educators supporting the Early Hearing Detection & Intervention (EHDI) programs. Consumer focus groups were coordinated to gather input on a variety of MCH related programs.

Family involvement in Virginia goes beyond including families in surveys and focus groups. The OFHS recognizes that families are seeking information and resources and are committed to changing systems to make possible a better life for those who follow. The Maternal and Child Health (MCH) team is very intentional in ensuring Title V activities are family-driven by including family representatives in all aspects of Title V, ranging from soliciting parent feedback on services, engaging family representatives in the Title V grant application process, and inviting family representatives to program planning, design, and implementation meetings. For example, Virginia has family representation on the core Title V team and has sent family representatives to MCH meetings and conferences. The MCH team partners regularly with the F2F program. The value of this partnership is reflected in the F2F center which includes over 80 culturally and linguistically diverse parents, self-advocacy staffs, and volunteer family navigators which provide emotional, informational, and systems navigational support families annually.

The core MCH team is committed to increasing the inclusion of more families in the Title V programs, including leadership positions.

The Care Connection for Children (CCC) centers employ parents of CYSHCN as parent coordinators. In addition, one CCC center has contractual relationships with Parent to Parent of Virginia for this work. The center navigators work closely with Virginia F2F to provide emotional, informational and systems navigational support to over 2,000 culturally and linguistically diverse families each year. The parent coordinators are responsible for sharing family stories, completing family assessments, and providing parent workshops. The parent coordinators meet annually to network, learn from each other, and receive updates on family engagement trends.

The Child Development Clinics (CDC) in 2016, in Norfolk and Roanoke partnered with F2F, the Tidewater Autism Society, and the parent support program at Virginia Tech’s Center on Autism Research to respond to referrals for over 250 families whose children were diagnosed with Autism Spectrum Disorder. Local families and parent led organizations also led focus groups and were critical members of community teams established by CDCs to meet quarterly to address the early diagnosis of autism in their communities.

A contract was established between F2F and the EHDI program for six parents of children who are deaf and hard of hearing. The purpose was for the families to visit one of the 38 birthing hospital newborn hearing screening teams and local audiology clinics to discuss EHDI protocols and learn more about practices used by hospitals and audiologists to encourage parents to return for rescreening for hearing tests. These parents also provided parent to parent support to 45 families referred by the EHSI programs to the F2F for emotional support.

Family representatives serve on the Regional Perinatal Councils, the Hemophilia Advisory Board, the Fetal Alcohol Spectrum Disorder Task Force, the Virginia EHDI Advisory Committee, and the Virginia Genetics Advisory Committee. Title V staff also participate in a number of organizations such as the Spina Bifida Foundation, Cystic Fibrosis Foundation, Virginia SIDS Alliance, Virginia Parents Against Lead, the Family Engagement Network, and the Virginia Congress of Parents and Teachers.

Dana Yarbrough, Executive Director of Parent to Parent of Virginia and Director of the Center for Family Involvement at Virginia Commonwealth University (home to the VA F2F), leads the voice of patient engagement, shared decision-making, family-centered practices, and cultural agility in the OFHS' medical neighborhood initiative. She represents Virginia as the family liaison delegate to the Association of Maternal and Child Health Programs (AMCHP) and the New York Mid Atlantic Consortium (NYMAC) for Genetic and Newborn Screening Services. Dana serves as the chair for the NYMAC Primary Care Linkages Workgroup. She also serves on AMCHP's Family and Youth Leader Committee and mentors parents who are selected for the Family Leader Lab. In addition to her professional role, Dana brings family wisdom and experience as the parent of a 22-year-old daughter with significant intellectual, physical, and sensory disabilities as the result of a premature birth.

A team consisting of VDH, VA-AAP, and Virginia's F2F Health Information Center staffs was accepted to an AMCHP and UNC Workforce Development sponsored training in Chicago, August 2016. In addition to the workforce development training, the F2F director serves as one of the leaders in the medical neighborhood projects and regularly attends AMCHP meetings as a member of the VDH Title V team.

Family and consumer partnerships at the individual program level have variable degrees of involvement. For example, one of the Sickle Cell centers has an ambassador program where they refer families of newly diagnosed newborns to other families for peer counseling. The unpaid parent volunteers initiate and maintain contact with the family for a mutually agreed upon time. In addition, the Center has a sickle cell support group. The goal is to enhance connections and build a community among the center families, strengthen support networks, and facilitate peer-to-peer support.

Information regarding feedback on service delivery and programs is obtained through the Virginia Hemophilia Foundation by email, monthly support groups, or patient feedback surveys (conducted every other year). The regional CCCs employ parent coordinators as staff; their role is to engage families to offer community resources and support. Many of the paid parent coordinators have a child with a special health care need which provides a unique perspective in working with families.

An area of focus for the upcoming year is to be more inclusive with quality improvement efforts and parent representation. Secondly, the needs assessment shows that Virginia is becoming more diverse and supports the belief that diversity enriches the state and the experiences of all Virginians. The MCH team recognizes that this diversity be represented in culturally relevant and appropriate ways in Title V programs and services as well as all outreach and educational efforts.

II.F.4. Health Reform

Information is not provided for this optional section.

II.F.5. Emerging Issues

Partnership

It takes a population to transform health. No individual organization, program, or profession can accomplish the transformation to population health without collaboration, pooled resources, and effective partnerships. Our maternal and child health, including CYSHCN, efforts in Virginia demonstrate a multidisciplinary partnership approach to health care by including traditional and non-traditional partners. This practice is reflected in our advisory committees (e.g., EHDI etc.), strategic planning (e.g., Population Health Plan) and our ongoing programs (e.g., CYSHCN etc.). These partnerships include representatives from medicine, nursing, social work, public health, behavioral health, education, social services, academia, community-based organizations (CBOs), and most importantly, families and individuals served by our programs. All of these entities contribute to the development, planning, implementation and evaluation of our efforts in the realm of maternal and child health.

Population Health

As a result of the transformation of Title V in Virginia, VDH is taking the lead to ensure all of Virginia's MCH programs are data driven to support the population health plan. In 2015, VDH initiated internal programmatic "dashboards" that are maintained to track progress and inform the agency dashboard representing a data snapshot of the health of Virginia. The MCH staff contributed to the development of the Plan for Well-Being including priorities such as infant mortality, teen pregnancy, early childhood health and development (using Bright Futures as the framework), and access to services and quality of care.

The MCH team stays informed about health events in the state through mechanisms described in the "Needs Assessment" section. For example, Virginia has several current issues that impact the MCH populations:

1. Opioid use, particularly among youth and pregnant women;
2. Zika;
3. Changes in the Medicaid system and infrastructure;
4. Toxic stress (e.g. adverse childhood experiences, ACEs);
5. Early childhood development and coordination of health services with other services at the community level.

The Virginia response to the sharp increase in opioid use across the state has been immediate, strategic, and multi-faceted. In the fall of 2016, the Virginia Commissioner of Health declared opioid use a public health emergency to raise awareness and mobilize state resources to support providers in caring for patients with substance abuse. The outcome of the declaration was a statewide standing order for Naloxone, the rescue medicine for opioid overdose. This was accomplished in close collaboration and consultation with the Virginia Department of Health Professions, the Board of Pharmacy, and the Virginia Department of Behavioral Health and Developmental Services (DBHDS).

The anecdotal reports of the increasing cases of neonatal abstinence syndrome in Virginia's birth hospitals stimulated a review of data by VDH and other agency partners and were the catalyst for DBHDS to apply for a technical assistance opportunity with SAMHSA. DBHDS convened a multi-disciplinary task force, including MCH VDH staff, to explore opioid use in Virginia among pregnant women and further understand resources, services, and treatment. Over 12 months of work resulted in two committees to: (1) focus on developing plans of safe care for the substance exposed infant; and (2) develop plans of safe care for the mother. In addition, other efforts to develop resources to address this effort included the development of professional education for nurses funded by a CDC grant.

Information was provided to the Department of Education, schools, and school nurses regarding the use of naloxone

in schools in an effort to address the opioid crisis with youth. The pros and cons of stock naloxone in schools were examined. The 2015 YRBS trend analysis showed a decreasing incidence of opioid use in high schools. The decision to stock naloxone was left to individual school districts within the Department of Education.

The second emerging issue was Zika. There was a multi-tiered approach to respond to Zika. On February 26, 2016 Governor Terry McAuliffe announced the creation of the Virginia Zika Task Force to coordinate the Commonwealth's efforts to prepare for and respond to locally transmitted cases of Zika in Virginia. The Virginia Department of Health (VDH) was named lead agency in this effort. Under the task force's command structure, VDH's Office of Epidemiology and Office of Family Health Services (OFHS) are collaborators within the maternal/fetal health task group. This group has been charged with planning and organizing efforts to address the educational and clinical needs related to maternal and fetal health for several groups: pregnant women, their infants, and several subsets of health care professionals, including but not limited to, OB-GYNs, pediatricians, neonatologists, pediatric neurologists and infectious disease specialists. VDH understands the need for more timely information about the outcomes of pregnant women and their children affected by the Zika virus and support multiple surveillance efforts to further guide and inform the public and healthcare providers.

OFHS has provided programmatic leadership and guidance on many health issues facing families throughout the state. In particular and relevant to Virginia's Zika preparedness activities, the Division of Child and Family Health (DCFH) brings experience in maternal and infant surveillance activities. DCFH oversees Virginia's newborn screening (NBS) programs as well as the surveillance and tracking of birth defects through the Virginia Congenital Anomalies Reporting and Education System (VaCARES), the state's birth defects registry. These programs are a core component of the maternal and infant health programs within the Commonwealth. The collaboration with community service providers (e.g., Early Intervention, Behavioral Health, Social Sciences, Department of Education and family support organizations) and the multi-disciplinary approach to newborn screening and birth defects surveillance has informed various health department prevention programs as well as developing strategies for early screening, diagnosis and referral to treatment and case management through Virginia's Children and Youth with Special Health Care Needs (CYSHCN) programs and other partners.

With this experience, DCFH was tasked with standing up and managing the CDC Zika Pregnancy Registry (ZPR) and Zika Birth Defects Surveillance (ZBDS) programs in Virginia, both funded through the CDC. The ZPR Coordinator has been tasked with overseeing all Zika pregnancy registry activities in Virginia. As of May 2017 a total of 64 pregnant women have been identified as eligible for the ZPR in Virginia; all with travel-associated laboratory evidence of Zika virus. These cases were spread through all regions of Virginia, with most prevalence in Fairfax County in the northern region of Virginia (D.C. suburb). Zika virus surveillance has also shifted birth defect monitoring from a passive system to a more active system in Virginia. The ZBDS program coordinator has been hired to implement this new approach. Both programs work in close collaboration with the CDC and MCH funded programs such as the Virginia Early Hearing Detection and Intervention (EHDI) to monitor health outcomes of infants born to women in the ZPR, as well as with CYSHCN programs. Infants identified with birth defects through Virginia's pregnancy registry and/or active surveillance are automatically eligible for care coordination and/or child development services through these respective CYSHCN Programs.

In conjunction with internal VDH programmatic Zika activities, the Virginia Zika Clinician Outreach task group met five times to address needs of the healthcare community and to coordinate a system of regional Zika-related clinical and consultation services. This group is comprised of statewide healthcare providers representing hospital systems, OB-GYNs, neonatologists, pediatricians and multiple specialists to advise and assist VDH in targeted Zika activities, including but not limited to, participation in the 2017 Virginia Zika Virus Clinician Forum and the CDC/March of Dimes initiative Zika Care Connect (ZCC). A regional Zika healthcare consultant list was published and available to Virginia healthcare providers. This list was shared with the CDC Zika Care Connect (ZCC) team. As

of the April 2017 launch of the ZCC website, Virginia has 29 specialist providers enrolled in the project. VDH plans to continue activities described above well into 2018.

Another emerging issue is related to changes in the Medicaid system and infrastructure. Virginia did not choose to expand Medicaid; however, efforts continue to examine strategic methods to improve access and quality of health care for all populations in Virginia, particularly MCH (i.e., women, pregnant women, infants, children, and adolescents). The DMAS team has worked closely with the Managed Care Organizations (MCO) to strengthen the system of care. The MCO leaders have been active participants in the MCH initiatives including infant mortality reduction and the LARC work group. The outcome from this partnership was the revision of the DMAS payment structure to allow the unbundling of postpartum LARCs to improve access for women choosing a LARC after delivery.

The number one emerging public health issue with lifelong consequences to health is from exposure to violence and abuse; in fact, it is the leading cause of death linked to 7/10 ACE instrument items. In an effort to better understand the importance adverse childhood events, Virginia added questions in 2016 to the Virginia BRFSS to obtain a baseline on the impact of ACES in the Commonwealth. In addition, to address toxic stress and childhood adversity (ACES/Bright Futures), the Virginia School Nurses and the VA-AAP partnered at the 2016 Virginia Pediatric Health Care Conference to increase the awareness of the long term impact of toxic stress on student health, brain effects, and adversity beyond childhood.

Maternal mental health and toxic stress puts families at greater risk for disease, homelessness, prison time, and early death. Decreasing the dose adversity of toxic stress and building resiliency of families over time will enable Virginia families to better achieve health and well-being.

Early screening is crucial for early intervention for all children. Therefore, we have prioritized comprehensive developmental screening to ensure all children in Virginia reach a state of optimal health and well-being.

II.F.6. Public Input

Public input is an ongoing process for Title V in Virginia and began with an extensive statewide maternal and child health needs assessment in 2015. This needs assessment involved a three-phase process of soliciting public input, allowing VDH to obtain feedback through multiple mechanisms.

During each phase, input from key stakeholders, key informants, and citizens of the Commonwealth was documented and analyzed. Final reports summarized consistent themes, pressing health concerns, and recommendations and strategies emerging from each phase. See Five Year Needs Assessment update for additional detail.

A summary of this process is presented below. The needs assessment results, paired with input received on an ongoing basis from families, programmatic partners, and other stakeholders, continue to inform the state's Title V priorities and strategies.

MCH Three-Phase Needs Assessment for 2015 – 2020 Grant Cycle

Phase 1: Stakeholder Meeting

The VDH Office of Family Health Services (OFHS) convened a stakeholder meeting on November 17, 2014. Forty-two community stakeholders met with members of OFHS staff to identify and discuss critical health issues currently affecting women and children across the state. This was an opportunity for VDH to learn about immediate and future MCH resource needs and to hear what stakeholders hoped to see addressed by 2020. OFHS also hoped to gain insight on how special populations in Virginia were faring, on the existence of continuing disparities, and on ways that community groups could collaborate with VDH and with each other to move the needle.

Organizations represented included:

· American Academy of Pediatrics
· American Lung Association
· Bon Secours
· Brain Injury Association of Virginia
· Breastfeeding Task Force
· CHIP of Virginia City of Richmond Crossover Healthcare Ministry
· March of Dimes
· Prevent Child Abuse Virginia
· Thomas Jefferson Health District
· United Way
· University of Virginia (UVA)
· Virginia Academy of Nutrition and Dietetics
· Virginia Commonwealth University (VCU)
· VCU Partnerships for People with Disabilities
· VCU Pediatrics
· Virginia Council of Churches
· Virginia Department for Aging and Rehabilitative Services
· Virginia Department for Behavioral Health and Developmental Services (DBHDS)

· Virginia Department for the Deaf and Hard of Hearing
· Virginia Department of Education (DOE)
· Virginia Department of Health (VDH)
· Virginia Department of Medical Assistance Services (DMAS)
· Virginia Department of Social Services (DSS)
· Virginia Early Childhood Foundation
· Virginia Healthy Start Initiative/Loving Steps Program
· Virginia Hemophilia Foundation
· Virginia Hospital & Healthcare Association (VHHA)
· Virginia Office of the Chief Medical Examiner (OCME)

Phase 2: Key Informant Interviews

Campbell & Company (C&C) conducted 22 interviews with key stakeholders in the central Virginia area in December 2014 and January 2015. Individuals interviewed included non-profit executives, leaders of foundations, state and local government officials, and physicians. Interviewees were experts in diverse areas, including health care administration and social services, dentistry, children and youth with special needs, pediatrics, women's health and mental health. Most interviewees served highest-need populations – specifically, Virginia residents living in poverty, suffering from poor health, and with little to no access to regular health services.

Stakeholders were encouraged to be candid in their responses as they spoke about the most critical health issues impacting Virginia families, specific health needs for individual population groups, and barriers or gaps impeding progress. They were also asked to share their perspective on what VDH does well with special population groups and to provide recommendations on strengthening the role of VDH and other sectors in improving collaboration, data collection, and data sharing.

Phase 3: Focus Groups

VDH OFHS convened six focus groups in January 2015 in key regions across the state to solicit input on critical health issues affecting women and children. Four focus groups included consumers, and two focus groups included parents of children and youth with special health care needs.

1. Central Region: Johnston-Willis Hospital (Richmond, VA)
2. Far Southwest Region: Johnston Memorial Hospital (Abingdon, VA)
3. Northern Region: Inova Fair Oaks Hospital (Falls Church, VA)
4. Far Southwest Region: CB Hale Community Service Building (Bristol, VA)
5. Eastern Region: Sentara Princess Anne Hospital (Virginia Beach, VA)
6. Northwestern Region: Shenandoah Valley Child Development Clinic (Harrisonburg, VA)

Ongoing Efforts

Annually, VDH puts the Title V annual report and application out for public comment on an online Town Hall platform from August to September. Any public comment received during this period will be noted in this section when the FY18 application is reopened for editing.

The application and contact information for Title V staff are also made publically available on the VDH website to facilitate submission of additional public responses and inquiries throughout the year.

No formal comments on the FY17 application were logged. However, Title V and MCH staff continue to work closely with and solicit input from with a large body of stakeholders through various coalitions, advisory boards, partnerships, and projects. Informal stakeholder feedback on the state's MCH efforts are regularly requested in the course of daily program operations to ensure state priorities remain relevant to current MCH needs. This input is taken into account during program planning and implementation and is reflected in annual updates to the state action plan.

The current state priorities and performance measures have been shared with key partners, such as DMAS, to support interagency alignment. Input from all 35 local health districts was also solicited in 2017 to gauge shifts in local needs and programmatic priorities.

II.F.7. Technical Assistance

Virginia was selected to receive technical assistance (TA) from the National MCH Workforce Development Center in Chapel Hill, North Carolina, as part of the 2015-2016 state cohort. Virginia's project, the *Medical Neighborhood,* is growing, and the VDH MCH team continues to reach out to the MCH Workforce Development Center for ongoing assistance and resources as necessary. For example, since the core "project team" has grown and new stakeholders are now engaged, the VDH MCH team requested assistance in identifying exercises to conduct a "review-visioning" of the project and to determine next steps.

In 2017, the VDH MCH team became engaged in two additional TA opportunities.

First, a team from Virginia was invited to participate in the Learning Collaborative on Improving Quality and Access to Care in Maternal and Child Health, sponsored by the NCSL, ASTHO, NGA, AMCHP, AAP, and NASHP. The Virginia team consists of 3 state senators, a representative from the Governor's Office, a VDH Deputy Commissioner, the MCH/Title V Director, the Title V CYSHCN Director, and the DMAS (Medicaid) Deputy Director. This team is working to develop and implement an action plan to support interagency collaboration and policy development to improve the health of MCH populations. This effort is ongoing.

Second, the National Governor's Association (NGA) invited a team of Virginia stakeholders to participate in the Governor's Bipartisan Health Reform Learning Network and MCH and Public Health Working Group Meeting. This Virginia team included Medicaid and private health insurance officials, representatives from the Governor's Office, and the MCH/Title V Director. The focus of the effort is to determine strategies to improve collaboration and coordination among programs, payors, and public and private partners. This effort is also ongoing.

Given the Virginia's MCH team level of commitment to these three significant, national-level technical assistance projects, there are no additional requests for TA at this time.

III. Budget Narrative

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$12,369,389	$12,025,842	$11,949,178	$10,634,892
Unobligated Balance	$0	$0	$0	$0
State Funds	$9,277,042	$9,019,382	$8,961,883	$7,976,169
Local Funds	$0	$0	$0	$0
Other Funds	$977,807	$991,958	$1,048,412	$1,167,422
Program Funds	$500,000	$0	$25,000	$26,562
SubTotal	$23,124,238	$22,037,182	$21,984,473	$19,805,045
Other Federal Funds	$145,527,761		$151,882,965	$164,569,656
Total	$168,651,999	$22,037,182	$173,867,438	$184,374,701

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2016		2017	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$12,025,842	$12,092,401	$12,072,934	
Unobligated Balance	$0	$0	$0	
State Funds	$9,019,382	$9,069,301	$9,054,701	
Local Funds	$0	$0	$0	
Other Funds	$1,152,718	$1,182,763	$1,125,000	
Program Funds	$0	$183,208	$0	
SubTotal	$22,197,942	$22,527,673	$22,252,635	
Other Federal Funds	$148,869,827	$170,217,550	$191,309,215	
Total	$171,067,769	$192,745,223	$213,561,850	

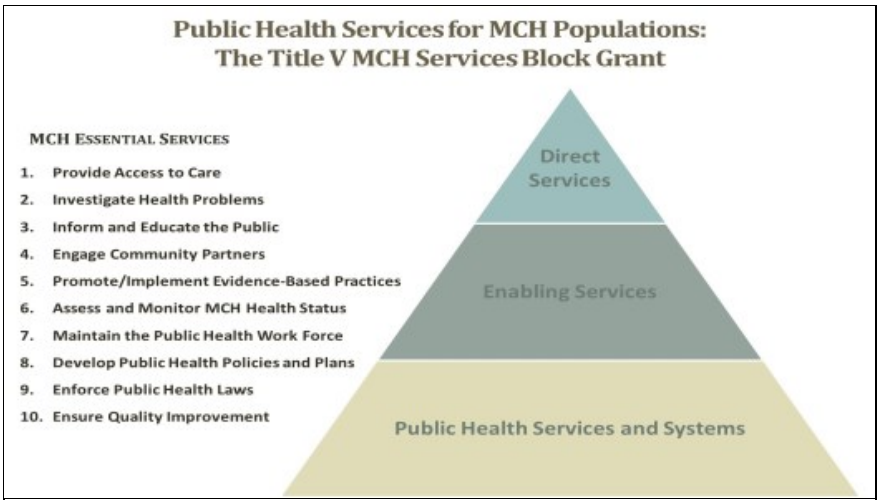
	2018	
	Budgeted	Expended
Federal Allocation	$12,092,401	
Unobligated Balance	$0	
State Funds	$9,069,301	
Local Funds	$0	
Other Funds	$1,125,000	
Program Funds	$200,000	
SubTotal	$22,486,702	
Other Federal Funds	$12,847,299	
Total	$35,334,001	

III.A. Expenditures

Form 2: For FY16, Virginia received a total federal allocation of $12,092,401, with matching expenditures totaling $10,394,301. Virginia expended $9,069,301 of State MCH Funds and $1,182,763 in Other Funds (to perform newborn screening services, as required by the Virginia General Assembly). In addition, a total of $183,208 in program income was generated and reinvested in delivery of Title V MCH services. FY16 expenditures for the state-federal Title V partnership totaled $22,486,702. Sec. 505 (a)(4) requires that states maintain the level of funds provided by the state in fiscal year 1989. Virginia's maintenance of effort (MOE) amount from 1989 was $8,718,003. With a match of $10,394,301, Virginia has exceeded this requirement. The overall FY16 budget was projected based on the total FY14 federal award ($12,025,842); the actual FY16 award ($12,092,401) was slightly higher. Variances between the budgeted and actual amounts were a result of this slightly greater federal award and strategic efforts to broaden the impact of Title V initiatives.

Form 3: On Form 3a, expenditure data was captured and grouped into categories of people served (Pregnant Women, Infants < 1 year old, etc.). On Form 3b, the expenditure data was captured and grouped by types of expenditures. The types of expenditures were grouped into the categories required on Form 5 (Direct Services, Enabling Services, Public Health Services and Systems, and Reported Services). Direct Health Care Services contain expenditures for Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to age one, Preventative and Primary Care Services for Children, and Services for CYSHCN. Reported services include: pharmacy, physician/office services, hospital charges (child emergency only), dental care (does not include orthodontic services), and laboratory services.

Virginia has worked to align spending by type with the MCH pyramid by reducing expenses for direct patient care and increasing expenses in enabling services and public health systems.



III.B. Budget

The Title V block grant 2018 application budget provides funds for maternal and child health (MCH) services, primary care for children and adolescents, and preventive and maintenance services to children with special health care needs (CSHCN). Preventive and primary care services include policy and procedural oversight, local health department (LHD) agreements, pharmacy and laboratory testing, newborn screening and referral for follow up, and reducing health problems and risk factors. Other services provided include population-based maternal and child health systems coordination, e.g. cross-coordination of providers, specialists, school systems, government agencies, and community partners. Employing appropriate and culturally relevant communication strategies is an increasing priority to better connect with priority MCH communities and “meet people where they are” (e.g. web-based community outreach and education through social media, the VDH online data portal, online training modules for families and health care providers).

Additionally, we have included $1,125,000 in Other Funds to perform newborn screening services as required by the Virginia General Assembly. This funding is dedicated to ensuring early screening, testing, and referral for Virginia’s infants.

Services for CSHCN include family-centered, community-based coordinated care for persons under the age of 21 years who have or are at risk for disabilities, handicapping conditions, chronic illnesses and conditions or health related educational or behavioral problems, and development of community-based systems of care for such children and families.

Virginia budgets 30 percent or more of MCH federal funding for preventive and primary care services for infants, children, and women. Approximately 50 percent of federal funding is budgeted for CSHCN. Finally, 10 percent of the federal allocation is budgeted for administration of Title V funds.

In addition, Virginia budgets for match on a 4 to 3 ratio of federal to state funds, keeping in mind the maintenance of effort (MOE). Sec. 505 (a)(4) requires that states maintain the level of funds provided (match) solely by the state for MCH health programs at a level at least equal to the level provided by the state in fiscal year 1989. Virginia's MOE is $8,718,003. The Fiscal Year 2018 Budget meets the match and MOE amount as follows:

FY18 Budget Amount
Federal amount: $12,092,401
State Match amount: $10,394,301

Administration costs include management, policy direction, accounting and budgeting services, personnel services, and support services.

For FY18, the Virginia Department of Health’s Office of Family Health Services has reviewed all federal investments relevant to the MCH state and national priorities that are received. We narrowed the criteria for inclusion in the state’s MCH budget (as reported on line 11 of Form 2) to more clearly define the fiscal landscape for Virginia’s MCH population. This will maximize opportunities to leverage different funding streams to meet Title V goals and objectives and also accurately demonstrate how Title V funds are used to support state priorities and complement the state’s investment.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - DMAS Agreement - Signed 04.25.2016.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - Virginias-Plan-for-Well-Being.pdf

Supporting Document #02 - Org Chart 5.10.17.pdf

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Virginia

	FY18 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 12,092,401	
A. Preventive and Primary Care for Children	$ 3,956,695	(32.7%)
B. Children with Special Health Care Needs	$ 5,390,214	(44.5%)
C. Title V Administrative Costs	$ 1,209,240	(10%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 9,069,301	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 1,125,000	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 200,000	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 10,394,301	
A. Your State's FY 1989 Maintenance of Effort Amount $ 8,718,003		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 22,486,702	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 12,847,299	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 35,334,001	

OTHER FEDERAL FUNDS	FY18 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 1,254,747
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	$ 7,648,351
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 225,482
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	$ 1,207,690
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 1,773,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Zika Surveillance Systems Grant Program	$ 488,029

	FY16 Annual Report Budgeted		FY16 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 12,025,842		$ 12,092,401	
A. Preventive and Primary Care for Children	$ 4,108,310	(34.2%)	$ 3,956,695	(32.7%)
B. Children with Special Health Care Needs	$ 6,714,948	(55.8%)	$ 5,390,214	(44.5%)
C. Title V Administrative Costs	$ 1,202,584	(10%)	$ 1,209,240	(10%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0		$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 9,019,382		$ 9,069,301	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 1,152,718		$ 1,182,763	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 183,208	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 10,172,100		$ 10,435,272	
A. Your State's FY 1989 Maintenance of Effort Amount $ 8,718,003				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 22,197,942		$ 22,527,673	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 148,869,827		$ 170,217,550	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 171,067,769		$ 192,745,223	

OTHER FEDERAL FUNDS	FY16 Annual Report Budgeted	FY16 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Behavioral Risk Factor Surveillance System (BRFSS)	$ 108,778	$ 234,866
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 156,274	$ 0
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 114,762	$ 101,001
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 2,184,979	$ 3,037,235
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 768,096	$ 826,635
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 971,250	$ 913,288
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	$ 7,641,240	$ 7,604,659
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	$ 140,000	$ 124,782
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Genetic Services Project	$ 299,713	$ 88,389
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health	$ 459,945	$ 0
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 95,374	$ 114,096
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000	$ 200,630

OTHER FEDERAL FUNDS	FY16 Annual Report Budgeted	FY16 Annual Report Expended
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 3,522,000	$ 3,048,325
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Breast & Cervical Ca	$ 2,474,054	$ 2,424,877
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Youth Risk Behavior	$ 60,000	$ 61,446
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Tobacco Use Control	$ 946,289	$ 1,074,234
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Quitline	$ 438,241	$ 521,771
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Making a Healthier V	$ 1,912,645	$ 1,294,957
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Closing the Gap	$ 2,664,121	$ 2,566,418
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Childrens Oral Healt	$ 246,278	$ 107,017
US Department of Agriculture (USDA) > Food and Nutrition Services > WIC/CACFP	$ 123,415,788	$ 145,872,924

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Services offered through the Child Development Centers (CDCs) are available to all children; funds for CDC services are thus included in expenditures for children's services to be inclusive of all children in the Commonwealth.	
2.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Title V funds supported salaries for dental hygienists who provide fluoride varnish for young children and train dental care providers to serve CSHCN. FY16 program income generated is here.	
3.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: Award to date is $143,825.	
4.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Zika Surveillance Systems Grant Program**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: Carrying forward for Zika registry and surveillance from FY17; original award was $560,000.	
5.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs**
	Fiscal Year:	**2016**

	Column Name:	**Annual Report Expended**
	Field Note: Did not receive grant funds.	
6.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Did not receive grant funds.	

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Virginia

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Pregnant Women	$ 768,126	$ 768,126
2. Infants < 1 year	$ 768,126	$ 768,126
3. Children 1-22 years	$ 3,956,695	$ 3,956,695
4. CSHCN	$ 5,390,214	$ 5,390,214
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 10,883,161	$ 10,883,161

IB. Non Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Pregnant Women	$ 1,077,831	$ 1,077,831
2. Infants < 1 year	$ 1,077,831	$ 1,077,831
3. Children 1-22 years	$ 1,218,474	$ 1,218,474
4. CSHCN	$ 263,212	$ 263,212
5. All Others	$ 4,762,381	$ 4,762,381
Non Federal Total of Individuals Served	$ 8,399,729	$ 8,399,729
Federal State MCH Block Grant Partnership Total	$ 19,282,890	$ 19,282,890

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Form 3b
Budget and Expenditure Details by Types of Services

State: Virginia

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Direct Services	$ 1,622,201	$ 1,321,073
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 76,813	$ 11,034
B. Preventive and Primary Care Services for Children	$ 197,835	$ 0
C. Services for CSHCN	$ 1,347,553	$ 1,310,039
2. Enabling Services	$ 3,291,082	$ 6,011,225
3. Public Health Services and Systems	$ 7,179,118	$ 4,760,103
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 154,794
Physician/Office Services		$ 1,162,655
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 3,624
Direct Services Line 4 Expended Total		$ 1,321,073
Federal Total	$ 12,092,401	$ 12,092,401

IIB. Non-Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Direct Services	$ 234,510	$ 964,822
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 107,783	$ 0
B. Preventive and Primary Care Services for Children	$ 60,924	$ 13,111
C. Services for CSHCN	$ 65,803	$ 951,711
2. Enabling Services	$ 1,926,244	$ 263,212
3. Public Health Services and Systems	$ 6,906,547	$ 7,841,267
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 964,822
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 964,822
Non-Federal Total	$ 9,067,301	$ 9,069,301

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Virginia

Total Births by Occurrence: 103,074

1. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Core RUSP Conditions	97,750 (94.8%)	2,559	246	246 (100.0%)

Program Name(s)				
Propionic acidemia	Methylmalonic acidemia (methylmalonyl-CoA mutase)	Methylmalonic acidemia (cobalamin disorders)	Isovaleric acidemia	3-Methylcrotonyl-CoA carboxylase deficiency
3-Hydroxy-3-methyglutaric aciduria	Holocarboxylase synthase deficiency	ß-Ketothiolase deficiency	Glutaric acidemia type I	Carnitine uptake defect/carnitine transport defect
Medium-chain acyl-CoA dehydrogenase deficiency	Very long-chain acyl-CoA dehydrogenase deficiency	Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	Trifunctional protein deficiency	Argininosuccinic aciduria
Citrullinemia, type I	Maple syrup urine disease	Homocystinuria	Classic phenylketonuria	Tyrosinemia, type I
Primary congenital hypothyroidism	Congenital adrenal hyperplasia	S,S disease (Sickle cell anemia)	S, βeta-thalassemia	S,C disease
Biotinidase deficiency	Cystic fibrosis	Severe combined immunodeficiences	Classic galactosemia	

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

There is no formal long-term monitoring or follow-up process that occurs with infants diagnosed with heritable disorders through the Virginia Newborn Screening Program (VNSP); however, the VNSP does have a process in place to refer screen positive infants to specialty providers to ensure timely diagnosis and entry into specialty care, as well as a process to refer confirmed infants to the Care Connection for Children Centers (CCC) . These programs partner with the newborn screening program to make ensure that families and their primary care providers have access to appropriate support
services.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

None

Data Alerts: None

Form 5a
Unduplicated Count of Individuals Served under Title V

State: Virginia

Reporting Year 2016

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	54,597	39.4	0.0	3.0	57.5	0.1
2. Infants < 1 Year of Age	102,863	30.8	0.0	62.4	4.7	2.1
3. Children 1 to 22 Years of Age	102,365	37.8	0.0	5.8	53.4	3.0
4. Children with Special Health Care Needs	7,894	56.7	5.1	33.7	4.5	0.0
5. Others	62,312	19.2	0.0	10.5	69.4	0.9
Total	330,031					

Form Notes for Form 5a:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2016**

Field Note:
This number includes the four CYSHCN programs at VDH. These programs are funded by Title V and state general funds that are part of the match.

Form 5b
Total Recipient Count of Individuals Served by Title V

State: Virginia

Reporting Year 2016

Types Of Individuals Served	Total Served
1. Pregnant Women	99,469
2. Infants < 1 Year of Age	103,074
3. Children 1 to 22 Years of Age	343,575
4. Children with Special Health Care Needs	7,894
5. Others	62,312
Total	616,324

Form Notes for Form 5b:

None

Field Level Notes for Form 5b:

1.	**Field Name:**	**Infants Less Than One Year**
	Fiscal Year:	**2016**

Field Note:
Total number of resident live births in 2015

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Virginia

Reporting Year 2016

I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	102,863	66,280	21,281	189	6,553	30	8,470	60
Title V Served	12,965	6,609	2,993	24	437	16	0	2,886
Eligible for Title XIX	30,717	15,007	11,087	43	675	8	3,845	52
2. Total Infants in State	102,863	66,280	21,281	189	6,553	30	8,470	60
Title V Served	102,863	66,280	21,281	189	6,553	30	8,470	60
Eligible for Title XIX	30,717	15,007	11,087	43	675	8	3,845	52

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	89,389	13,474	0	102,863
Title V Served	7,741	4,363	861	12,965
Eligible for Title XIX	25,039	5,678	0	30,717
2. Total Infants in State	89,389	13,474	0	102,863
Title V Served	89,389	13,474	0	102,863
Eligible for Title XIX	25,039	5,678	0	30,717

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Virginia

A. State MCH Toll-Free Telephone Lines	2018 Application Year	2016 Reporting Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 230-6977 x211	(800) 230-6977 x211
2. State MCH Toll-Free "Hotline" Name	Virginia Statewide Human Serivces I&R System (211)	Virginia Statewide Human Services I&R System (211)
3. Name of Contact Person for State MCH "Hotline"	Cornelia Deagle, PhD, MPH	Cornelia Deagle, PhD, MPH
4. Contact Person's Telephone Number	(804) 864-7751	(804) 864-7751
5. Number of Calls Received on the State MCH "Hotline"		100,679

B. Other Appropriate Methods	2018 Application Year	2016 Reporting Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	http://www.vdh.virginia.gov/vdhlivewell/infants-children-and-teens/	http://www.vdh.virginia.gov/vdhlivewell/infants-children-and-teens/
4. Number of Hits to the State Title V Program Website		0
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Virginia

1. Title V Maternal and Child Health (MCH) Director	
Name	Cornelia Deagle, PhD, MSPH
Title	Director, Division of Child and Family Health
Address 1	109 Governor Street
Address 2	
City/State/Zip	Richmond / VA / 23219
Telephone	(804) 864-7691
Extension	
Email	Cornelia.Deagle@vdh.virginia.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Marcus Allen, MPH
Title	Director, Children and Youth with Special Healthcare Needs
Address 1	109 Governor Street
Address 2	
City/State/Zip	Richmond / VA / 23219
Telephone	(804) 864-7716
Extension	
Email	Marcus.Allen@vdh.virginia.gov

3. State Family or Youth Leader (Optional)	
Name	Janet Wright, BSN, RN, NCSN
Title	School and Adolescent Health Specialist
Address 1	109 Governor Street
Address 2	
City/State/Zip	Richmond / VA / 23219
Telephone	(804) 864-7689
Extension	
Email	Janet.Wright@vdh.virginia.gov

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Virginia

Application Year 2018

No.	Priority Need
1.	Safe Sleep: Increase safe sleep practices.
2.	Tobacco: Decrease smoking among pregnant women and in households with children.
3.	Medical Home: Promote the importance of medical home among providers and families.
4.	Transition: Promote independence and transition of young adults with and without special healthcare needs.
5.	Child/Adolescent Injury: Reduce injuries, violence, and suicide among Title V populations.
6.	Woman/Maternal Health: Support the physical and emotional well-being of women and their children.
7.	Developmental Screening: Support optimal mental health and social-emotional development of all children.
8.	Oral Health: Increase access to oral health services.

Form 9 State Priorities-Needs Assessment Year - Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Safe Sleep	New	Priority has state and national performance measures.
2.	Breastfeeding	New	Priority has state and national performance measures.
3.	Physical Activity	New	Priority has state and national performance measures.
4.	Tobacco	New	Priority has state and national performance measures.
5.	Medical Home	New	Priority has state and national performance measures.
6.	Transition	New	Priority has state and national performance measures.
7.	Child/Adolescent Injury	New	Priority has state and national performance measures.
8.	Woman/Maternal Health	New	Priority has state and national performance measures.

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10a
National Outcome Measures (NOMs)

State: Virginia

Form Notes for Form 10a NPMs, NOMs, SPMs, SOMs, and ESMs.

Ratio is of black infant mortality to white infant mortality (2012-2013)

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	79.9 %	0.1 %	72,042	90,155
2014	80.9 %	0.1 %	60,618	74,896
2013	77.5 %	0.2 %	57,327	73,938

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

State Provided Data

	2016
Annual Indicator	85.8
Numerator	84,116
Denominator	98,008
Data Source	Division of Health Statistics, VDH
Data Source Year	2015

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	155.3	4.1 %	1,447	93,204
2013	151.6	4.1 %	1,390	91,678
2012	156.4	4.2 %	1,441	92,136
2011	159.3	4.2 %	1,469	92,190
2010	144.0	4.0 %	1,330	92,389
2009	148.0	4.0 %	1,384	93,526
2008	141.1	3.9 %	1,349	95,628

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

FAD Not Available for this measure.

State Provided Data	
	2016
Annual Indicator	36.3
Numerator	
Denominator	
Data Source	Office of the Chief Medical Examiner , VDH
Data Source Year	2013

NOM 3 - Notes:

None

Data Alerts: None

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	7.9 %	0.1 %	8,111	103,273
2014	7.9 %	0.1 %	8,130	103,255
2013	8.0 %	0.1 %	8,182	102,091
2012	8.1 %	0.1 %	8,375	102,940
2011	8.0 %	0.1 %	8,184	102,590
2010	8.2 %	0.1 %	8,448	102,949
2009	8.4 %	0.1 %	8,779	104,992

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.1 - Notes:

None

Data Alerts: None

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	1.5 %	0.0 %	1,545	103,273
2014	1.5 %	0.0 %	1,547	103,255
2013	1.5 %	0.0 %	1,559	102,091
2012	1.6 %	0.0 %	1,610	102,940
2011	1.6 %	0.0 %	1,597	102,590
2010	1.5 %	0.0 %	1,588	102,949
2009	1.6 %	0.0 %	1,703	104,992

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.2 - Notes:

None

Data Alerts: None

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	6.4 %	0.1 %	6,566	103,273
2014	6.4 %	0.1 %	6,583	103,255
2013	6.5 %	0.1 %	6,623	102,091
2012	6.6 %	0.1 %	6,765	102,940
2011	6.4 %	0.1 %	6,587	102,590
2010	6.7 %	0.1 %	6,860	102,949
2009	6.7 %	0.1 %	7,076	104,992

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.3 - Notes:

None

Data Alerts: None

NOM 5.1 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	9.3 %	0.1 %	9,549	103,273
2014	9.2 %	0.1 %	9,517	103,268
2013	9.4 %	0.1 %	9,599	102,083
2012	9.5 %	0.1 %	9,774	102,964
2011	9.5 %	0.1 %	9,738	102,598
2010	10.1 %	0.1 %	10,395	102,963
2009	10.2 %	0.1 %	10,702	104,987

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.1 - Notes:

None

Data Alerts: None

NOM 5.2 - Percent of early preterm births (<34 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	2.8 %	0.1 %	2,835	103,273
2014	2.7 %	0.1 %	2,804	103,268
2013	2.9 %	0.1 %	2,929	102,083
2012	2.9 %	0.1 %	3,014	102,964
2011	3.0 %	0.1 %	3,024	102,598
2010	3.0 %	0.1 %	3,057	102,963
2009	3.0 %	0.1 %	3,145	104,987

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.2 - Notes:

None

Data Alerts: None

NOM 5.3 - Percent of late preterm births (34-36 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	6.5 %	0.1 %	6,714	103,273
2014	6.5 %	0.1 %	6,713	103,268
2013	6.5 %	0.1 %	6,670	102,083
2012	6.6 %	0.1 %	6,760	102,964
2011	6.5 %	0.1 %	6,714	102,598
2010	7.1 %	0.1 %	7,338	102,963
2009	7.2 %	0.1 %	7,557	104,987

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.3 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	24.1 %	0.1 %	24,902	103,273
2014	24.0 %	0.1 %	24,775	103,268
2013	24.3 %	0.1 %	24,807	102,083
2012	24.7 %	0.1 %	25,457	102,964
2011	25.3 %	0.1 %	25,905	102,598
2010	26.6 %	0.1 %	27,356	102,963
2009	27.2 %	0.1 %	28,588	104,987

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015/Q2-2016/Q1	1.0 %			
2015/Q1-2015/Q4	1.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	2.0 %			
2014/Q2-2015/Q1	2.0 %			
2014/Q1-2014/Q4	2.0 %			
2013/Q4-2014/Q3	3.0 %			
2013/Q3-2014/Q2	4.0 %			
2013/Q2-2014/Q1	5.0 %			

Legends:

Indicator results were based on a shorter time period than required for reporting

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	5.6	0.2 %	582	103,562
2013	6.4	0.3 %	650	102,432
2012	6.6	0.3 %	686	103,300
2011	6.7	0.3 %	691	102,938
2010	6.6	0.3 %	680	103,306
2009	6.4	0.3 %	676	105,331

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	5.7	0.2 %	584	103,300
2013	6.2	0.3 %	631	102,147
2012	6.5	0.3 %	668	103,013
2011	6.8	0.3 %	697	102,652
2010	6.8	0.3 %	703	103,002
2009	7.1	0.3 %	750	105,059

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	3.8	0.2 %	391	103,300
2013	4.4	0.2 %	451	102,147
2012	4.7	0.2 %	480	103,013
2011	4.7	0.2 %	481	102,652
2010	4.6	0.2 %	475	103,002
2009	4.7	0.2 %	493	105,059

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	1.9	0.1 %	193	103,300
2013	1.8	0.1 %	180	102,147
2012	1.8	0.1 %	188	103,013
2011	2.1	0.1 %	216	102,652
2010	2.2	0.2 %	228	103,002
2009	2.5	0.2 %	257	105,059

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	198.5	13.9 %	205	103,300
2013	264.3	16.1 %	270	102,147
2012	249.5	15.6 %	257	103,013
2011	262.1	16.0 %	269	102,652
2010	259.2	15.9 %	267	103,002
2009	290.3	16.7 %	305	105,059

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	101.7	9.9 %	105	103,300
2013	75.4	8.6 %	77	102,147
2012	88.3	9.3 %	91	103,013
2011	94.5	9.6 %	97	102,652
2010	104.9	10.1 %	108	103,002
2009	107.6	10.1 %	113	105,059

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

FAD Not Available for this measure.

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	7.3	0.3 %	678	93,276
2013	6.9	0.3 %	633	91,763
2012	5.3	0.2 %	484	92,137
2011	4.3	0.2 %	393	92,190
2010	3.7	0.2 %	341	92,389
2009	3.4	0.2 %	319	93,526
2008	2.8	0.2 %	269	95,628

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	15.5 %	1.4 %	268,154	1,736,068

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	17.5	1.4 %	163	930,662
2014	16.3	1.3 %	152	931,531
2013	14.6	1.3 %	136	932,216
2012	17.4	1.4 %	161	927,706
2011	19.1	1.4 %	176	922,806
2010	16.1	1.3 %	148	921,396
2009	15.7	1.3 %	143	913,341

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	29.5	1.7 %	313	1,059,818
2014	26.2	1.6 %	277	1,059,336
2013	26.8	1.6 %	283	1,057,209
2012	28.9	1.7 %	306	1,058,560
2011	29.7	1.7 %	314	1,059,168
2010	27.3	1.6 %	290	1,062,211
2009	26.1	1.6 %	278	1,063,377

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013_2015	9.8	0.8 %	158	1,612,618
2012_2014	10.6	0.8 %	171	1,616,074
2011_2013	11.2	0.8 %	181	1,623,241
2010_2012	11.8	0.9 %	193	1,637,028
2009_2011	11.8	0.8 %	194	1,648,677
2008_2010	14.3	0.9 %	237	1,657,939
2007_2009	17.2	1.0 %	285	1,657,396

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013_2015	9.1	0.8 %	147	1,612,618
2012_2014	9.0	0.8 %	145	1,616,074
2011_2013	8.3	0.7 %	134	1,623,241
2010_2012	7.8	0.7 %	127	1,637,028
2009_2011	7.4	0.7 %	122	1,648,677
2008_2010	7.7	0.7 %	128	1,657,939
2007_2009	7.5	0.7 %	125	1,657,396

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	20.4 %	1.4 %	377,683	1,849,178
2007	20.8 %	1.3 %	380,525	1,829,149
2003	17.6 %	0.9 %	314,930	1,792,362

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	19.6 %	1.7 %	53,858	275,453

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	1.3 %	0.3 %	19,413	1,546,211
2007	1.4 %	0.4 %	20,585	1,526,510

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	8.7 %	1.1 %	133,653	1,543,781
2007	7.9 %	0.9 %	120,811	1,523,033

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	52.6 %	6.6 %	65,930	125,281
2007	72.5 %	5.7 %	87,217	120,257
2003	62.5 %	5.5 %	56,750	90,824

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	89.2 %	1.2 %	1,643,230	1,841,514
2007	88.0 %	1.1 %	1,608,914	1,828,764
2003	90.1 %	0.8 %	1,614,832	1,792,362

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	29.8 %	2.4 %	245,163	822,997
2007	31.0 %	2.2 %	249,272	804,576
2003	30.5 %	1.8 %	249,807	819,587

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	39.4 %	0.2 %	22,847	57,983
2012	39.9 %	0.2 %	20,669	51,739
2010	41.9 %	0.2 %	20,514	48,920
2008	40.4 %	0.2 %	17,106	42,364

Legends:

Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	28.1 %	1.3 %	84,846	301,582
2013	26.7 %	1.1 %	94,064	352,225
2011	28.3 %	1.8 %	103,840	366,797

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	4.9 %	0.3 %	91,415	1,869,889
2014	5.9 %	0.3 %	109,627	1,867,159
2013	5.7 %	0.3 %	106,008	1,863,314
2012	5.5 %	0.3 %	102,837	1,855,004
2011	5.8 %	0.3 %	107,695	1,853,192
2010	6.5 %	0.3 %	119,764	1,853,506
2009	6.7 %	0.3 %	124,160	1,846,249

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	64.4 %	4.2 %	96,290	149,556
2014	73.7 %	4.5 %	111,178	150,878
2013	69.2 %	5.1 %	104,185	150,476
2012	69.8 %	3.9 %	104,231	149,242
2011	68.3 %	3.6 %	104,315	152,773
2010	55.2 %	3.4 %	86,228	156,154
2009	40.0 %	3.9 %	64,151	160,571

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) - Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2016	62.4 %	2.2 %	1,086,888	1,740,971
2014_2015	65.0 %	2.2 %	1,135,952	1,746,813
2013_2014	61.9 %	2.4 %	1,059,657	1,711,340
2012_2013	61.3 %	2.9 %	1,060,831	1,729,774
2011_2012	50.6 %	2.9 %	882,291	1,743,986
2010_2011	54.9 %	2.3 %	941,040	1,714,099
2009_2010	49.8 %	3.3 %	849,428	1,705,679

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen (Female)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	61.2 %	5.7 %	157,210	256,938
2014	59.2 %	5.3 %	151,461	255,680
2013	51.9 %	6.5 %	131,510	253,273
2012	50.9 %	5.6 %	128,594	252,490
2011	46.9 %	4.9 %	119,190	254,247
2010	54.0 %	5.0 %	133,850	247,731
2009	36.8 %	4.4 %	91,914	249,895

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Teen (Male)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	40.1 %	5.4 %	107,420	267,833
2014	36.3 %	5.3 %	97,067	267,078
2013	26.4 %	5.4 %	70,046	265,592
2012	12.1 %	2.9 %	31,935	264,659
2011	NR	NR	NR	NR

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	82.2 %	3.3 %	431,301	524,771
2014	91.2 %	2.0 %	476,967	522,759
2013	83.6 %	3.3 %	433,804	518,865
2012	88.7 %	2.2 %	458,761	517,148
2011	77.9 %	2.9 %	405,505	520,702
2010	72.0 %	3.2 %	365,111	506,826
2009	56.1 %	3.2 %	286,211	510,091

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	66.8 %	3.9 %	350,435	524,771
2014	72.5 %	3.4 %	379,117	522,759
2013	64.2 %	4.3 %	333,122	518,865
2012	62.1 %	3.8 %	321,221	517,148
2011	61.8 %	3.1 %	321,925	520,702
2010	54.5 %	3.5 %	276,139	506,826
2009	48.1 %	3.2 %	245,326	510,091

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

Form 10a
National Performance Measures (NPMs)

State: Virginia

NPM 2 - Percent of cesarean deliveries among low-risk first births

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2016
Annual Objective	25.3
Annual Indicator	25.1
Numerator	5,664
Denominator	22,588
Data Source	NVSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	24.5	23.3	22.8	22.3	21.8	21.5

Field Level Notes for Form 10a NPMs:

None

NPM 5 - Percent of infants placed to sleep on their backs

FAD for this measure is not available for the State.

State Provided Data	
	2016
Annual Objective	78.5
Annual Indicator	80.2
Numerator	
Denominator	
Data Source	PRAMS
Data Source Year	2013
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	81.0	82.0	83.0	84.0	85.0	86.0

Field Level Notes for Form 10a NPMs:

None

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	
Annual Indicator	29.1
Numerator	143,283
Denominator	491,741
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	30.0	32.0	34.0	36.0	38.0	40.0

Field Level Notes for Form 10a NPMs:

None

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19 (Child Health)

Federally Available Data	
Data Source: HCUP - State Inpatient Databases (SID) - CHILD	
	2016
Annual Objective	86.5
Annual Indicator	87.0
Numerator	899
Denominator	1,033,738
Data Source	SID-CHILD
Data Source Year	2014

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	85.5	84.0	83.0	82.0	80.0	79.7

Field Level Notes for Form 10a NPMs:

None

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19 (Adolescent Health)

Federally Available Data	
Data Source: HCUP - State Inpatient Databases (SID) - ADOLESCENT	
	2016
Annual Objective	180
Annual Indicator	172.4
Numerator	1,826
Denominator	1,059,470
Data Source	SID-ADOLESCENT
Data Source Year	2014

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	172.0	171.8	171.5	171.1	170.5	170.1

Field Level Notes for Form 10a NPMs:

None

NPM 11 - Percent of children with and without special health care needs having a medical home

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2016
Annual Objective	49
Annual Indicator	47.3
Numerator	173,295
Denominator	366,760
Data Source	NSCH-CSHCN
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	49.0	52.0	54.0	57.0	58.0	59.0

Field Level Notes for Form 10a NPMs:

None

NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Federally Available Data	
Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)	
	2016
Annual Objective	46
Annual Indicator	44.9
Numerator	50,747
Denominator	113,089
Data Source	NS-CSHCN
Data Source Year	2009_2010

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	45.3	46.1	46.8	47.3	47.8	50.0

Field Level Notes for Form 10a NPMs:

None

NPM 13 - A) Percent of women who had a dental visit during pregnancy

FAD for this measure is not available for the State.

State Provided Data	
	2016
Annual Objective	
Annual Indicator	43.6
Numerator	
Denominator	
Data Source	PRAMS
Data Source Year	2010-2011
Provisional or Final ?	Provisional

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	45.0	46.0	47.0	48.0	49.0	50.0

Field Level Notes for Form 10a NPMs:

None

NPM 13 - B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	
Annual Indicator	78.5
Numerator	1,362,891
Denominator	1,735,196
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	79.0	80.0	81.0	82.0	83.0	84.0

Field Level Notes for Form 10a NPMs:

None

NPM 14 - A) Percent of women who smoke during pregnancy

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2016
Annual Objective	7.5
Annual Indicator	6.8
Numerator	6,167
Denominator	91,149
Data Source	NVSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	6.5	6.3	6.0	5.7	5.5	5.0

Field Level Notes for Form 10a NPMs:

None

NPM 14 - B) Percent of children who live in households where someone smokes

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	22.5
Annual Indicator	23.4
Numerator	426,945
Denominator	1,824,329
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	23.1	22.8	22.5	22.2	21.9	21.6

Field Level Notes for Form 10a NPMs:

None

Form 10a
State Performance Measures (SPMs)

State: Virginia

SPM 1 - Teen Pregnancy Prevention: Rate of females age 15-19 using most effective contraceptive methods

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	21.7
Numerator	11,662
Denominator	538,332
Data Source	APCD
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	22.0	22.7	23.4	23.9	24.3	25.0

Field Level Notes for Form 10a SPMs:

None

SPM 2 - Maternal Mental Health: Proportion of women who attend a postpartum visit with a health care worker within 6 weeks after getting birth

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	90
Numerator	
Denominator	
Data Source	PRAMS
Data Source Year	2014
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	91.0	91.5	91.9	92.3	92.8	93.0

Field Level Notes for Form 10a SPMs:

None

SPM 3 - Infant Mortality Disparity: Infant Mortality Disparity Ratio

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	1.7
Numerator	7.8
Denominator	4.7
Data Source	Virginia Department of Health
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.6	1.5	1.4	1.3	1.2	1.0

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note:	
	2015 data (live births and infant death tables)	

SPM 4 - Unintended Pregnancy: Proportion of females ages 15-44 using Tier 1 (most effective) contraceptive methods

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	2.6	3.0	3.3	3.5	3.8	4.0

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**Annual Objective**

Field Note:
Numerator (APCD): 87,220 women
Demoninator (Population): 3,411,536

SPM 5 - Maternal Mental Health Screening: Proportion of women who attend a postpartum visit with a healthcare provider within 6 weeks after giving birth and are screened using an SBIRT tool

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	80.0	80.5	81.0	81.5	82.0	82.5

Field Level Notes for Form 10a SPMs:

None

Form 10a
State Outcome Measures (SOMs)

State: Virginia

SOM 1 - Teen Pregnancy Rate

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	23.2
Numerator	6,141
Denominator	264,140
Data Source	Division of Health Statistics
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	23.0	22.7	22.5	22.2	22.0	21.7

Field Level Notes for Form 10a SOMs:

None

SOM 2 - Infant Mortality Disparity: Infant Mortality Rate

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	5.9
Numerator	605
Denominator	103,074
Data Source	Division of Health Statistics
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	5.8	5.7	5.6	5.5	5.4	5.3

Field Level Notes for Form 10a SOMs:

None

SOM 3 - Maternal Mental Health Screening: Proportion of women who are educated and/or screened during pregnancy or after delivery about depression by a health care worker

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	79.2
Numerator	
Denominator	
Data Source	PRAMS
Data Source Year	2014
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	80.0	80.5	81.0	81.5	82.0	82.5

Field Level Notes for Form 10a SOMs:

None

SOM 4 - Unintended Pregnancy: Rate of unintended pregnancy among all women of child-bearing age

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	40.0	38.0	36.0	34.0	32.0	30.0

Field Level Notes for Form 10a SOMs:

None

Form 10a
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Virginia

ESM 2.1 - Proportion of birthing hospitals who have adopted a policy to reduce low risk cesarean deliveries

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	100
Numerator	57
Denominator	57
Data Source	Virginia Healthcare and Hospital Association
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	50.0	65.0	80.0	95.0	100.0	100.0

Field Level Notes for Form 10a ESMs:

None

ESM 2.2 - Completion of a report identifying primary cesarean data/rates for all Virginia delivering hospitals to identify facilities for C/S reduction/QI interventions

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	No	No	No	No	No	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 5.1 - Proportion of partnering hospitals who have implemented a standardized safe sleep curriculum

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	7
Numerator	4
Denominator	57
Data Source	Office of Family Health Services, VDH
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	10.0	15.0	20.0	25.0	30.0	35.0

Field Level Notes for Form 10a ESMs:

None

ESM 5.2 - Number of visits to the SafeSleepVA.com website

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	150.0	200.0	250.0	300.0	350.0	400.0

Field Level Notes for Form 10a ESMs:

None

ESM 5.3 - Number of partners who have implemented a quality improvement plan for standardization of safe sleep messaging in their organization

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	5.0	7.0	10.0	12.0	15.0	25.0

Field Level Notes for Form 10a ESMs:

None

ESM 6.1 - Number of LHDs, community partners, and providers receiving developmental screening resources, training, and TA

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	7.0	15.0	20.0	25.0	35.0	50.0

Field Level Notes for Form 10a ESMs:

None

ESM 6.2 - Number of individuals (families, providers, community members) accessing social media messaging about the importance of regular developmental screening

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	100.0	125.0	200.0	250.0	300.0	350.0

Field Level Notes for Form 10a ESMs:

None

ESM 7.1 - Proportion of maternity centers with prenatal courses including Virginia's injury prevention curriculum

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Office of Family Health Services, VDH
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	15.0	20.0	25.0	30.0	35.0

Field Level Notes for Form 10a ESMs:

None

ESM 7.2 - Number of Family Assessment and Planning Teams (FAPT) teams that have incorporated suicide prevention practices into their workflow and/or policies

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	10.0	25.0	50.0	75.0	90.0	100.0

Field Level Notes for Form 10a ESMs:

None

ESM 11.1 - Number of providers in Virginia who have completed the medical home training module

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Division of Child and Family Health
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	25.0	100.0	250.0	400.0	500.0	525.0

Field Level Notes for Form 10a ESMs:

None

ESM 11.2 - Percentage of VDH CYSHCN who report a primary care provider

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	89.2
Numerator	4,061
Denominator	4,555
Data Source	Office of Family Health Services, VDH
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	90.0	91.5	93.0	94.5	96.0	97.5

Field Level Notes for Form 10a ESMs:

None

ESM 11.3 - Percentage of children enrolled in public schools who report a primary care provider

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	30.6
Numerator	200,000
Denominator	653,103
Data Source	Virginia Department of Education
Data Source Year	2015-2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	40.0	42.5	45.0	47.5	50.0	53.0

Field Level Notes for Form 10a ESMs:

None

ESM 12.1 - Number of providers in Virginia who have completed the transition training module.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Division of Child and Family Health
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	25.0	100.0	250.0	400.0	500.0	525.0

Field Level Notes for Form 10a ESMs:

None

ESM 13.1 - Completion of action plan identifying strategies and partners for addressing top 3 MCH population oral health needs in Virginia

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	No	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 14.1 - Number of pregnant women who initate a call to the Quitline

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	60
Numerator	
Denominator	
Data Source	Division of Prevention and Health Promotion
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	200.0	350.0	500.0	750.0	1,000.0	1,000.0

Field Level Notes for Form 10a ESMs:

None

ESM 14.2 - Number of pregnant women who complete the Quitline cessation program (10 counseling calls)

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	3
Numerator	
Denominator	
Data Source	Division of Prevention and Health Promotion
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	25.0	35.0	50.0	75.0	100.0	100.0

Field Level Notes for Form 10a ESMs:

None

Form 10b
State Performance Measure (SPM) Detail Sheets

State: Virginia

SPM 1 - Teen Pregnancy Prevention: Rate of females age 15-19 using most effective contraceptive methods
Population Domain(s) – Women/Maternal Health, Adolescent Health, Perinatal/Infant Health, Cross-Cutting/Life Course

Measure Status:	Inactive - Replaced
Goal:	Increased number of females age 15-19 using most effective contraceptive methods
Definition:	**Numerator:** Number of females age 15-19 using Tier 1 method of contraceptive **Denominator:** Number of females age 15-19 **Unit Type:** Rate **Unit Number:** 1,000
Healthy People 2020 Objective:	Reduce pregnancies among adolescent females aged 15 to 17 years (FP-8.1), Reduce pregnancies among adolescent females aged 18 to 19 years (FP-8.2)
Data Sources and Data Issues:	Virginia All Payers Claim Database, NCHS Population Estimate
Significance:	This state priority measure was identified through the Title V needs assessment, Virginia's Well-being Plan, CDC winnable battle, and Healthy People 2020.

SPM 2 - Maternal Mental Health: Proportion of women who attend a postpartum visit with a health care worker within 6 weeks after getting birth
Population Domain(s) – Women/Maternal Health, Perinatal/Infant Health, Cross-Cutting/Life Course

Measure Status:	Inactive - Replaced
Goal:	Increase the number of women who attend a postpartum visit with a health care worker within 6 weeks after giving birth
Definition:	**Numerator:** Number of women who attend a postpartum visit with a health care worker within 6 weeks after getting birth **Denominator:** Number of live births **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	[Developmental] Increase the proportion of women giving birth who attend a postpartum care visit with a health worker (MICH-19)
Data Sources and Data Issues:	Virginia PRAMS
Significance:	This state priority measure was identified through the Title V needs assessment, Virginia's Well-being Plan, Virginia DMAS/Medicaid priority, and Healthy People 2020.

SPM 3 - Infant Mortality Disparity: Infant Mortality Disparity Ratio
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	Eliminate the racial disparity in Virginia's infant morality rate.
Definition:	**Numerator:** Rate of African-American infant mortality **Denominator:** Rate of White infant mortality **Unit Type:** Ratio **Unit Number:** 1
Data Sources and Data Issues:	Virginia Vital Records
Significance:	This state priority measure was identified through the Title V needs assessment, Virginia's Well-being Plan, CDC winnable battle, and Virginia Health Opportunity Index.

SPM 4 - Unintended Pregnancy: Proportion of females ages 15-44 using Tier 1 (most effective) contraceptive methods
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	Virginians plan their pregnancies.
Definition:	**Numerator:** Number of females ages 15-44 using Tier 1 method of contraceptive **Denominator:** Number of females ages 15-44 **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Increase the proportion of pregnancies that are intended (FP-1). Increase the percentage of adult females aged 20 to 44 years who are at risk of unintended pregnancy that adopt or continue use of the most effective or moderately effective methods of contraception (FP-16.1). Increase the percentage of adolescent females aged 15 to 19 years who are at risk of unintended pregnancy that adopt or continue use of the most effective or moderately effective methods of contraception (FP-16.2). Reduce pregnancies among adolescent females aged 15 to 17 years (FP-8.1). Reduce pregnancies among adolescent females aged 18 to 19 years (FP-8.2).
Data Sources and Data Issues:	Virginia All Payers Claim Database (APCD), NCHS Population Estimate
Significance:	This state priority measure was identified through the Title V needs assessment, CDC winnable battle, and Healthy People 2020. The goal aligns with the Virginia Plan for Well-Being (Goal 2.1). Comprehensive family planning and preconception health lead to improved birth outcomes, which are associated with better health and cognition as children mature. Family planning services include providing education and contraception. These services help families have children when they are financially, emotionally, and physically ready. Publicly-supported family planning services prevent an estimated 1.3 million unintended pregnancies a year in the United States. The trend toward having smaller families and waiting at least 24 months between pregnancies has contributed to better health of infants and children. Preconception health services for females and males include health screenings, counseling, and clinical services that enable them to become as healthy as possible before pregnancy.

SPM 5 - Maternal Mental Health Screening: Proportion of women who attend a postpartum visit with a healthcare provider within 6 weeks after giving birth and are screened using an SBIRT tool
Population Domain(s) – Women/Maternal Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the number of women who are screened for substance abuse and depression within 6 weeks after giving birth.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number of women who attend a postpartum visit with a healthcare provider within 6 weeks after giving birth and are screened using an SBIRT tool</td></tr>
<tr><td>Denominator:</td><td>Number of live births</td></tr>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2020 Objective:</td><td>[Developmental] Increase the proportion of women giving birth who attend a postpartum care visit with a health worker (MICH-19).</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>To be determined.</td></tr>
<tr><td>Significance:</td><td>This state priority measure was identified through the Title V needs assessment, Virginia's Plan for Well-Being, Virginia DMAS/Medicaid priority, and Healthy People 2020.</td></tr>
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Form 10b
State Outcome Measure (SOM) Detail Sheets

State: Virginia

SOM 1 - Teen Pregnancy Rate
Population Domain(s) – Women/Maternal Health, Adolescent Health, Cross-Cutting/Life Course, Perinatal/Infant Health

Measure Status:	Inactive - Replaced
Goal:	Reduce Virginia's teen pregnancy rate to the lowest in the United States by 2020
Definition:	**Numerator:** Number of teen pregnancy (live births, terminations, and fetal demises) to females ages 15-19 years **Denominator:** Total number of females ages 15-19 years **Unit Type:** Rate **Unit Number:** 1,000
Healthy People 2020 Objective:	Reduce pregnancies among adolescent females aged 15 to 17 years (FP-8.1), Reduce pregnancies among adolescent females aged 18 to 19 years (FP-8.2)
Data Sources and Data Issues:	Virginia Vital Records, NCHS Population Estimate
Significance:	This state priority measure was identified through the Title V needs assessment, Virginia's Well-being Plan, CDC winnable battle, and Healthy People 2020.

SOM 2 - Infant Mortality Disparity: Infant Mortality Rate
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	Reduce Virginia's infant morality rate to the lowest in the United States by 2020.
Definition:	**Numerator:** Total number of infants deaths that occur in the first 365 days of life **Denominator:** Total live births **Unit Type:** Rate **Unit Number:** 1,000
Healthy People 2020 Objective:	Reduce the rate of all infant deaths (within 1 year) [MICH-1.3]
Data Sources and Data Issues:	Virginia Vital Records
Significance:	This state priority measure was identified through the Title V needs assessment, Virginia's Well-being Plan, CDC winnable battle, Virginia Health Opportunity Index, and Healthy People 2020.

SOM 3 - Maternal Mental Health Screening: Proportion of women who are educated and/or screened during pregnancy or after delivery about depression by a health care worker
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	Increase the number of women who are educated and/or screened during pregnancy or after delivery about depression by a health care worker
Definition:	**Numerator:** Number of women reporting a healthcare worker discussing depression during pregnancy or after delivery **Denominator:** Total number of live births **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	[Developmental] Decrease the proportion of women delivering a live birth who experience postpartum depressive symptoms (MICH-34).
Data Sources and Data Issues:	Virginia PRAMS
Significance:	This state priority measure was identified through the Title V needs assessment, Virginia's Well-being Plan, Virginia DMAS/Medicaid priority, and Healthy People 2020.

SOM 4 - Unintended Pregnancy: Rate of unintended pregnancy among all women of child-bearing age
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	Reduce Virginia's unintended pregnancy rate to the lowest in the United States by 2020.
Definition:	**Numerator:** Number of women reporting pregnancy was unintended or mistimed **Denominator:** Female respondents, excluding those reporting fetal demise **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Increase the proportion of pregnancies that are intended (FP-1)
Data Sources and Data Issues:	Virginia PRAMS
Significance:	This state priority measure was identified through the Title V needs assessment, Virginia's Well-being Plan, CDC winnable battle, and Healthy People 2020.

Form 10c
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Virginia

ESM 2.1 - Proportion of birthing hospitals who have adopted a policy to reduce low risk cesarean deliveries
NPM 2 – Percent of cesarean deliveries among low-risk first births

Measure Status:	Inactive - Replaced
Goal:	To reduce non-medically necessary EEDs, to less than 2% by 2020.
Definition:	**Numerator:** Number of birthing hospitals who have adopted a policy to reduce low risk cesarean deliveries **Denominator:** Number of birthing hospitals **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Virginia Healthcare and Hospital Association
Significance:	This ESM was identified through the Title V needs assessment, Virginia's Well-being Plan, and Healthy People 2020 (MICH-7).

ESM 2.2 - Completion of a report identifying primary cesarean data/rates for all Virginia delivering hospitals to identify facilities for C/S reduction/QI interventions
NPM 2 – Percent of cesarean deliveries among low-risk first births

Measure Status:	Active
Goal:	To produce a report on NTSV data/rates for all Virginia delivering hospitals.
Definition:	**Numerator:** N/A **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	Virginia Vital Statistics Data, All Payers Claims Database (APCD)
Significance:	This ESM was identified through the ongoing Title V needs assessment activities and is a priority for the Virginia Hospital and Healthcare Association (VHHA).

ESM 5.1 - Proportion of partnering hospitals who have implemented a standardized safe sleep curriculum
NPM 5 – Percent of infants placed to sleep on their backs

Measure Status:	Inactive - Replaced
Goal:	Increase the number of infants in a safe sleep environment
Definition:	**Numerator:** Number of partnering hospitals who have implemented a standardized safe sleep curriculum **Denominator:** Number of partnering hospitals **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Virginia Healthcare and Hospital Association
Significance:	This ESM was identified through the Title V needs assessment, Virginia's Well-being Plan, and Healthy People 2020 (MICH-20).

ESM 5.2 - Number of visits to the SafeSleepVA.com website
NPM 5 – Percent of infants placed to sleep on their backs

Measure Status:	Active
Goal:	To promote safe sleep practices to parents, providers, and caregivers of infants.
Definition:	**Numerator:** Number of visits to the SafeSleepVA.com website **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1,000,000
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Child and Family Health
Significance:	Reducing sleep-related infant deaths is a state priority.

ESM 5.3 - Number of partners who have implemented a quality improvement plan for standardization of safe sleep messaging in their organization
NPM 5 – Percent of infants placed to sleep on their backs

Measure Status:	Active
Goal:	To increase consistent messaging regarding safe sleep practices.
Definition:	**Numerator:** Number of partners who have implemented a quality improvement plan for standardization of safe sleep messaging in their organizations **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Child and Family Health
Significance:	Reducing safe sleep deaths is a state priority.

ESM 6.1 - Number of LHDs, community partners, and providers receiving developmental screening resources, training, and TA
NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Measure Status:	Active
Goal:	To increase developmental screening rates for all children in Virginia.
Definition:	**Numerator:** Number of LHDs, community partners, and providers receiving developmental screening resources, training, and TA **Denominator:** N/A **Unit Type:** Count **Unit Number:** 150
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Child and Family Health
Significance:	Increasing early identification of disease or conditions through developmental screening will improve referral and treatment for children with special needs.

ESM 6.2 - Number of individuals (families, providers, community members) accessing social media messaging about the importance of regular developmental screening
NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Measure Status:	Active
Goal:	To improve awareness and understanding among families, providers, and community members about the importance of regular developmental screening for children.
Definition:	**Numerator:** Number of individuals (families, providers, community members) accessing social media messaging about the importance of regular developmental screening **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1,000
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Child and Family Health
Significance:	Increasing early identification of disease or conditions through developmental screening will improve referral and treatment for children with special needs.

ESM 7.1 - Proportion of maternity centers with prenatal courses including Virginia's injury prevention curriculum
NPM 7 – Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Measure Status:	Active
Goal:	Reduce hospitalizations due to injuries among the population 0-19
Definition:	**Numerator:** Maternity centers with prenatal courses including Virginia's injury prevention curriculum **Denominator:** Maternity centers **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Prevention and Health Promotion
Significance:	This ESM was identified through the Title V needs assessment, Virginia's Well-being Plan, and Healthy People 2020 (IVP 1.2).

ESM 7.2 - Number of Family Assessment and Planning Teams (FAPT) teams that have incorporated suicide prevention practices into their workflow and/or policies
NPM 7 – Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Measure Status:	Active
Goal:	To facilitate adoption of suicide prevention practices and policies among community organizations.
Definition:	**Numerator:** Number of Family Assessment and Planning Teams (FAPT) teams that have incorporated suicide prevention practices into their workflow and/or policies **Denominator:** N/A **Unit Type:** Count **Unit Number:** 132
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Prevention and Health Promotion
Significance:	Reducing adolescent suicide is a state priority.

ESM 11.1 - Number of providers in Virginia who have completed the medical home training module
NPM 11 – Percent of children with and without special health care needs having a medical home

Measure Status:	Active
Goal:	Increase the number of typical and children with special health care needs who can identify a primary care provider as a medical home
Definition:	**Numerator:** Number of providers in Virginia who have completed the medical home training module **Denominator:** n/a **Unit Type:** Count **Unit Number:** 100,000
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Child and Family Health
Significance:	This ESM was identified through the Title V needs assessment, Virginia's Well-being Plan, and Healthy People 2020 (MICH-30).

ESM 11.2 - Percentage of VDH CYSHCN who report a primary care provider
NPM 11 – Percent of children with and without special health care needs having a medical home

Measure Status:	Active
Goal:	Increase the number of typical and children with special health care needs who can identify a primary care provider as a medical home
Definition:	**Numerator:** Number of VDH CYSHCN who report a primary care provider **Denominator:** Total number of VDH CYSHCN **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Services, Division of Child and Family Health
Significance:	This ESM was identified through the Title V needs assessment, Virginia's Well-being Plan, and Healthy People 2020 (MICH-30).

ESM 11.3 - Percentage of children enrolled in public schools who report a primary care provider
NPM 11 – Percent of children with and without special health care needs having a medical home

Measure Status:	Active
Goal:	Increase the number of typical and children with special health care needs who can identify a primary care provider as a medical home
Definition:	**Numerator:** Number of children enrolled in public schools who report a primary care provider **Denominator:** Total number of children enrolled in public schools **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Department of Education
Significance:	This ESM was identified through the Title V needs assessment, Virginia's Well-being Plan, and Healthy People 2020 (MICH-30).

ESM 12.1 - Number of providers in Virginia who have completed the transition training module.
NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Measure Status:	Active
Goal:	Increase the number of children ages 10-24 engaged in transition services to adult health care
Definition:	**Numerator:** Number of providers in Virginia who have completed the transition training module **Denominator:** n/a **Unit Type:** Count **Unit Number:** 100,000
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Child and Family Health
Significance:	This ESM was identified through the Title V needs assessment, Virginia's Well-being Plan, and Healthy People 2020 (DH-5).

ESM 13.1 - Completion of action plan identifying strategies and partners for addressing top 3 MCH population oral health needs in Virginia
NPM 13 – A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	To collaborate with state oral health partners to identify priority needs and resource gaps and to develop an action plan to address them.
Definition:	**Numerator:** N/A **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Prevention and Health Promotion
Significance:	Due to changes in resources at the community-level, oral health is a reemerging Title V priority for Virginia.

ESM 14.1 - Number of pregnant women who initate a call to the Quitline
NPM 14 – A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Measure Status:	Active
Goal:	Decrease the proportion of pregnant women who smoke during pregnancy by 10% (2020) and decrease the proportion of children who are exposed to secondhand smoke.
Definition:	**Numerator:** Number of pregnant women who initate a call to the Quitline **Denominator:** n/a **Unit Type:** Count **Unit Number:** 100,000
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Prevention and Health Promotion
Significance:	This ESM was identified through the Title V needs assessment, Virginia's Well-being Plan, and Healthy People 2020 (MICH-11.3, MICH-18).

ESM 14.2 - Number of pregnant women who complete the Quitline cessation program (10 counseling calls)
NPM 14 – A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Measure Status:	Active
Goal:	Decrease the proportion of pregnant women who smoke during pregnancy by 10% (2020) and decrease the proportion of children who are exposed to secondhand smoke.
Definition:	**Numerator:** Number of pregnant women who complete the Quitline cessation program (10 counseling calls). **Denominator:** n/a **Unit Type:** Count **Unit Number:** 100,000
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Prevention and Health Promotion
Significance:	This ESM was identified through the Title V needs assessment, Virginia's Well-being Plan, and Healthy People 2020 (MICH-11.3, MICH-18).

Form 11
Other State Data

State: Virginia

The Form 11 data are available for review via the link below.

Form 11 Data

State Action Plan Table

State: Virginia

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

Abbreviated State Action Plan Table

State: Virginia

Women/Maternal Health

State Priority Needs	NPMs	ESMs	SPMs
Woman/Maternal Health: Support the physical and emotional well-being of women and their children.	NPM 2 - Low-Risk Cesarean Delivery	ESM 2.1 *Inactive* ESM 2.2	
Woman/Maternal Health: Support the physical and emotional well-being of women and their children.			SPM 5
Woman/Maternal Health: Support the physical and emotional well-being of women and their children.			SPM 4

Perinatal/Infant Health

State Priority Needs	NPMs	ESMs	SPMs
Safe Sleep: Increase safe sleep practices.	NPM 5 - Safe Sleep	ESM 5.1 *Inactive* ESM 5.2 ESM 5.3	
Woman/Maternal Health: Support the physical and emotional well-being of women and their children.			SPM 3

Child Health

State Priority Needs	NPMs	ESMs	SPMs
Child/Adolescent Injury: Reduce injuries, violence, and suicide among Title V populations.	NPM 7 - Injury Hospitalization	ESM 7.1 ESM 7.2	
Developmental Screening: Support optimal mental health and social-emotional development of all children.	NPM 6 - Developmental Screening	ESM 6.1 ESM 6.2	

Adolescent Health

State Priority Needs	NPMs	ESMs	SPMs
Child/Adolescent Injury: Reduce injuries, violence, and suicide among Title V populations.	NPM 7 - Injury Hospitalization	ESM 7.1 ESM 7.2	

Children with Special Health Care Needs

State Priority Needs	NPMs	ESMs	SPMs
Medical Home: Promote the importance of medical home among providers and families.	NPM 11 - Medical Home	ESM 11.1 ESM 11.2 ESM 11.3	
Transition: Promote independence and transition of young adults with and without special healthcare needs.	NPM 12 - Transition	ESM 12.1	

Cross-Cutting/Life Course

State Priority Needs	NPMs	ESMs	SPMs
Tobacco: Decrease smoking among pregnant women and in households with children.	NPM 14 - Smoking	ESM 14.1 ESM 14.2	
Oral Health: Increase access to oral health services.	NPM 13 - Preventive Dental Visit	ESM 13.1	