Maternal and Child Health Services Title V Block Grant

Virginia

FY 2017 Application/ FY 2015 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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June 30, 2016

Michele Lawler, M.S., R.D.
Acting Director
Division of State and Community Health
Maternal and Child Health Bureau
Health Resources and Services Administration
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 FY 2017. Virginia's Application, in response to the grant announcement HRSA 15-001 has been submitted through the Electronic Handbook (EHB) as required.

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, Child and Family Health
Office of Family Health Services
Virginia Department of Health

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 (MCH) Block Grant funds are used to improve the health of women, infants, children, and adolescents with and without special health care needs in the Commonwealth of Virginia. While MCH programs are available to all women, infants and children, emphasis is placed on women of childbearing age, low-income populations, and those who do not have access to health care. Section 32.1-77 of the Code of Virginia authorizes the Virginia Department of Health (VDH) to prepare and submit to the U.S. Department of Health and Human Services the state Title V plan for maternal and child health services and services for children with special health care needs and the Commissioner of Health is authorized to administer the plan and expend the Title V funds.

Virginia's FY 2017 Title V Block Grant allocation is approximately $12.0 million. Federal law mandates that at least 30 percent of the funds be spent on services for children and youth with special health care needs (CYSHCN), and at least 30 percent be spent on preventive and primary care services for children. In accordance with federal requirements, Virginia conducted a comprehensive statewide needs assessment and has designed an implementation plan informed by that process.

FY 2015-2020 Needs Assessment Priorities

The FY 2015- 2020 MCH Needs Assessment served as an essential tool to reflect on system changes and examine the health status of Virginia's families. Although there have been improvements in some areas, there continue to be disparities based on race, income, age, insurance coverage, and geographic distribution of resources across the state. These variations continue to present challenges to improving maternal and child health. Based on the assessment, the following MCH priorities were identified and will provide guidance for related activities and funding during FY 2015 – 2020 for pregnant women and children, particularly:

1. Decrease tobacco use in households and among pregnant women.
2. Increase the number of infants who are ever breastfed as well as those breastfed exclusively for 6 months.
3. Decrease low-risk cesarean deliveries in pregnant women at 39 weeks or less gestation.
4. Increase safe sleep practices, including increasing the number of infants placed on their backs to sleep.
5. Improve access to health care services and the use of medical home for children with and without special health care needs.
6. Promote independence and transition of young adults with and without special health care needs.
7. Increase physical activity in children and adolescents.
8. Reduce injuries, violence, and suicide among Title V populations.

The following sections provide detailed descriptions of the MCH activities for each population group covered by the block grant noted earlier:

Children & Youth with Special Health Care Needs (CYSHCN)

Virginia emphasizes the CYSHCN programs in the selection of Title V funding priorities and funding activities. VDH's CYSHCN program provides services to youth and their families from birth to age 21. Youth are eligible for services if they 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. Most of the services provided to this vulnerable population consist of care coordination services and developmental and behavioral assessments. To maximize federal funding and facilitate the process of linking families to care, most of the CYSHCN programs are provided in partnership with major health care systems or universities. The CYSHCN program supports coordination of care for children and families with diseases such as cystic fibrosis, diabetes, sickle cell anemia, hemophilia, and cerebral palsy, among others. It also helps fund the early diagnosis of complex behavioral and developmental conditions requiring in-depth assessments of children that most pediatricians or family practice clinics are not equipped to provide. During FY15, the CYSHCN program provided services to more than 7,900 families. This represents an increase of more than 1,200 families served when compared with FY14.

Two of the premier CYSHCN programs that are supported by Title V funds include the Care Connection for Children (CCC) program and the Child Development Center (CDC) program. The CCC is a statewide network of six centers of excellence located regionally throughout the state of Virginia. Most of the centers operate within major medical centers where the families served have easy access to specialty providers. The hallmark service of the CCC centers is care coordination, which helps reduce or eliminate barriers that families face when trying to access services. This may include, but is not limited to: medical insurance benefit evaluation and referral (to include Medicaid), linkage to a primary care provider/medical home, information and referral to necessary resources, family to family support via parent coordinators, support from the Virginia Department of Education via state educational consultants, connection to appropriate specialty services, and access to a pool of funds for families who are underinsured or uninsured and have no other means for obtaining life preserving medications and durable medical equipment. During FY15, the CCC program served more than 3,000 families. Currently, an extensive evaluation of the program is underway and it is anticipated that a final report will be issued by the beginning of FY17. The purpose of the evaluation is to explore the quality, complexity, and comprehensiveness of services provided, as well as identify options that may exist for the leveraging of non-MCH funding sources to help diversify program funding.

The CDC program serves families with children who are suspected of having behavioral or developmental disorders such as autism, ADD/ADHD, learning disabilities, anxiety/PTSD, and mood disorders, among others. Centers provide multidisciplinary assessments of each child, as well as diagnoses and short term care coordination with families to link them to necessary services beyond the capabilities of most primary care providers. In addition, the centers are equipped with multidisciplinary teams consisting of social workers, Virginia Department of Education funded consultants, psychologists, and clinical staff. As a result of program restructuring, FY15 was the first full year that all five regional centers of excellence were fully operational. During FY15, the CDC program served more than 3,000 families and this resulted in more than 5,500 diagnoses and more than 6,000 referrals for additional services. This represents an increase of approximately 1,000 more families served than in FY14. The CDC program is of critical importance because it helps to fill an existing void (in Virginia and multiple other states) representing a shortage of developmental and behavioral pediatric service providers. During FY15-16, planning began for a CYSHCN evaluation with the CDC program and it is expected to be completed by the beginning of FY17.

FY 2017 – Selected Planned Activities for Children and Youth with Special Health Care Needs (CYSHCN)

· Strengthening family partnerships is a key objective for all CYSHCN programs. There will be parent and staff representation at each CCC statewide director's meeting, as well as CYSHCN staff representation at family involvement committees such as the Virginia Department of Education and the Family Involvement Network. In addition, staff will maintain an existing partnership with Virginia Commonwealth University and Partnership for People with Disabilities, which houses Family 2 Family and Parent 2 Parent programs for Virginia.

· The Child Development Centers, the Care Connection for Children Centers, the Virginia Bleeding Disorders Program (VBDP), and the Sickle Cell Program will refer all potentially eligible children to Medicaid, FAMIS, compassionate use, and SSI programs, and will follow-up with families as needed to assure that their applications are processed in a timely manner. Program staff will also educate families regarding their insurance options, including insurance offered through the Affordable Care Act.

· The Care Connection for Children (CCC) network of six Centers of Excellence will continue providing both information as well as referrals to resources, care coordination, family-to-family support, and assistance to families of CYSHCN.

· CCC staff will pursue national case management certification as funding permits.

· The CCC centers plan to survey families to determine their satisfaction with services and make necessary changes to more effectively meet family needs.

· The systematic approach to care, "Care Coordination Notebook – Financing and Managing Your Child's Health Care" will continue to be used to inform program improvements for family support

· The CCC and the VBDP will partner with the Virginia Dental Program to improve access to dental care and promote dental homes for CYSHCN.

· The Child Development Centers will provide multidisciplinary diagnostic evaluations of children suspected of having developmental and/or behavioral disorders, and refer these children for specialty services.

· The VBDP will provide coordinated, family-oriented, multidisciplinary services for persons with bleeding disorders and will support families who infuse at home. The program will also maintain a strong network of social workers to help families meet their insurance needs.

· The Hearing Aid Loan Bank will provide gap-filling services to families of children with hearing loss.

· The Sickle Cell Program will provide information about the disorder to the public and health care professionals and offer screening, referral, counseling and follow-up services to Virginians at risk for sickle cell disease and their families.

· The CCC, VBDP and the Sickle Cell Program staff will assist families with the development of transition plans based on best practices.

· The CYSHCN program plans to work with other MCH staff to develop a transition and medical home module for providers in order to encourage both transition activities as well as the development of Patient Centered Medical Homes and Patient Centered Specialty Providers.

·The CYSHCN team will continue work with MCH core staff to develop its Medical Neighborhood concept. This will include improvements to the newly formed multi-disciplinary team, medical neighborhood web page, and possible regional medical neighborhood collaboratives that will commence in the Blue Ridge Region of the state.

FY 2017 – Selected Planned Activities for Pregnant Women and Infants

· In partnership with MCH Staff, the Virginia Healthy Start Initiative (VHSI), the Maternal, Infant and Early Childhood Home Visiting projects, and the local health department maternity and family planning clinics will screen women for tobacco use during both pregnancy as well as the inter-conception period. They will also refer women to the Virginia Quitline for smoking cessation counseling.

· VDH and key community partners will offer a web-based training course in lactation management and a web-based performance improvement initiative (www.BFConsortium.org) to promote and support exclusive breastfeeding.

· VDH and community partners will work with hospitals in Virginia to encourage them to apply for the 10-step program to become “breast feeding friendly”.

· VHHA, VDH, ACOG, and other partners will continue to implement a quality improvement program in hospitals intended to decrease early elective deliveries/low risk cesareans.

· The local health departments delivering prenatal care will provide education regarding the signs and symptoms of pre-term labor.

· VDH will continue to provide Text4Baby messages in English and Spanish to educate and support pregnant women to improve birth outcomes and refer to Virginia Resources.

· Local health departments will continue to offer pregnancy testing, counseling and referral for prenatal care.

· To reduce the risk of neural tube defects, local health departments will continue to promote the use of folate to women of reproductive age receiving services at health department clinics.

· VHHA, VDH, and other partners will work through a quality improvement program in the birthing hospitals throughout the Commonwealth to educate families about safe sleep practices. First steps include establishing a written protocol, data gathering tool, and safe sleep training to increase safe sleep programming and standardization within labor delivery units. A workgroup has been established for this effort.

· The Virginia Maternal Mortality Review Team, partially supported by Title V, will review maternal deaths to assess the community systems of care and identify system changes that may prevent future pregnancy-related deaths.

FY 2017 – Selected Planned Activities for Children

· Title V Block Grant funds will support local health department services to address the following state priorities: tobacco (utilization during pregnancy or children exposed to second-hand smoke), or safe sleep, physical activity, injury prevention, and intended pregnancy. In addition, funding will be used to support local efforts to promote physical activity, prevent injury, and reduce unintended pregnancy.

· VDH will continue to collaborate with multiple state and local partners to help reduce rates of uninsured individuals by partnering with DMAS to increase enrollment. VDH will integrate outreach and referral activities into program efforts and continue to participate in the state mandated Children's Health Insurance Program Advisory Committee (CHIPAC). The Title V Director currently serves on CHIPAC.

· Title V Block Grant funds will continue to support the Virginia Youth Survey and other surveillance activities that provide information that may be used to monitor changes in health status, and to measure progress toward goals of improving children's health.

· The State Child Fatality Review Team will continue to examine the specific circumstances of child death and make recommendations for prevention of child injury and violence which will inform strategies for Virginia.

For further detailed information on the activities funded by the Title V block grant in Virginia, please contact the Title V director, Dr. Cornelia Deagle, 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 region 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 has grouped its 134 localities (cities and counties) into 35 health districts and 5 health planning regions. The Northern Region, 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 region, and limited translation and interpretation services, communication can be problematic and interfere with access to health services. In addition, residents of this region experience severe traffic congestion on a daily basis. Conversely, the Southwest Region, 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 Region is composed of Southside, Piedmont, Crater, Chesterfield, Richmond, Henrico, Chickahominy, Three Rivers and Rappahannock health districts. West Central Region is made up of Pittsylvania/Danville, Central Virginia, Thomas Jefferson, Central Shenandoah, Rappahannock/Rapidan and Lord Fairfax. These two regions 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 Region, 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 region has the largest concentration of military bases and facilities of any metropolitan area in the world. The coastal region has many bridges and tunnels that create transportation barriers to services. Individuals in the region 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 nearly 8.4 million in 2015, 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 were non-Hispanic White, 19.7 percent were non-Hispanic Black, and 6.3 percent were Asian. Compared with the nation as a whole, Virginia had a slightly higher proportion of Black or African-American population. The proportion of Hispanics in Virginia (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 region (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 region) 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 region) 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 regions have the highest population density rates, while the Southside region 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 region, and 29.5 in the Southside region. 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.

The number of Virginians age 85+ will increase dramatically between 1990 and 2025 -- five times faster than the state's total population growth. This population will be predominantly female, as women have a longer life expectancy than men. As baby boomers age, the percentage of older workers will increase, as will the average age of the labor force. The senior population will exhibit vastly different levels of needs, abilities and resources. In addition, the oldest seniors are more likely to live in poverty, be less educated, and have more health problems. Elderly women

significantly outnumber elderly men. Among those 85 and older, the ratio is more than two to one. Women are more likely to be widowed, live alone, and live in poverty. While the senior population in Virginia is less diverse than the overall population, the percentage of older Virginians who are members of racial/ethnic minority groups will continue to grow over the next several decades.

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% are African American, 6% are Hispanic/Latino, 3% are Asian, and 56% are 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 indicate they are 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. Tidewater, where the population is mostly comprised of non- Hispanic White and non- Hispanic Black, is also home to one of the largest Asian populations in the state. While non-Hispanic Whites will continue to make up the majority of Virginia's population in the next few decades, the proportion of Asians and Hispanics will grow.

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, Hispanics 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 being Hispanic. Among Hispanics 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%. One in ten Virginians are living below the federal poverty level, which in 2014 was $12,061. African-Americans, Hispanics, and households headed by a single female are more likely to face poverty or near poverty.

In 2014, poverty rates again rose for every region except the Northern, Central, and Southside regions. Southside still had the highest percentage of individuals (21.3%) living below the poverty level of any region in the state, followed by the Southwest region (20.8%). With poverty levels of 16% each, the Eastern and West Central regions

did not fare much better. At the other end of the scale, the Northern region had the lowest percentage of individuals living below the poverty level (6.5%), followed by the Central (12.4%) and Hampton Roads (13.2%) regions. 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 region (Falls Church City) had the highest median household income ($121,250) in 2014. In 2014, Danville city (Southside) 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 region 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 region had the highest per capita personal income in 2014 at $66,121. The Southside and Southwest regions 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. TANF rates in 2013 among both adults and children were 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 regions have routinely experienced higher rates of unemployment than other regions, 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.

In Virginia, obesity is more prevalent among non-Hispanic blacks at 38.9% than non-Hispanic whites at 26.7%. The 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. This is just one specific population, but the data highlights overweight and obesity for all children. The prevalence of smoking also varies by race and ethnicity in the state; 15.2% of Hispanics smoked in 2014 compared to 19.5% of non-Hispanic blacks and 20.2% percent of non-Hispanic Whites.

Health Insurance

Based on the latest U.S. Census Bureau estimates, the national average for 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 regions of Virginia except the Hampton Roads region. The Eastern (17.1%), Southside (16.7%), Valley (16.3%), and Southwest (16.0%) regions had the highest uninsured rates. The Northern region 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%.

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% are white, non-Hispanic; 22.8% are black, non-Hispanic; 21.6% are Hispanic; 6.9% are Asian/Pacific Islander; and 2.8% are of other or multiple racial/ethnic backgrounds. However, Hispanics are uninsured at higher rates than any other ethnic group (32%). Among these different groups, non-Hispanic whites 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

According to Virginia Performs, the high school graduation rate is one measure of the success of a state's elementary and secondary educational system and the quality of its workforce. 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. Graduation rates continued to improve in nearly every Virginia region 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%) regions had rates that exceeded the statewide average. The remaining regions 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 regions, 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%) regions had dropout rates below the statewide average; the remaining regions had rates above the statewide average. Only the Southside region 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

House Bill 2097, passed by the 2003 General Assembly, requires that each state agency implement a state performance-based budgeting system. Since that time, an ad hoc advisory group of agency representatives designed the new planning and budgeting model requiring all state agencies to develop strategic plans that are tied to their budget and that use consistent language and structure. The planning process was unveiled to agency heads by Governor Warner in December 2004. Since that time, state agencies, including VDH, have developed their strategic plans and area service plans (operational plans) that are tied to the strategic plan and budgets. This significant change in state government planning and budgeting promotes a greater level of transparency in government by making public the manner in which taxpayer dollars are spent, and the subsequent return on investment.

II.B. Five Year Needs Assessment Summary

2016 Five-Year Needs Assessment Summary

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 (Submitted on July 15, 2015)

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 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-

Health Issue	Strategies to Address the Issue
	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
2	Breastfeeding
3	Physical Activity
4	Tobacco
5	Medical Home
6	Transition
7	Child/Adolescent Injury
8	Woman/Maternal Health

The following three state priorities were identified as critical needs and selected for the state performance measures:

Teen Pregnancy

Teen pregnancy is a critical public health issue affecting the health, educational, social, and economic future of the mother and child. Teen pregnancy is also a significant factor in numerous other social issues of concern, including: welfare dependency, out-of-wedlock births, responsible fatherhood, and workforce development. Adolescents may be less likely to seek out prenatal care because they are afraid, embarrassed, or unaware of available resources. This lack of prenatal care, coupled with the mother's usually immature physical development, result in higher rates of low birth-weight babies than in other age groups. As the offspring of adolescent mothers grow, they are more apt to have health and cognitive problems.

Over the past decade, the rate for adolescent births in Virginia and across the nation has generally declined. The birth rate for Virginia teens was 36.1 per 1,000 females aged 15 to 19 years old in 2005, but by 2014 this rate had dropped to 18.3 births, giving Virginia the 12th lowest incidence of teen births among the 50 states. Latest available data from the Guttmacher Institute indicate that Virginia's teen pregnancy rate improved in line with national trends. At 48 pregnancies per 1,000 female teens in 2010, Virginia ranked 22nd lowest among the 50 states. The national average in 2010 was 57 pregnancies per 1,000 female teens. Within Virginia, teen pregnancy has generally been decreasing, with every region exhibiting a lower rate in 2014 than it had the previous year -- and markedly lower rates in nearly all regions when compared to a decade ago. According to data from the Virginia Department of Health, the Eastern region had the highest teen pregnancy rates (41.9%), while the Northern region had the lowest (21.2%). Overall, there were 6,566 reported teen pregnancies in Virginia in 2014 -- an average of 24.9 per 1,000 females aged 15 to 19.

Infant Mortality

Infant mortality is one of the most important indicators of the health of a state, as it is associated with a variety of

factors, including maternal health, quality and access to medical care, socioeconomic conditions, and public health practices. In 2013, Virginia's infant mortality rate was 5.2 per 1,000 live births, while the black infant mortality rate was 12.2 per 1,000 live births. While we have made significant progress in the Commonwealth to reduce the overall infant mortality rate, we still have a large amount of work to ameliorate these disparities among racial/ethnic groups. We continue to monitor infant mortality trends for all groups, and are focusing on modifying the behaviors, lifestyles, and conditions that affect birth outcomes, such as smoking, substance abuse, poor nutrition, lack of prenatal care, and/or late entry into prenatal care.

Maternal Mental Health

Maternal depression takes a particularly large toll on pregnant and postpartum women because it affects their children, partners and other family members. Maternal depression is the most common complication of pregnancy. According to PRAMS, from 2012-2013, 10.2% of women delivering a baby in Virginia reported symptoms of postpartum depression. Research has shown that untreated perinatal mood and anxiety disorders (during pregnancy or postpartum) can negatively affect birth outcomes and infant development, including mother-infant attachment and bonding, infant mental health and brain development, long-term social and cognitive development of the child, and the well-being of the entire family unit. Maternal risk factors for developing perinatal mood and anxiety disorders can be reliably identified, assessed, and treated by health care providers and public health systems. With proper awareness, education, intervention, and access to resources, perinatal mood and anxiety disorders are highly treatable, with interventions demonstrating positive effects on both mothers and children.

In 2015, Virginia designated the month of May to be maternal mental health awareness month. Virginia is working to increase screenings at all postpartum visits, in addition to providing education and training to healthcare providers to recognize early signs of maternal depression and to use screening tools throughout pregnancy for reimbursement.

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 4 - A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months
- NPM 5 - Percent of infants placed to sleep on their backs
- NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19
- NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day
- 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 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 2017 Title V Block Grant application, the OFHS Management Team, along with a number of our external partners, reviewed the previous Title V priorities, the National and State Performance Measures, the Health Systems Capacity Indicators, the Health Status Indicators, as well as needs assessment data that included qualitative data from key stakeholder interviews, focus groups, and the district health nurse manager survey. As a result, the following priorities were identified, and will be used to focus OFHS activities and resources during the coming year:

1. Reduce infant mortality through safe sleep practices.
2. Reduce injuries, violence and suicide.
3. Decrease low-risk cesarean deliveries in pregnant women less than 39 weeks.
4. Increase breastfeeding practices.
5. Increase physical activity for children and adolescents.
6. Improve access to health care services for all including children and youth with special health care needs by promoting medical homes in practice.
7. Promote independence of all young adults including those with special health care needs by strengthening transition supports and services.
8. Decrease incidence of tobacco smoking by pregnant women and in the family household.

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

- SPM 1 - Teen Pregnancy Prevention: Rate of females age 15-19 using most effective contraceptive methods
- SPM 2 - Maternal Mental Health: Proportion of women who attend a postpartum visit with a health care worker within 6 weeks after getting birth
- SPM 3 - Infant Mortality Disparity Ratio

As part of the Five Year Needs Assessment, Virginia developed eight statewide priorities for 2015-2020. The selected priorities illustrate the relationship between Virginia's maternal and child health (MCH) priorities and specific required elements of the annual block grant report: national performance measures (NPM), evidence-based/informed strategic measures (ESM), national outcome measures (NOM), state performance measures (SPM), and state outcome measures (SOM). The priorities are not ranked by importance. The issue of health disparities, children and youth with special health care needs, and teen pregnancy are cross cutting issues that underlie each of the priorities (see Section II.C).

II.F. Five Year State Action Plan

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

The following narrative explains the five-year state action plan, beginning in 2016. The Virginia Department of Health identified eight (8) national priorities and three (3) state priorities. Each of the priorities is situated within a Maternal and Child Health domain. Each domain clarifies the population served. The three state priorities identified by the Virginia Department of Health for the next five years include:

· Teen Pregnancy Prevention

· Maternal Mental Health

· Infant Mortality Reduction

Each priority will be implemented either as a component of a current public health program, or through an existing collaborative partnership. The following report includes the next five-year state action plan table, the current application year plans, and the FY 2015 Progress Report for each respective MCH domain. Many of the accomplishments in the FY 2015 Progress Report are a result of the collaborative efforts with other public health programs. The VDH Title V grant application priorities span many divisions and departmental lines. As a result, priority accomplishments are actualized through the efforts of numerous individuals and programs.

Women/Maternal Health

State Action Plan Table

State Action Plan Table - Women/Maternal Health - Entry 1

Priority Need
Woman/Maternal Health

NPM
Percent of cesarean deliveries among low-risk first births

Objectives
Decrease early elective deliveries by 10% over 5 year period (2020).

Strategies

Partner with ACOG, VHHA and March of Dimes to adopt best practices and provide education to labor and delivery hospitals and OB providers.

Partner with insurance companies and DMAS to reduce low risk cesarean deliveries by implementing policies that withhold reimbursement to providers who allow non-medically necessary low risk cesarean delivery.

ESMs

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

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 - Women/Maternal Health - Entry 2

Priority Need

Woman/Maternal Health

SPM

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

Objectives

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

Strategies

Partner with ACOG and AWHONN to adopt best practices and delivery of mental health services for pregnant/postpartum women to increase the number of providers who educate and/or screen during pregnancy or after delivery for depression.

Collaborate with text4baby and other community partners to educate women about signs and symptoms of postpartum depression through the use of social media to reduce stigma, increase advocacy, and improve population health.

Develop a training module for health care providers to educate on best practices for mental health services of pregnant/postpartum women.

Measures

NPM 2 - Percent of cesarean deliveries among low-risk first births

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	26.1	25.9	25.6	25.2	24.9	24.5

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	25.9 %	0.3 %	4,928	19,056
2013	26.3 %	0.3 %	4,591	17,440
2012	28.0 %	0.3 %	6,680	23,840
2011	30.1 %	0.2 %	11,470	38,062
2010	30.6 %	0.2 %	11,496	37,514
2009	30.8 %	0.2 %	11,971	38,874

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

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

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

Women/Maternal Health - Plan for the Application Year

Plan for the Application Year

For the Woman/Maternal Health priority domain, Virginia has chosen to work on the Low-Risk Cesarean Delivery National Performance Measure (NPM). Objectives include the reduction of non-medically necessary early elective deliveries (EED) to fewer than 2% of all births by 2020. A strategy set forth to accomplish this objective includes partnering with ACOG, VHHA and March of Dimes to adopt best practices and to further educate labor and delivery hospitals and OB providers. Another strategy will include the establishment of partnerships with insurance companies and DMAS to reduce low-risk cesarean deliveries by implementing policies that may withhold reimbursement to providers who allow non-medically necessary low-risk cesarean deliveries. The National Outcome Measures (NOMs) used to measure progress around the aforementioned strategies are included in the state action plan table.

Virginia selected maternal mental health as a state priority and identified screening for postpartum depression as the State Performance Measure (SPM). The objective includes increasing the percentage of postpartum women who attend a postpartum visit within 6 weeks of giving birth by 5% by 2020. Strategies include partnering with ACOG and AWHONN to implement best practices for screening and treating women for postpartum depression, educating the population, and training providers. The State Outcome Measure (SOM) used to measure progress toward this goal is included in the state action plan table.

Women/Maternal Health - Annual Report

FY 2015 Progress Report

National Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

In order to accomplish National Performance Measure (NPM) 15, the Title V MCH program collaborated with the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program, Virginia Healthy Start/Loving Steps, and Resource Mothers program. The MIECHV project had twenty-five localities assess women for tobacco use during pregnancy and the interconception period; provide smoking cessation education and counseling to women who smoke; educate women on the hazards of second-hand smoke for infants and children; and provide referrals to smoking cessation programs including Virginia's Quitline. In addition to making referrals to the Virginia Quitline, all local district health departments educated pregnant mothers and families on tobacco cessation.

The Virginia Healthy Start/Loving Steps and the Resource Mothers Program continued to monitor smoking status among participants and utilizes this status as a performance measure for the program. Smoking cessation was encouraged and appropriate referrals were made when indicated.

Child fatality reviews involve examination of the precise details of a child's death to determine how a death could

have been prevented, and to make recommendations for education, training, and intervention. Child death reviews highlight changes needed in health care, education, social services, and death investigation practices. In 2015, the child fatality review team found that more than 70% of the infants in the review were exposed to second hand smoke, and half of the deceased infants were born to mothers who smoked during pregnancy. The review team recommended that tobacco education messages include information about smoke as a risk factor for Sudden Unexpected Infant Death (SUID).

The Tobacco Cessation among Pregnant Women implementation team was initiated in 2014, and outlined the goal of increasing enrollment of pregnant women in the Quitline. The team developed a work plan with action steps addressing the objectives and strategies outlined in the Infant Mortality Strategic Plan, specific to tobacco cessation among pregnant women. The team consisted of 26 members from across the states, AAP, FQHC, ACOG, DMAS, MCOs, March of Dimes, and Eastern Virginia Medical School.

2015 provisional data indicate that 5.3% of Virginia women smoked in their last three months of pregnancy as compared to 5.6% in 2014.

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

One of the key measures for determining the well-being of any community is the assessment of maternal health. One indicator used to assess maternal health is early access and entry into prenatal care. Poverty and difficulty accessing prenatal care can have long-term effects on individuals, families, and communities. Individual pregnancy outcomes can be improved through the use of technological advances, the prevention of unintended pregnancies, the promotion of healthy lifestyles, and the improvement of access to health care for childbearing women.

The 2015 provisional data indicate that 84.9% of infants were born to women who received prenatal care beginning in the first trimester, an increase of 2% from 2014. However, racial/ethnic disparities along this indicator continue to exist.
Within the Department of Health, 19 local health departments provided prenatal care in FY15, funded in part by Title V. The remaining 16 health departments facilitated entry into community care while also focusing on care coordination and case management. All health departments referred eligible families to Medicaid.

The Title V MCH program collaborated with Virginia Healthy Start Initiative's (VHSI) local sites and targeted outreach to providers, programs, and clinics providing pregnancy testing services. This was done in order to increase referrals early in pregnancy and to assist women in accessing prenatal care in the first trimester.

In collaboration with multiple internal and external stakeholders across the Commonwealth, VDH developed the Thriving Infants Strategic Plan in 2013 (formerly referred to as the Infant Mortality Reduction Strategic Plan, or IMRSP. Across several meetings, over 65 individuals representing state and private agencies, non-profits, educational research institutions, and community organizations identified 5 goals; (1) preconception health; (2) preterm birth and LDWBW; (3) interconception and family planning; (4) positive parenting; and (5) data. A comprehensive implementation plan was launched in December 2013. Several strategies were proposed to address issues surrounding access to and timely utilization of prenatal care. One such strategy included engaging with community partners and health care providers to promote the benefits of prenatal care beginning in the first trimester. Workgroups related to priorities (e.g., access to family planning services, reduction of smoking among pregnant women, Safe Sleep, etc.) have been operational since 2013 and have blended with the National CoIIN initiative. The CoIIN priority for Virginia is Safe Sleep. CoIIN efforts continued in FY15.

Title V staff continued to collaborate with text4baby to increase awareness and access to Virginia specific services through promoting best practices, decreasing infant mortality, and educating about available Virginia resources to pregnant women and new mothers. The text4baby messages include topics such as breastfeeding, early prenatal care, smoking and alcohol use during pregnancy, proper nutrition, and other best practices. The messages are available in both English and Spanish. In FY15, a mean number of 443 Virginians enrolled in the text4baby program monthly.

State Performance Measure 1: *Percent of women ages 18-44 who report good/very good/excellent health.*

According to the Behavior Risk Factor Surveillance Survey (BRFSS), 88.1% of women aged 18-44 reported good/very good/excellent health in 2014. In FY15, the local health districts continued to support maternity, family planning, immunization, and flu vaccination clinics. VDH provided trainings to providers around outreach and enrollment in Medicaid, as well as the impact of the Affordable Care Act. VDH staff collaborated with the Department of Medical Assistance Services (DMAS) and the Department of Social Services (DSS) to develop new ways to increase access to health services while also addressing barriers to program enrollment/utilization. Some local health departments partnered with patient navigators to assist with health coverage applications.

VDH also continued to offer Quit Now Virginia: a toll-free tobacco cessation phone counseling service provided to Virginia residents aged 13 and older, 24 hours a day, seven days a week. Callers to the Virginia Quitline receive one-on-one cessation counseling, information and self-help materials. VDH's clinics screen for tobacco use and refer to Quit Now Virginia. Through partnerships, a strategy of a local health district in Northern Virginia was to support an Outreach Committee tasked with identifying areas of need in order to expand family planning and maternity clinics for FY16 program activities.

The VDH Office of the Chief Medical Examiner (OCME) continued to coordinate the Maternal Mortality Review Team's (MMRT) review of pregnancy-associated deaths. To date, the MMRT has identified several major risk factors for pregnancy-associated death and has made recommendations to address them. This resulted in policy and practice changes, including enacting improvements in screening for substance abuse, intimate partner violence and behavioral health among reproductive age women as well as the provision of resources and guidance documents for practitioners addressing addiction and pain management, and for medically assisted substance abuse treatment during pregnancy.

Perinatal/Infant Health

State Action Plan Table

State Action Plan Table - Perinatal/Infant Health - Entry 1

Priority Need

Safe Sleep

NPM

Percent of infants placed to sleep on their backs

Objectives

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

Strategies

Partner with Virginia Home Visiting Consortium, the Virginia chapter of AAP, local health districts, hospitals, March of Dimes, text4baby, and community partners to provide standard messaging, training, and resources to reduce sleep related deaths among infants.

Evaluate changes in policy and procedures in partnering hospitals to promote safe sleep practices.

Collaborate with OCME to establish a standard definition and investigation mechanism for classifying sleep related deaths.

ESMs

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

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 - Perinatal/Infant Health - Entry 2

Priority Need

Breastfeeding

NPM

A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Objectives

Increase the proportion of woman who initiate breastfeeding before hospital discharge by 5% (2020); Increase the proportion of women who exclusively breastfeed through 6 months of age by 10% (2020).

Strategies

Partner with Virginia Maternity Quality Improvement Collaborative and Family to Family (F2F) Health Information Center to promote best practices with breastfeeding education and resources for all new mothers and caregivers in birthing hospitals, prior to discharge for children, including those with special health care needs.

Collaborate with local health districts, the Virginia chapter of AAP, March of Dimes, maternity centers, text4baby, and community partners, to educate families and health care providers on benefits and implementation tools, and to provide support around breastfeeding sustainability during the prenatal and perinatal period.

Support comprehensive breastfeeding education and best practices to be initiated into a hospital setting, with the state MCH Breastfeeding Coordinator to serve on the Virginia Maternity Quality Improvement Collaborative in order to increase the enrollment of maternity centers in the statewide program.

ESMs

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

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

NOMs

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 - Perinatal/Infant Health - Entry 3

Priority Need

Woman/Maternal Health

SPM

Infant Mortality Disparity Ratio

Objectives

Eliminate the racial/ethnic disparity of infant mortality by 2020.

Strategies

Collaborate with FQHC, text4baby, and other community partners to expand the number of safety net providers of prenatal care services to vulnerable populations.

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

Collaborate with OCME to establish a standard definition and investigation mechanism for classifying sleep related deaths.

Measures

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	81.0	81.5	82.0	82.5	83.0	83.5

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	82.8 %	3.5 %	83,969	101,412
2011	80.5 %	4.2 %		
2010	80.1 %	3.5 %		
2009	79.8 %	2.9 %		
2008	81.4 %	2.4 %		
2007	75.3 %	2.8 %		

Legends:

Indicator has an unweighted denominator <50 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NPM-4 B) Percent of infants breastfed exclusively through 6 months

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	23.0	23.5	24.0	24.5	25.0	25.5

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2012	23.6 %	3.6 %	23,645	100,115
2011	22.9 %	4.2 %		
2010	16.6 %	2.8 %		
2009	17.2 %	2.2 %		
2008	15.2 %	1.9 %		
2007	13.7 %	1.9 %		

Legends:

Indicator has an unweighted denominator <50 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

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

Annual Objectives					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	25.0	45.0	60.0	75.0	90.0

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

Annual Objectives					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	40.0	55.0	70.0	85.0	100.0

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

Annual Objectives						
	2016	**2017**	**2018**	**2019**	**2020**	**2021**
Annual Objective	78.5	80	82	84	85	86

FAD not available for this measure.

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	50.0	75.0	90.0	95.0	100.0

Perinatal/Infant Health - Plan for the Application Year

Plan for the Application Year

The Commonwealth of Virginia selected two National Performance Measures (NPMs) and one State Performance Measure (SPM) within the Perinatal/Infant Health domain. The first National Priority Measure is the percent of infants placed to sleep on their backs. The objective includes increasing the percentage of infants placed in a safe environment to sleep by 10% (2020). Strategies to achieve this goal include educating parents and caregivers upon discharge from the hospital, and implementing standardized messaging on appropriate sleep practices for an infant's individual needs (including those with special healthcare needs) during physician visits. In addition to these strategies, local health departments were asked to select either safe sleep or tobacco initiatives to focus on for the next five-year grant cycle. Each health district is on a fiscal year from July 1, 2016 to June 30, 2017. Therefore, semiannual reports, including these initiatives, will be used to measure progress by January 31, 2017, along with annual reporting by July 31, 2017. Progress observed at the community level will be included in the Title V application each year.

The second National Priority Measure (NPM) is the A) Percent of infants who are ever breastfed AND B) Percent of infants breastfed exclusively through 6 months. The related objectives include increasing the proportion of women initiating breastfeeding prior to hospital discharge by 5% (2020); and increasing the proportion of women exclusively breastfeeding through 6 months of age by 10% (2020). Strategies include promoting best practices for hospital-based education for new mothers and caregivers in the prenatal, perinatal, and immediate postpartum periods. Additional strategies include partnering with WIC to enroll women in breastfeeding peer counseling, increasing access to International Board Certified Lactation Consultants (IBCLC) and Certified Lactation Consultants (CLC), and promoting breastfeeding friendly workplaces. National Outcome Measures (NOMs) associated with these objectives are included in the State Action Plan Table.

The State Performance Measure (SPM) selected was Infant Mortality Reduction. The objective related to this measure is the elimination of racial/ethnic disparities in infant mortality rates by 2020. A strategy developed to achieve this objective is to collaborate with FQHC and other community partners in order to expand the number of safety net providers of prenatal care services to vulnerable populations. Another strategy is to partner with the Home Visiting Consortium and local health districts to increase access to and promote the benefits of early prenatal services. Title V staff will continue to collaborate with text4baby to increase awareness and access to Virginia specific services through promoting best practices, decreasing infant mortality, and educating about available Virginia resources to pregnant women and new mothers. The text4baby messages include topics such as breastfeeding, early prenatal care, smoking and alcohol use during pregnancy, proper nutrition, and other best practices.

Perinatal/Infant Health - Annual Report

FY 2015 Progress Report

In FY15, the major focus around perinatal health continued to be on newborn screening, including hearing screening, promoting breastfeeding, reducing infant deaths and injuries caused by motor vehicle crashes, promoting safe sleep practices, and reducing infant mortality by ensuring that both low birth weight infants are delivered in facilities for high risk infants, and by reducing the number of infants born preterm. Title V funds were also awarded to the district health departments to support programs that address breastfeeding, child health, injury prevention, and perinatal and infant mortality.

National Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their state-sponsored newborn screening programs.*

In FY15 the Virginia Newborn Screening Program (VNSP) continued to ensure the screening of all infants, tracked and followed up on presumptive positive results, and assured that confirmed cases were referred into treatment and care coordination services in a timely manner. VNSP and the Division of Consolidated Laboratory Services (DCLS) collaborated on quality improvement measures to decrease the transit time of dried blood spot samples. Quality improvement measures were also implemented in order to increase the mandated documentation of Critical Congenital Heart Disease (CCHD) results on the electronic birth certificate (EBC). VNSP developed and distributed a screening algorithm for CCHD to Virginia birthing hospitals for nursing staff. Education and technical assistance for these quality improvement activities were provided at approximately 20 sites and during statewide webinars. A CME/CEU website on newborn screening was launched (www.newbornscreeningeducation.org) and included modules on dried blood spot screening and CCHD.

State regulations were implemented to add screening for Severe Combined Immunodeficiency (SCID) and CCHD to Virginia's NBS panel. SCID screening of Virginia's infants went live June 2015. A legislative mandate was received to investigate adding Krabbe disease screening to Virginia's NBS panel. The Genetics Advisory Committee (GAC) reviewed the risks and benefits of Krabbe screening and recommended that this test not be implemented at that time. Additional modifications to the EBC were requested to expand CCHD screening documentation in order to improve validity and assist with surveillance efforts. Current contracts with three metabolic treatment centers remained in place. Staff participated in HRSA & NewSteps projects as requested. Staff also presented at national conferences, provided expert knowledge to various list serves, and participated in NYMAC collaborative activities. As in previous years, 100% of newborns screening positive received timely follow-up to diagnosis as well as clinical management of their condition.

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

The Virginia Early Hearing Detection and Intervention Program (VEH DIP) continued to conduct activities related to screening, follow-up, family-to-family support, and process improvements. Site visits for technical assistance continued to take place. Family to Family (F2F) held trainings targeting VEHDIP stakeholders in order to increase outreach and education. The Virginia Infant Screening and Infant Tracking System (VISITS) continued to be linked with the Virginia Immunization Information System (VIIS) in order to share screening results with primary care providers electronically. Early Intervention and VEHDIP will continue to share referral and enrollment information through an automated notification to each local Part-C Coordinator, which will be generated from a report of permanent hearing loss in VISITS. The first phase of this linkage was completed in 2014.

VEHDIP continued to conduct ongoing surveillance of data to provide targeted technical support to hospital staff and audiologists. Hospitals not meeting data reporting requirements received targeted technical assistance. VEH DIP continued to enhance the VISITS system by developing a new quarterly report for audiologists and hospital users. VEHDIP implemented the use of Early Hearing Detection and Intervention Pediatric Link to Services (EHDI PALS), and encouraged audiologists to register on this site as an approved pediatric diagnostic facility. The provisional 2015 data indicated that 99.2% of all newborns received hearing screening, as compared with 98.4% in 2014.

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

In preparation of the transformation of the Title V block grant in FY16, local districts planned in FY15 to promote education and resources in pursuit of the goal of decreasing the rate of fatalities caused by motor vehicle crashes. These strategies included providing education for families and caregivers of children aged 0-14 on vehicular safety and providing appropriate vehicular restraints. In FY15, the local health district of Norfolk used Title V funds to support staff time in order to enable participation in the VDH Low-Income Safety Seat Distribution and Education Program (LISSDEP). LISSDEP provides free safety seats and installation education to financially eligible families who could otherwise not afford them. The program is offered weekly and provides educational instruction, demonstrations and hands-on training regarding the proper usage of child safety restraints. Twenty-five (25) car safety seat education classes were provided to 189 families who were enrolled and successfully completed the program. A total of 206 Titan Convertible and Maestro booster seats were distributed in this district.

State Performance Measure 4: *The rate of childhood unintentional injury hospitalizations per 100,000 children ages 0-19.*

The Injury and Violence Epidemiologist, partially funded by Title V funds, maintains 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 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 responds to data requests that could not be addressed through the VOIRS system from constituents.

Division of Policy and Evaluation (DPE) staff, partially funded by Title V funds, provided technical assistance to programmatic staff in the drafting of responses for constituent inquiries about the prevention of sexual assault. DPE staff were also paramount in the tracking of legislation introduced in the Virginia 2015 General Assembly which addressed multiple injury prevention issues: HB 2006 and SB 998 requiring local school divisions to establish a management plan for the implementation of and compliance with policies and procedures regarding the identification and handling of suspected concussions in student-athletes; and SB 1093 requiring the board of health to promulgate regulations establishing safety standards for movable soccer goals. Staff not only tracked but also drafted enrolled bill summaries for legislation which were successfully voted into law: HB 1515 adding information about safe sleep environments for infants to the list of information that licensed nurse midwives, licensed midwives, and hospitals must provide to maternity care patients; and SB 1325 and HB 2036 which prohibit the sale of liquid nicotine unless it is in a container satisfying the child-resistant packaging standards and including a warning label indicating that the container should be kept out of reach of children.

In preparation of the transformation of the Title V block grant in FY16, local districts planned in FY15 to promote education and resources addressing the measure of decreasing the rate of unintentional injury hospitalizations in childhood. These strategies included providing education for families of children aged 0-19 and providing appropriate vehicular restraints, performing preemptive sports physicals on school age children prior to participation to ensure fitness, and training child care staff on safety measures. In FY15, the local health district of Norfolk used Title V funds to support staff time to enable participation in the VDH Low Income Safety Seat Distribution and Education Program (LISSDEP). LISSDEP provides free safety seats and installation education to financially eligible families who could otherwise not afford them. The program is offered weekly and provides educational instruction, demonstrations and hands-on training regarding the proper usage of child safety restraints. Twenty-five (25) car safety seat education classes were provided to 189 families who were enrolled and successfully completed the program. A total of 206 Titan Convertible and Maestro booster seats were distributed in this district.

The rate of unintentional injury related hospitalizations among children aged 19 or younger continues to demonstrate a decreasing trend. It is important to note that the indicator used is a proxy, as Virginia is unable to measure the total

number of nonfatal injuries.

National Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

The Virginia Breastfeeding Advisory Committee (VBAC), supported by Title V staff, continued to conduct quarterly meetings in Richmond. In coordination with the Health Commissioner's Infant Mortality Work Group on breastfeeding endeavors, the VBAC worked to increase the number of birthing hospitals in Virginia implementing part or all of the ten Steps to Successful Breastfeeding, by launching the Virginia Maternity Care Quality Improvement Collaborative. This collaborative works with Virginia's maternity centers on quality improvement in maternity care practices in order to protect, promote, and support safe and effective infant feeding and care. Funded by the CDC 1305 grant, the Collaborative is well underway with monthly quality improvement webinars facilitated by volunteer faculty from participating facilities. The second in-person collaborative took place in Richmond on September 25, 2015. Fifty-one out of 54 birthing facilities registered. A total of 86 representatives, including Managers/Directors, Physicians/APRNs, Direct Care Nurses, and Lactation Consultants participated. All birthing facility faculty members are now enrolled on the Institute for Healthcare Improvement Extranet for data collection and collaboration. Monthly webinars began October 13, 2015, and ran through April 2016. There were two webinars each month, with facilities divided by size (annual births greater than or less than 1500). Collaborators will develop the agenda during the monthly webinars.

In May of 2015, VDH launched the Virginia Maternity Center Breastfeeding-Friendly Designation (VMCBFD) program. The designation was based on the World Health Organization's Ten Steps to Successful Breastfeeding. These steps support the initiation, exclusivity, and continuation of breastfeeding. The goal is for 30 of Virginia's 55 maternity centers to become designated. The (VMCBFD) program is free and voluntary, with recognition awarded incrementally to help support continuous improvement. The Division of Community Nutrition continued to work with the University of Virginia's Office of Continuing Medical Education to host a web-based training course in lactation management as well as a web-based performance improvement initiative. The course provides 20 continuing education hours, required for maternity care facilities wishing to obtain a Baby-Friendly Hospital designation. In addition, the BFConsortium.org site is heavily utilized by the Maternity Centers working within the Virginia Maternity Care Quality Improvement Collaborative.

Two important sections of legislation regarding breastfeeding have been adopted since the previous progress report: § 32.1- 370: Right to breastfeed, was enacted and took effect on July 1, 2015. It reads: "A mother may breastfeed in any place where the mother is lawfully present, including any location where she would otherwise be allowed on property that is owned, leased, or controlled by the Commonwealth in accordance with § 2.2-1147.1. 2015, cc. 45, 105." VA WIC Program developed a strategic plan to increase breastfeeding rates. The VA WIC Program continued to move forward with efforts to increase the number of International Board Certified Lactation Consultants (IBCLCs) in the WIC Program. In 2014, 53.7% of Virginia mothers were breastfeeding their infants at 6 months of age.

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

Virginia has seen a continued decrease in infant mortality since 2007. Strong collaborative networks among public, private, and non-profit organizations have formed, and have focused on evidence-based methods of reducing infant mortality rates. VDH, along with its stakeholders and partners, has identified objectives and strategies intended to improve birth outcomes and reduce infant mortality. This collaboration led to the completion of the "Thriving Infants' Strategic Plan," which draws upon best practices for evidence-based interventions to reduce infant mortality. One successful evidence-based intervention involves ensuring that low birth weight infants are born in facilities for high-risk deliveries. Provisional data indicated that in FY15, 84.9% of these infants were born in said facilities, compared with 87.9% in FY14, indicating an ongoing need for this collaboration.

During FY15, staff continued to support the utilization of telemedicine for patients living in remote and underserved

areas through the use of funding from the VDH Office of Minority Health and Health Equity. The Virginia Commonwealth University Health System and the University of Virginia continued partnerships to support telemedicine links between local health clinics. This continuing collaboration has provided real-time distant consultation services (including live video feed of patient ultrasound studies) and education to ancillary support staff, healthcare providers, and community.

Child Health

State Action Plan Table

State Action Plan Table - Child Health - Entry 1

Priority Need

Child/Adolescent Injury

NPM

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

Objectives

Reduce hospitalizations due to injuries among the child population 0-9 by 10% (2020).

Strategies

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.

Implement Safe Environments for Every Kid (SEEK) model of enhanced primary care. SEEK is an evidence-based practical approach to the identification and management of targeted risk factors for child maltreatment, (e.g.intimate partner violence), for families with children ages 0-5, which is then integrated into pediatric primary care. By addressing these issues, SEEK aims to strengthen families, support parents, enhance children's health, development and safety, while also working to prevent child maltreatment.

Collaborate with Safe Kids Virginia, Virginia Foundation for Healthy Youth, local health districts, DOE, school nurses, and other community partners to educate school age adolescents and families regarding safety.

ESMs

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

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 - Child Health - Entry 2

Priority Need

Physical Activity

NPM

Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Objectives

Increase the number of children ages 6-11 and adolescents ages 12-17 who are physically active at least 60 minutes per day by 10% (2020).

Strategies

Partner with physical education and activity specialists to conduct tailored Comprehensive School Physical Activity Program (CSPAP) training within the 15 targeted school divisions.

Provide ongoing professional development and technical assistance to help schools develop, implement, and evaluate CSPAP. This includes quality physical education and physical activity programming before, during and after school. This programming includes activities such as recess, classroom activity breaks, walking/biking to school, physical activity clubs, and after school sports/clubs.

Partner with multiple stakeholders and the 15 targeted schools divisions' School Health Advisory Board (SHABs) wellness champions to conduct a "Building Virginia School Wellness Champions" workshop. Goals of this workshop including building sustainable and successful SHABs, completing the School Health Index on at least one elementary, middle, and high school per division, creating action plans to adopt and implement at least one nutrition and one physical activity policy, and revising existing Local School Wellness Policies.

ESMs

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

NOMs

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

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

Measures

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19 (Child Health)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	139	135	132.5	130	125	122

Data Source: State Inpatient Databases (SID) - CHILD

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2013	87.9	2.9 %	915	1,041,031
2012	96.1	3.0 %	1,035	1,076,691
2011	105.4	3.2 %	1,113	1,056,045
2010	104.7	3.2 %	1,064	1,016,744
2009	106.5	3.3 %	1,077	1,010,863
2008	119.8	3.5 %	1,186	989,821

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

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

Annual Objectives					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	0.0	25.0	40.0	55.0	70.0

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day (Child Health)

Annual Objectives						
	2016	**2017**	**2018**	**2019**	**2020**	**2021**
Annual Objective	50	52.5	55	57.5	60	63.5

Data Source: National Survey of Children's Health (NSCH) - CHILD

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2011_2012	33.2 %	2.8 %	195,681	589,617
2007	32.9 %	2.6 %	194,030	589,431
2003	30.0 %	2.1 %	172,391	574,580

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

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

Annual Objectives					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	77,100.0	382,400.0	573,600.0	754,200.0	874,400.0

Child Health - Plan for the Application Year

Plan for the Application Year

For the next five years, the Commonwealth of Virginia will be working on two priority needs within the child health domain. The realigned Title V position of School and Adolescent Health Specialist will be a key partner for both priorities within this domain and the Adolescent Health domain. The first priority need is child/adolescent injury. The National Performance Measure (NPM) includes decreasing the rate of hospitalization for non-fatal injury per 100,000 children aged 0-9. The coordinating objective is to reduce hospitalizations due to injuries among the population aged 0-9 by 10% (2020). The strategies that will be used to accomplish these objectives include developing an injury prevention curriculum for prenatal classes at maternity centers for children (including those with special health care needs), providing education on car seat and vehicular safety, and collaborating with the Child Safety Network to increase education around the use of helmets and the prevention of injury. The National Outcome Measures (NOMs) linked to this priority need are detailed in the State Action Plan Table.

The second priority need is physical activity. The associated National Performance Measure (NPM) includes increasing the percentage of children aged 6 through 11 who are physically active at least 60 minutes per day. The objective includes increasing the number of children aged 6-11 and adolescents 12-17 who are physically active at least 60 minutes per day by 10% (2020). Strategies for achieving this objective include: partnering with school divisions, providing continuing education and technical assistance for physical education initiatives, and developing customized Comprehensive School Physical Activity Programs (CSPAP). The National Outcome Measures (NOMs) linked to this priority need are detailed in the State Action Plan Table.

Child Health - Annual Report

FY 2015 Progress Report

During 2015, the major focus regarding child health continued to be on the promotion of immunizations, the prevention of injury, and childhood obesity/nutrition. In addition to central office activities addressing child health, Title V funds were awarded to the district health departments to support child health, childcare health and safety, injury and violence prevention, and the prevention of childhood obesity.

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

Changes in nomenclature with accompanying adjustments to NIS numbers have created some variability in overall numbers from year to year, particularly from 2010-2014. Some reports are based on a primary series and others reflect a full series (431331 PS; 431431-FS). This has created a lack of data equivalency and uncertainty as to how to best interpret trends. In 2014, the percent of 19 to 35 month olds who received a full schedule of age-appropriate immunizations was 72.6%, compared with 71.1% in 2013. NIS data for 2015 are not currently available.

Title V staff continued to work with the Division of Immunization to promote vaccination in accordance with the recommended schedule. Title V supported activities continued to have an impact on improving immunization rates (and other health indicators), specifically by continuing to work with childcare providers. The Early Childhood Project staff sustained the number of active childcare health consultants to approximately 130 statewide, with consultants situated in 30 of the 35 health districts to support childcare health and safety around vaccinations and a medical home. Health Districts reviewed CASA results to determine how they can most effectively work with local childcare providers to improve rates within their districts. Education, training, and outreach activities were conducted for childcare and Head Start staff to monitor immunization records.

Title V staff continued partnering with DSS to reach childcare providers and families. A bi-annual Child Care Health and Safety electronic web newsletter had over 10,000 hits and is currently archived on the VDH web site. Topics focus on timely issues such as: the importance of immunizations and keeping medical records up-to-date, health insurance, pandemic flu and communicable disease prevention, pest infestation (such as head lice and bed bugs), addressing Ebola concerns, vaccine updates, physical activity and nutrition, developmental screening, mental health and social/emotional competence, and working with CYSHCN.

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

In preparation for the transformation of the Title V block grant in FY16, local districts planned in FY15 to promote education and resources in pursuit of the measure to decrease the rate of fatalities caused by motor vehicle crashes. These strategies included education for families and caregivers of children aged 0-14 on vehicular safety and providing appropriate vehicular restraints. In 2015, the local health district of Norfolk used Title V funds support staff time to enable participation in the VDH Low Income Safety Seat Distribution and Education Program (LISSDEP). LISSDEP provides free safety seats and installation education to financially eligible families who could otherwise not afford them. The program is offered weekly and provides educational instruction, demonstrations and hands-on training regarding the proper usage of child safety restraints. Twenty-five (25) car safety seat education classes were provided to 189 families who were enrolled and successfully completed the program. A total of 206 Titan Convertible

and Maestro booster seats were distributed in this district.

National Performance Measure 14: *Percent of children, ages 2 to 5 years, receiving WIC service with a BMI of or above the 85 percentile*.

The Healthy Eating and Active Living Program (HEAL) continued to promote the adoption of healthy behaviors and lifestyles for all Virginians by providing statewide consultation, training, and technical assistance on healthy eating, active living, and obesity prevention for families and children aged 2-5 years. Staff also participated in various community obesity prevention coalitions in order to provide obesity prevention presentations.

In FY15, HEAL launched 9-5-2-1-0 for Health's childhood obesity media campaign, with the intent of increasing awareness of daily habits that can help children, adults, and families live healthier lives. The media campaign consisted of two 30-second radio advertisements in English and Spanish, one 30-second and one 10-second television spot, and one 15-second voiceover for Pandora. The Spanish radio advertisement aired on two Hispanic radio stations located in Norfolk and Richmond. In addition to the media campaign, bilingual 9-5-2-1 -0 for Health's prescription tear pads were printed to aid in dialogue and to engage audiences. Funding for the HEAL program ended in FY15.

The number of children aged 2 to 5 enrolled in WIC decreased to 81,417 in 2015 (down from 96,385 in 2014). The percent of these children with a BMI at or above the 85th percentile increased from 32.1% in 2014 to 33.5% in 2015.

State Performance Measure 04: *The rate of childhood unintentional injury hospitalizations per 100,000 ages 0-19.*

The Injury and Violence Epidemiologist, partially funded by Title V funds, maintains 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 responds to data requests from constituents that could not be addressed through the VOIRS system.

Division of Policy and Evaluation (DPE) staff, partially funded by Title V funds, provided technical assistance to programmatic staff in the drafting of responses for constituent inquiries about the prevention of sexual assault received by the agency. DPE staff were also paramount in the tracking of legislation introduced in the Virginia 2015 General Assembly which addressed multiple injury prevention issues: HB 2006 and SB 998 requiring local school divisions to establish a management plan for the implementation of and compliance with policies and procedures regarding the identification and handling of suspected concussions in student-athletes, and SB 1093 requiring the board of health to promulgate regulations establishing safety standards for movable soccer goals. Staff not only tracked but also drafted enrolled bill summaries for legislation which successfully were voted into law: HB 1515 adding information about safe sleep environments for infants to the list of information that licensed nurse midwives, licensed midwives and hospitals must provide to maternity care patients; and SB 1325 and HB 2036 prohibiting the sale of liquid nicotine unless it is in a container satisfying the child-resistant packaging standards and including a warning label indicating that the container should be kept out of the reach of children.

During the transformation of the Title V block grant in FY1 6, local districts planned in FY1 5 to promote education and resources for the measure of decreasing the rate of unintentional injury hospitalizations in childhood. These

strategies included education for families of children 0-19, providing appropriate vehicular restraints, perform preemptive sports physicals on school age children prior to participation to ensure fitness, and train child care staff on safety measures. In 2015, the local health district of Norfolk used Title V funds to support staff time to enable participation in the VDH Low Income Safety Seat Distribution and Education Program (LISSDEP). LISSDEP provides free safety seats and installation education to financially eligible families who could otherwise not afford them. The program is offered weekly and provides educational instruction, demonstrations and hands-on training on proper usage of child safety restraints. Twenty-five (25) car safety seat education classes were provided to 189 families who were enrolled and successfully completed the program. A total of 206 Titan Convertible and Maestro booster seats were distributed in this district.
The rate of unintentional injury-related hospitalizations among children aged 19 or younger continues to demonstrate a decreasing trend. It is important to note that the indicator used is a proxy as Virginia is unable to measure the total number of nonfatal injuries.

State Performance Measure 08: *Percent of eligible for WIC that are enrolled in WIC.*

In June 2014, the Division of Community Nutrition (DCN) completed the implementation of the Crossroads and eWIC system for Virginia. These systems allow for flexibility in terms of being able to not only tailor food packages, but also to provide a more streamlined shopping experience for WIC participants. eWIC allows participants to shop more often and buy items as needed, as opposed to using a check where all items had to be purchased at one time. These changes have made the Virginia WIC Program more user-friendly by removing potential barriers to WIC family enrollment.
DCN continued to collaborate with Head Start programs across the state in order to establish WIC clinics in 15 Head Start locations around the state. Through program outreach, education, and potential service integration, the WIC Program continues to work toward reaching eligible populations that may not currently be enrolled in the WIC Program.

Overall enrollment and participation for the WIC Program nationwide has decreased, and Virginia is no exception. The percentage of enrolled children in 2015 was 70.21%, compared with 60.1% if enrolled children to date in 2016. DCN will continue to work on establishing communication and collaborating with the Child and Adult Care Food Program (CACFP) in an effort to increase the overall enrollment of children into the WIC Program. DCN houses both the WIC and CACFP programs which facilitates communication and coordination between the two programs.

Adolescent Health

State Action Plan Table

State Action Plan Table - Adolescent Health - Entry 1

Priority Need

Physical Activity

NPM

Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Objectives

Increase the number of children ages 6-11 and adolescents ages 12-17 who are physically active at least 60 minutes per day by 10% (2020).

Strategies

Partner with physical education and activity specialists to conduct tailored Comprehensive School Physical Activity Program (CSPAP) training within the 15 targeted school divisions.

Provide ongoing professional development and technical assistance to help schools develop, implement, and evaluate CSPAP. This includes quality physical education and physical activity programming before, during and after school. This programming includes activities such as recess, classroom activity breaks, walking/biking to school, physical activity clubs, and after school sports/clubs.

Partner with multiple stakeholders and the 15 targeted schools divisions' School Health Advisory Board (SHABs) wellness champions to conduct a "Building Virginia School Wellness Champions" workshop. Goals of this workshop including building sustainable and successful SHABs, completing the School Health Index on at least one elementary, middle, and high school per division, creating action plans to adopt and implement at least one nutrition and one physical activity policy, and revising existing Local School Wellness Policies.

ESMs

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

NOMs

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

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

State Action Plan Table - Adolescent Health - Entry 2

Priority Need

Child/Adolescent Injury

NPM

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

Objectives

Reduce hospitalizations due to injuries among the adolescent population 10-19 by 5% (2020).

Strategies

Implement Safe Environments for Every Kid (SEEK) model of enhanced primary care. SEEK is an evidence-based practical approach to the identification and management of targeted risk factors for child maltreatment, (e.g.intimate partner violence), for families with children ages 0-5, which is then integrated into pediatric primary care. By addressing these issues, SEEK aims to strengthen families, support parents, enhance children's health, development and safety, while also working to prevent child maltreatment.

Collaborate with Safe Kids Virginia, Virginia Foundation for Healthy Youth, local health districts, DOE, school nurses, and other community partners to educate school age adolescents and families regarding safety.

ESMs

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

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

Measures

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19 (Adolescent Health)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	139	135	132.5	130	125	122

Data Source: State Inpatient Databases (SID) - ADOLESCENT

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	182.6	4.1 %	1,972	1,079,897
2012	180.5	4.1 %	1,984	1,099,148
2011	192.2	4.2 %	2,071	1,077,687
2010	202.7	4.4 %	2,115	1,043,565
2009	228.0	4.7 %	2,389	1,048,034
2008	238.9	4.8 %	2,497	1,045,037

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	0.0	25.0	40.0	55.0	70.0

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day (Adolescent Health)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	50	52.5	55	57.5	60	63.5

Data Source: Youth Risk Behavior Surveillance System (YRBSS) - ADOLESCENT

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	23.8 %	0.8 %	85,533	358,829
2011	24.1 %	1.9 %	91,420	378,837

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2011_2012	19.5 %	2.3 %	124,223	635,789
2007	20.0 %	2.1 %	126,413	631,456
2003	17.9 %	1.7 %	112,928	630,077

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

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

Annual Objectives					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	77,100.0	382,400.0	573,600.0	754,200.0	874,400.0

Adolescent Health - Plan for the Application Year

Plan for the Application Year

For the next five years, the Commonwealth of Virginia will be working on two priority needs within the adolescent health MCH domain. The realigned Title V position of School and Adolescent Health Specialist will be a key partner for both priorities within this domain and the Child Health domain. The first state priority need is physical activity. The National Performance Measure (NPMs) selected include increasing the percentage of children aged 6 through 11 and adolescents 12-17 who are physically active at least 60 minutes per day. The associated objective includes increasing the number of adolescents aged 12-17 who are physically active at least 60 minutes per day by 10% (2020). Strategies for achieving this objective include: partnering with school divisions, providing continuing education and technical assistance for physical education initiatives, and developing customized Comprehensive School Physical Activity Programs (CSPAP). The National Outcome Measures (NOMs) linked to this priority need are detailed in the State Action Plan Table.

The second state priority need is adolescent injury. The National Performance Measure (NPM) selected includes decreasing the rate of hospitalization for non-fatal injury per 100,000 children aged 0-9 and adolescents aged 10 through 19. The associated objectives include increasing the rate of adolescents aged 10 through 19, (including children and youth with special health care needs) that use the appropriate safety restraints while in a motor vehicle by 10% (2020), and increasing the proportion of adolescents that utilize appropriate safety equipment by 10% (2020). The strategies associated with this objective include partnering with the Department of Education (and other agencies serving youth) to provide education about and increase the use of appropriate safety restraints and equipment. National Outcome Measures (NOMs) linked to this priority need can be found in the State Action Plan

Table.

Adolescent Health - Annual Report

FY 2015 Progress Report

During FY15, the major focus in adolescent health continued to be on the prevention of suicide and injuries and on teen pregnancy. In addition to central office activities addressing adolescent health, approximately $282,000 was awarded to district health departments in FY15 to support injury and violence prevention, as well as teen pregnancy prevention programs. The district family planning programs also provide services to the adolescent population.

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

In FY15, preparation for the grant transformation in FY16 included aligning funding with the priorities identified by partners and stakeholders. Based on this initiative, funding was redirected toward developing data and policy. Division of Policy and Evaluation (DPE) staff, partially funded by Title V funds, provided technical assistance to programmatic staff in the drafting of a response to a constituent inquiry from a state senator regarding the type of data that VDH collects and tracks related to suicides.

State Performance Measure 3: *Percent of 9th-12th graders who have ever been bullied on school property during the past 12 months.*

In FY15, preparation for the grant transformation in FY16 included aligning funding with the priorities identified by partners and stakeholders. Based on this initiative, funding was redirected toward developing data and policy. Agency capacity for adolescent health was evaluated and efforts were initiated to re-establish baseline policy and measures, including intentional and unintentional injury. Previous funding for the bullying program was leveraged for a more comprehensive adolescent data system.

State Performance Measure 4: *The rate of childhood unintentional injury hospitalizations per 100,000 children ages 0-19.*

The Injury and Violence Epidemiologist, partially funded by Title V funds, maintains 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 responds to data requests from constituents that could not be addressed through the VOIRS system.

Division of Policy and Evaluation (DPE) staff, partially funded by Title V funds, provides technical assistance to programmatic staff in the drafting of responses for constituent inquiries about the prevention of sexual assault. DPE staff were also paramount in the tracking of legislation introduced in the Virginia 2015 General Assembly which addressed multiple injury prevention issues: HB 2006 and SB 998 requiring local school divisions to establish a management plan for the implementation of and compliance with policies and procedures regarding the identification and handling of suspected concussions in student-athletes, and SB 1093 requiring the board of health to promulgate regulations establishing safety standards for movable soccer goals. Staff not only tracked but also drafted enrolled bill summaries for legislation which were successfully voted into law: HB 1515 adding information

about safe sleep environments for infants to the list of information that licensed nurse midwives, licensed midwives and hospitals must provide to maternity care patients; and SB 1325 and HB 2036 which prohibits the sale of liquid nicotine unless it is in a container satisfying the child-resistant packaging standards and including a warning label indicating that the container should be kept out of the reach of children.

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

In Virginia, the rate of pregnancies among teens aged 10-19 years declined by 51.2% from 2008 to 2014. In 2008, the rate of birth for teenagers aged 15 through 17 was 15.5 per 1,000, and in 2014 it was 7.7. MCH staff partnered with the nine health districts and community partners funded by the Virginia Abstinence Education Grant Program. The health districts provided an evidence-based, AEP-approved curriculum. In addition, staff coordinated “train-the-trainer” workshops for these curricula and conducted site visits to provide technical assistance and program evaluation tools. Staff continued to support the development of collaborative relationships with other state agencies, such as the Youth and Foster Care Division and the Department of Education. English and Spanish Talk2Me toolkits were distributed throughout the state.

The Resource Mothers Program continued to provide mentoring services to pregnant teens. This program has been supported by state and federal Medicaid administrative funds, with federal MCH Block grant funds providing administrative support. Due to the Department of Medical Assistance Services (Medicaid) eliminating funding in FY14, program outreach and effectiveness was limited.

During the transformation of the Title V block grant in FY16, local districts planned in FY15 to use Title V funds to support teen pregnancy prevention efforts by focusing on health education (including reproductive health) provided to middle and high school students in schools and community settings. A pilot district set a goal for 100% of teenagers to be established on effective contraceptives at the first postpartum visit in FY16.

Children with Special Health Care Needs

State Action Plan Table

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

Priority Need

Medical Home

NPM

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

Objectives

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

Partner with AAP, community partners, and Virginia's CYSHCN centers (CCC, CDC, VBDP, SCP) 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.

Collaborate with DOE, VA Chapter 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

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

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 - Children with Special Health Care Needs - Entry 2

Priority Need

Transition

NPM

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

Objectives

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

Strategies

Collaborate with the VA Chapter of AAP, community partners, and Virginia's regional CYSHCN centers (CCC, CDC, VBDP, SCP) 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.

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.

Contract with the Campus Suicide Prevention Center of Virginia to target colleges and universities to establish policies and procedures in alignment with a comprehensive approach to suicide prevention and community-clinical partnerships. This can be done through the regional suicide prevention council, which supports the provision of mental health services.

ESMs

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

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

Measures

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	45	47	48	49	50	51.5

Data Source: National Survey of Children's Health (NSCH) - CSHCN

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	47.3 %	4.0 %	173,295	366,760
2007	49.7 %	3.4 %	186,971	376,027

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: National Survey of Children's Health (NSCH) - NONCSHCN

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	59.1 %	2.0 %	848,286	1,435,549
2007	61.2 %	1.8 %	856,467	1,399,206

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

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

Annual Objectives

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

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

Annual Objectives

	2017	2018	2019	2020	2021
Annual Objective	50.0	65.0	80.0	90.0	100.0

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

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

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	40	41	42	43	44	45

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	44.9 %	3.5 %	50,747	113,089
2005_2006	37.8 %	3.1 %	40,436	106,884

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

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

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

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

Plan for the Application Year

For the Children with Special Health Care Needs priority domain, Virginia has chosen to work on two state priority needs. The first priority need is medical home. The National Performance Measure (NPM) associated with this need is to increase the percentage of children with and without special health care needs that have a medical home. The objective associated with this measure includes increasing the percentage of children with and without special health care needs that have an identified primary care provider by 10% (2020). Strategies to be implemented include

partnering with the AAP to develop a training module on medical home, educate the public on the importance of establishing and maintaining a medical home, and promote scheduled wellness visits and recommended screenings to achieve optimal health. The National Outcome Measures (NOMs) associated with these strategies are detailed in the State Action Plan Table.

The second priority in the Children with Special Health Care Needs domain is transition. The National Performance Measure (NPM) associated with this domain is to increase the percentage of adolescents with and without special health care needs receiving necessary services for transition to adult health care. The objective of this measure is to increase the number of children aged 10-24 engaged in transition services to adult health care by 10% (2020). A strategy intended to accomplish this objective is to collaborate with the AAP and community partners to develop training modules, educate on best practices for delivering transition services, provide transition tools, and train providers and educators to develop individualized health care plans on transitioning children and adolescents to childcare, elementary/middle/high school entry, and into adulthood. Another strategy intended to accomplish this objective is to contract with the Campus Suicide Prevention Center of Virginia to establish of policies and procedures in alignment with a comprehensive approach to suicide prevention. The National Outcome Measures (NOMs) are detailed in the State Action Plan Table.

Children with Special Health Care Needs - Annual Report

FY 2015 Progress Report

The Virginia Children and Youth with Special Health Care Needs (CYSHCN) program consists of four components: Care Connection for Children (CCC); Child Development Clinics (CDC); the Virginia Bleeding Disorders Program (VBDP); and the Sickle Cell Program (SCP). In FY15, these programs served approximately 7,945 children and families in Virginia. This figure represents an increase of approximately 1,200 families from FY14, and is mostly due to an increase in service capacity resulting from the reorganization of the CDC. In addition, the CYSHCN director, Marcus Allen, hired a Blood Disorders Program Coordinator, Christen Crews, to manage the VBDP and the SCP. Having someone in this position allowed the program more flexibility in order to focus on strategic planning and the development of performance measures as required by the Maternal and Child Health Bureau.

National Performance Measure 2: *The percent of children with special health care needs ages 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive.*

During FY15, 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%. The regional Care Connection for Children centers (CCC) continued to employ parent coordinators as staff and have actively engaged with 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 these families may face. The CCC program also continued to include parents and staff in the quarterly statewide directors meetings. At these meetings, CCC leadership made critical policy decisions and brainstormed more effective ways to potentially serve CYSHCN and their families. The attendance of parents and staff at these meetings is critical because it helps to ensure that policies enacted actually benefit CYSHCN living with chronic health conditions.

In addition, the CYSHCN programs maintained their partnerships with parent organizations, local/regional support groups, and the Virginia Department of Education Family Involvement Network. CYSHCN staff continued to work

closely with the Family-to-Family Network (F2F) that is part of the Virginia Commonwealth University Partnership for People with Disabilities, Center for Family Involvement. During FY15, 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. These positions were established in 2009 with funds from the CYSHCN program, and have been sustained by F2F. One specific example of our partnership with F2F and the Partnership for People with Disabilities was the outreach that F2F completed with two of our CDC centers (Carilion in Roanoke and Children's Hospital of the King's Daughter in the eastern part of the state). Through this partnership, F2F offered family support, brought community teams together to discuss strategies to support the screening and diagnosis of young children with autism, offered training/assistance on the MCHAT and ADOS tools, and provided information regarding best practices when talking with families about autism.

The Virginia Bleeding Disorders Program (VBDP) continued to sponsor networking events for families and supported parents/caregivers who infuse at home. The Sickle Cell Program (SCP) regional centers provided events for families, including social gatherings and overnight camps with educational and group activities focusing on transition and self-advocacy. These events are supported by physicians, social workers, educational consultants, and MCH staff. These gatherings are anticipated and significant to the adolescents because they provide an opportunity to engage with peers and continue education on vocation, disease process, and transition.

National Performance Measure 3: *The percent of children with special health care needs ages 0 to 18 receiving coordinated, ongoing, and comprehensive care within a medical home*

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 CYSHCN (37.1%), or Hispanic CYSHN (33.1%). Low-income families were also the least likely to meet this outcome.

During state FY15, the SCP reported that more than 88% of the children in their care had a primary care provider identified as a medical home. The VBDP monitored program applications quarterly in order to identify medical homes to assure that proper coordination was occurring. The CCC program worked directly with primary care providers to provide care coordination services for families. 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.

A significant accomplishment of the Virginia MCH leadership team during FY15 was acceptance into the National MCH Workforce Development Center (Cohort 4). The team's original desire was to focus on medical home for CYSHCN, but after attending the first training session, team members realized that the focus needed to be broader. This was mostly due to the personal experiences and expertise relayed by the Virginia MCH family partner, indicating that family need is about more than the establishment of a medical home. In fact, she stated that families need to be part of a "Medical Neighborhood", where the medical home is "one of the neighbors" that surrounds families of CYSHCN. The "Medical Neighborhood" would then utilize a comprehensive approach, including medical, psychosocial, educational, and community partners focused on meeting the true needs of the family. The MCH leadership team is currently working organically to put this model into practice and has received consistent and strong support from their coach.

National Performance Measure 4: *The percent of children with special health care needs ages 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need.*

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 FY15, 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 as well. This included support from trained social workers working with families to explore all insurance options (public and private). In addition, the VBDP staff continued to work 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). During FY15, PSI continued to provide insurance case management and premium assistance to help eligible families maintain insurance 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.

National Performance Measure 5: *Percent of children with special health care needs ages 0 to 18 whose families report the community-based services systems are organized so they can use them easily.*

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 FY15, 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, instead of asking them to make an additional trip to CCC offices.

Some SCP sites offered bus tickets to families to assist with travel costs, and one of our CDC centers in a remote region of Virginia continued to consult with families over the phone prior to beginning travel for an on-site developmental or behavioral assessment. The purpose of these phone consultations was to confirm that families qualified for services. In some instances, families were not actually in need of an assessment, and may have just needed help understanding the resources available to their child. One of the SCP sites implemented a satellite clinic in an area with a geographic need for services in order to improve family access of care. In addition, families continued to have access to Virginia Department of Education (DOE) 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.

National Performance Measure 6: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

During FY15, the CYSHCN programs continued to emphasize transition. The CYSHCN director and the CCC

directors completed work on their program-specific transition tool, and began to implement it throughout every region in Virginia. The tool will be used with families, beginning around the age of 12, in order to help them prepare for all aspects of adult life, including education/vocation/employment, health and wellness, mobility/transportation/recreation, and legal/insurance/adult benefits/housing. The Pediatric Sickle Cell Center at the Children's Hospital of the King's Daughters employed a social worker as a full-time transition coordinator to improve transition services for their sickle cell families. The other three sickle cell centers continued to utilize the previously developed sickle cell transition notebook and participate in transition activities outside of regular clinic hours. The Pediatric Sickle Cell Center at the Children's Hospital of Richmond at Virginia Commonwealth University (VCU) held bi-annual overnight transition camps for their families of transition age to focus on education, transition issues, social interaction, and self-advocacy. In addition, the CYSHCN program staff continued to work with VCU's research project to demonstrate the effectiveness of patient navigators in improving the percentage of sickle cell disease patients in specialty care (Phase 1) and to improve hydroxyurea initiation and adherence (Phase II) among patients with sickle cell disease. The VBDP required that each of its centers designate one employee to serve as a transition coordinator. The state VBDP coordinator continued to meet with each VBDP center on a regular basis to address transition and other initiatives.

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.

Cross-Cutting/Life Course

State Action Plan Table

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

Priority Need

Tobacco

NPM

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

Objectives

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 by 10% (2020).

Strategies

Collaborate with coordinators in each of the five health regions to educate health care providers in best practices of screening for tobacco use and implementation of a referral system to the Quit Now Virginia hotline, with an emphasis on OB/GYN providers, WIC Clinics and Community Service Boards.

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

Partner with coordinators in the five health planning regions to assess tobacco use policy status at local public housing authorities.

Collaborate with March of Dimes, local health districts, and community partners to promote the new legislation (unlawful to smoke in a vehicle with a minor under the age of 8 years old present).

ESMs

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

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

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 - Cross-Cutting/Life Course - Entry 2

Priority Need

Woman/Maternal Health

SPM

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

Objectives

Reduce rate of pregnancies for females of ages 15-19 by 10% (2020).

Strategies

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

Collaborate with FQHC and community partners to expand safety net services.

Partner with local health districts and community partners to increase number of abstinence programs available to adolescents.

Measures

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	8.0	7.7	7.5	7.3	7.0	6.8

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	7.8 %	0.1 %	5,726	73,480
2013	8.4 %	0.1 %	6,396	76,009

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

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	23.0	22.4	21.8	21.5	21.0	20.8

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	23.4 %	1.5 %	426,945	1,824,329
2007	25.8 %	1.5 %	468,194	1,818,547
2003	30.2 %	1.3 %	476,796	1,580,062

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

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

Annual Objectives

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

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

Annual Objectives

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

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

Plan for the Application Year

With regards to the state priorities along the Cross-Cutting/Life Course priority domain, Virginia has chosen tobacco and teen pregnancy prevention. The National Performance Measure (NPMs) selected for the tobacco priority include A) decreasing the percent of women who smoke during pregnancy; and B) decreasing the percent of children who live in households where someone smokes. The associated objectives include decreasing the proportion of pregnant women who smoke during pregnancy by 10% (2020), and decreasing the number of smoking in households by 10% (2020). The strategy used to further these objectives includes partnering with and referring eligible individuals to Quitline, partnering with tobacco control programs to leverage their existing efforts, and providing other resources to educate all household members on the dangers of tobacco.

In addition, for the first time, the local health departments were asked to select either safe sleep or tobacco initiatives to focus on for the next five-year grant cycle. Each health district is on a fiscal year from July 1, 2016 to June 30,

2017. As a result, semi-annual reports including these initiatives will be monitored to measure progress by January 31, 2016, in addition to annual reporting July 31, 2016. This progress at the community level will be included in the Title V application each year. The National Outcome Measures (NOMs) associated with this objective are detailed on the State Action Plan Table.

The State Performance Measure (SPM) selected for the teen pregnancy prevention priority includes increasing the rate of use of effective contraceptive methods among females aged 15-19. The associated objective includes reducing the rate of pregnancies among females aged 15-19 by 10% (2020). A planned strategy includes partnering with local health districts, health care providers, and community partners to increase access to and use of quality family planning services. Another strategy is to expand safety net services and increase the number of abstinence programs available to adolescents. The State Outcome Measures (SOMs) associated with this objective are detailed on the State Action Plan Table.

Cross-Cutting/Life Course - Annual Report

FY 2015 Progress Report

Virginia's 2015 cross-cutting/life course issues include health care coverage, as it pertains to access to care and oral health. The impact of health care coverage is also explored with regard to the life course of children and the potential health of pregnant women and their pregnancy outcomes.

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

The National Survey of Children's Health 2011/2012 indicated that 5.3% of children in Virginia do not have healthcare coverage. This includes health insurance, prepaid plans such as HMOs, or government plans such as Medicaid. This rate is slightly lower than the national rate of 5.5%. However, only 86.6% of children in Virginia received a preventive medical visit during the past year, and only 56.7% of children in Virginia received care in a medical home.

During FY15, collaboration with multiple state and local partners continued, in order to help reduce uninsurance rates and to promote the importance of medical homes. The integration of outreach and referral activities into program efforts, as well as participation in the state-mandated Children's Health Insurance Program Advisory Committee (CHIPAC) continued with the Title V Director serving on the committee. Use of the WebVISION FAMIS and PlanFirst link is ongoing.

In FY15, MCH staff collaborated with DMAS and DSS to continue promoting "Cover Virginia", a system where individuals can apply for public insurance over the phone or online. Under the Affordable Care Act, Virginia opted to participate in the federal health insurance exchange. Virginia has not elected to expand Medicaid. Data will be reported in FY16.

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

FY15 was a critical transition year for Title V in Virginia. The Title V team carefully reviewed current programs and funding as well as the needs identified for the future block grant (FY16-FY20) and began the alignment of programs, services, and infrastructure into the life course model. Programs with other funding sources were realigned with those resources. Oral health is an example of the realignment from the Division of Child and Family Health to the

Division of Prevention and Health Promotion.

During FY15, Title V funds supported the salary for the Children and Youth with Special Health Care Needs (CYSHCN) Dental Educator, in the Division of Prevention and Health Promotion, to coordinate oral health programs for children and youth with special needs. These included clinical provider trainings and the provision of preventive services, although programmatic costs were covered by other federal funds. In FY15, VDH provided training to 29 dental professionals on dental care for CYSHCN and very young children. The hands-on portion of the training allowed providers to treat 18 patients. VDH provided CYSHCN in Care Connection for Children Specialty Clinics in Southwest Virginia with 259 oral screenings, 254 varnish applications, 158 dental referrals and oral health education for 479 parents of CYSHCN.

State Performance Measure 5: *Percent of low income children (ages 0-5) with dental caries.*

FY15 was a critical transition year for Title V in Virginia. The Title V team carefully reviewed current programs and funding as well as the needs identified for the future block grant (FY16-FY20) and began the alignment of programs, services, and infrastructure into the Life Course model. Programs with other funding sources were realigned with those resources. Oral health is an example of the realignment from the Division of Child and Family Health to the Division of Prevention and Health Promotion.

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State Performance Measure 6: *Percent of low income third grade children with dental caries.*

FY15 was a critical transition year for Title V in Virginia. The Title V team carefully reviewed current programs and funding as well as the needs identified for the future block grant (FY16-FY20) and began the alignment of programs, services, and infrastructure into the Life Course model. Programs with other funding sources were realigned with those resources. Oral health is an example of the realignment from the Division of Child and Family Health to the Division of Prevention and Health Promotion.

During FY15, Title V funds supported the salary for the Children and Youth with Special Health Care Needs (CYSHCN) Dental Educator, in the Division of Prevention and Health Promotion, to coordinate oral health programs for children and youth with special needs. These included clinical provider trainings and the provision of preventive services, although programmatic costs were covered by other federal funds. In FY15, VDH provided training to 29 dental professionals on dental care for CYSHCN and very young children; the hands-on portion of the training allowed providers to treat 18 patients. VDH provided CYSHCN in Care Connection for Children Specialty Clinics in Southwest Virginia with 259 oral screenings, 254 varnish applications, 158 dental referrals and oral health education for 479 parents of CYSHCN.

State Performance Measure 7: *Percent of women with a live birth who went to a dentist during pregnancy.*

FY15 was a critical transition year for Title V in Virginia. The Title V team carefully reviewed current programs and funding as well as the needs identified for the future block grant (FY16-FY20) and began the alignment of programs, services, and infrastructure into the Life Course model. Programs with other funding sources were realigned with those resources. Oral health is an example of the realignment from the Division of Child and Family Health to the Division of Prevention and Health Promotion. In FY15, DMAS convened a multi-agency effort to explore oral health care for pregnant women in Virginia. The Virginia Oral Health Coalition, including VDH and the Title V Director, successfully revised policy to expand dental coverage for pregnant women in Virginia. This two-year effort (2014-2015) included diverse stakeholders, payers, advocates, and consumers. Data will be available in FY17.

According to the 2012 Virginia Pregnancy Risk Assessment and Monitoring System (PRAMS), approximately half of Virginia women with a live birth went to a dentist during their pregnancy.

Other Programmatic Activities

No content was entered for Other Programmatic Activities in the State Action Plan Narrative section.

II.F.2 MCH Workforce Development and Capacity

There are three main ways in which Virginia would like to continue to focus our training efforts. Our workforce development interests are in the following areas: 1) health transformation and population health; 2) MCH across the lifespan and the life course model; and 3) interdisciplinary collaboration across sectors. There is a vast interdisciplinary comprehension of health transformation in the state, and an awareness of the necessity of improving the health and welfare of mothers and children in order to ultimately impact population health. The Virginia Department of Health is taking a leadership role in the development of the state Population Health Plan. This plan includes maternal and child health indicators, as well as health promotion, prevention and, when necessary, direct service delivery (as safety net providers). This plan is in development.

To support both staff development in population health and the continuation of the life course model for programs and data collection, the Virginia Department of Health has developed a MCH Epidemiological team "MCH Epi Team" that will be dedicated to all of the MCH programs in the department. There is one Full Time (FT) lead MCH Epidemiologist, and two additional FT data experts. This change in structure focuses the MCH related data responsibilities to a smaller, streamlined team of experts working closely with the MCH program experts. This interdisciplinary team is looking at developing an MCH "dashboard" to share data with stakeholders in the community in order to increase the utility of the data beyond VDH, providing a more global population health perspective.

FY15 started the transition for the Virginia Title V grant and infrastructure. The previous Title V Director resigned from VDH and Lillian Peake, MD, MPH ,was appointed as the Title V director. In FY15, Dr. Peake began the VDH agency transition into a population health organization both in mission and practice by assuming the role as the new Deputy Commissioner for Population Health. Within VDH’s central office, the Title V Block Grant is managed by the Office of Family Health Services (OFHS). Vanessa Walker Harris, MD was appointed as the OFHS director in November 2015. She reports directly to the Deputy Commissioner for Population Health. Cornelia Deagle, PhD, MSPH is the Title V Director and Director for the Division of Child and Family Health. Jennifer O’Brien, MCH Consultant for Virginia MCH Director, left this position in January 2016. Marcus Allen, MPH was confirmed as the director of the CYSHCN program in November 2014. The Title V School Health Specialist position was expanded to the role of School and Adolescent Health Specialist for focusing on the emerging priority of adolescent health within the agency. Please review the included organizational chart (see Section V, Supporting Documents) for additional information.

Dr. Deagle realigned the Division of Child and Family Health (DCFH) programs based on the Life Course model and

Ecological Model (see Section V, Supporting Documents). The purpose of the division realignment was to (1) eliminate program silos; (2) improve coordination among programs; (3) streamline programs and services for families; and (4) establish the infrastructure to support the movement of Title V program activities into the Life Couse model reflected in the federal vision of Dr. Michael Liu and HRSA. Dr. Deagle hypothesized that this change in infrastructure would position Virginia's programs in the most advantageous structure in order to support the evolving Title V vision and mission as well as provide a clearer division for performance measures and fiscal investment.

Virginia possesses strong leadership across the state in 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 in some cases, broader MCH. There are many partnerships in the state, and many public and private organizations 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 current efforts create an optimal environment for the advancement of maternal and child health in Virginia.

Workforce Challenges

All the aforementioned strengths also describe some of the challenges in Virginia. While there is a common foundation of knowledge around health transformation/ACA, there are also competing priorities for agencies and organizations, in addition to limited resources. Each agency/organization has a defined scope of service and/or grant deliverables that must be met. In addition, there are finite amounts of General Fund (state dollars) or federal funding available to support all these important programs. With funding and agency priorities pulling the programs and their staff in multiple directions, it can be difficult to organize and integrate all the state systems into an effective network of coordinated care. There is statewide recognition that coordinated, multidisciplinary approaches comprise the most effective means of improving health and promoting healthy human development (or example the population health plan); however, making that coordination occur seamlessly across state agencies is challenging. To address this, the Governor has initiated several key initiatives.

The state level initiatives such as the Children's Cabinet and the Commonwealth Council on Childhood Success (2014-2015) have successfully mobilized key stakeholders. As a result, a spirit of collaboration is present among the agencies. To distribute the workload, each state agency is leading at least one large initiative and is included in other efforts. The design of these collaborative efforts is intended to support the cross-fertilization of ideas, activities and impacts. For VDH, the population health plan effort has resulted in a high level of engagement and multidisciplinary participation in planning. In FY15, the Virginia Title V team began transition planning including understanding how Title V fits into the state population health plan. The first priority of the team was to look across MCH programs to identify gaps and continuity of care across programs. The team prioritized the need for true systems integration, which would benefit MCH and CYSHCN. One first step is an analysis of the state policies and regulations that may challenge the development of cross-agency systems integration, particularly for CYSHCN. For example, eligibility criteria for different programs and different insurance reimbursement rates for services may be defined somewhat differently (e.g., Behavioral Health, VDH) and may or may not be easily modified. The team also began planning an evaluation of CYSHCN programs to maximize services provided and number of families served.

The federal initiative, Collaborative Improvement & Innovation Network (CoIIN) to Reduce Infant Mortality, has allowed VDH to expand the partnerships from state agencies to the private sector. The chosen CoIIN initiative for VDH is safe sleep. The CoIIN team is chaired by a Sentara Health Systems nurse manager, and assisted by a VDH subject matter expert, VDH data lead, and the VDH CoIIN Coordinator. Other team members include partners from the Virginia Hospital Association, Home Visiting Consortium, Office of the Medical Examiner, and Department of Social Services. The CoIIN team developed an action template that includes hospital interventions intended to educate and

visually show new parents and caregivers safe sleep positions. This best practice methodology allows the education to take place before the parents and caregivers go home, in addition to giving hands-on advice. Data will be uploaded throughout FY16.

II.F.3. Family Consumer Partnership

The Office of Family Health Services (OFHS) at VDH provides a number of opportunities for family input into the MCH and CYSHCN programs. For example, a parent feedback survey is used to assess the services provided by Care Connection for Children centers, Bleeding Disorders Program, and the Child Development Clinics. Focus groups were held to gather input on a variety of MCH related programs. Additionally, 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.

The Care Connection for Children (CCC) centers each employ a parent of CYSHCN as a parent coordinator (one CCC center has contractual relationships with Parent to Parent of Virginia for this work). All work closely with the Virginia F2F which provides emotional, informational and systems navigational support to over 1,000 culturally and linguistically diverse families each year.

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 Virginia Chapter of the Hemophilia Foundation, 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), serves as Virginia's family liaison delegate to the Association of Maternal and Child Health Programs (AMCHP). Dana is also the parent of a 21-year-old daughter with significant intellectual, physical, and sensory disabilities.

II.F.4. Health Reform

In Virginia, the current health transformation context can be described as an environment of change, adaptation, and engagement. The Virginia Health Reform Initiative ensures that meaningful reform is achieved throughout the Commonwealth. From insurance and payment reforms, to how care is delivered, the initiative will continue to work with stakeholders to reduce costs and improve quality of care. Virginia is embracing the exciting but challenging evolution from a medical paradigm of health built upon a public health foundation, to a more authentic population health paradigm that includes families, communities, and groups.

The Commissioner of Health, Dr. Marissa Levine, has challenged Virginia to become the “Healthiest State in the Nation”. This vision is inclusive of all adults and children in the Commonwealth, with and without special health care needs, and commences with Maternal and Child Health. Improving pre-conception health could take Virginia more than two thirds (82.0%) of the way to our goal of having the best term rates in the country, with 2,295 more infants born at full-term. While there have been ongoing efforts in Virginia to improve the health and welfare of women, infants and children, there is currently an increased emphasis on the improved health of children. The completion of the population health plan, or “Wellness Plan for Virginia”, provides a road map for Virginia to achieve Dr. Levine’s goal.

Maternal and Child Health in Virginia is moving from emphasizing the use of strategies to provide direct services to individuals, into a paradigm of prevention, health promotion, and population health outcomes across the lifespan, to including children and youth with special health care needs. While the Virginia Department of Health (VDH) remains a safety net provider of select clinical services within communities (including prenatal care, family planning and communicable disease prevention e.g., immunization), the nascent area is within population health activities that "...maintain and improve the health of the entire population and reduce inequalities in health between population groups" (Health Canada, 1998). Examples of this shift in Virginia include: (1) the integration of social determinants of health (SDOH) into health planning and program design; (2) the inclusion of children and youth with special health care needs into the child and adolescent health initiatives as reflected in our metrics; and, (3) the focus on chronic disease for all populations, including the use of lifestyle and behavioral measures across the lifespan.

While VDH will continue to collect individual level health data measures, we are looking at both the short-term and long-term health outcomes of our efforts. The data collection itself is evolving, and we continue to report the individual measures (in aggregate), while also recognizing that these traditional measures do not capture the SDOH or CYSHCN completely. As a result, we are expanding our data collection and analysis into a population health approach. For example, we will be utilizing analyses such as perinatal periods of risk (PPOR), and continuing to ensure health inequities are uncovered as well as enhancing our internal data workforce by aligning epidemiologists more closely to population and program areas.

The transformation in Virginia is happening on many levels. From the actions of Secretary of Health to grassroots community change, our state is experiencing a transformation in maternal and child health, including CYSHCN programs. In the Office of the Secretary for Health and Human Services for Virginia, there are several initiatives that cross state agencies. For example the VPI+ (Virginia Preschool Initiative plus), the establishment of the Children's Cabinet in the Governor's Office, and the Commonwealth Council on Childhood Success are efforts established to improve the health, well-being and positive development of children in the Commonwealth. The Office of the Commissioner of Health is represented on all of these bodies and MCH staff have and continue to participate in the operations of these efforts.

A key partner with VDH in the transformation of the state is the Department of Medical Assistance Services (DMAS). DMAS is the state agency that administers the Medicaid program for families in Virginia. Their mission is to provide a system of high quality and cost-effective health care services to qualifying Virginians and their families. VDH staff work closely with DMAS colleagues, whose respective leadership teams meet regularly. DMAS has been a co-leading agency in our Thriving Infants/CoIIN initiative. Thriving Infants is a national and state initiative to improve birth outcomes for all babies, with a long-term goal of eliminating disparities related to birth outcomes. A 25 member state team of key stakeholders is collaborating to implement evidence-based strategies at the state, regional, and local levels to reduce Virginia's infant mortality rate (IMR), and to reach short-term and long term-goals by 2018. This plan continues to evolve and will be updated for the FY16/FY18 Title V grant application.

It is important to note the significant recent successes in transforming access to quality MCH care, including: (1) presumptive eligibility: if a woman states she is pregnant, she is presumed pregnant, and therefore eligible for services (if she meets the income requirements); and, (2) the automatic enrollment of families into Plan First, a program covering family planning services, when they enroll in Medicaid. Both these efforts will have a significant impact on access to MCH services. In addition, VDH and DMAS have recently been exploring the reimbursement patterns for CYSHCN (as previously noted) and will continue to work together to ensure the optimal level of care for this population. DMAS is also responsible for implementing EPSDT (early periodic screening, diagnosis, and treatment program). EPSDT is geared to the early assessment of children's healthcare needs through periodic screenings. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible. In addition, Virginia's public schools provide health related services to children enrolled in special education. DMAS'

School Services program helps public schools fund those health related services in the child's Individualized Education Program (IEP). The Title V School and Adolescent Health Specialist and Director of the CYSHCN programs work closely with these partners.

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. Our partners, including public and private primary care providers (including Federally Qualified Health Centers), bring a diverse range of health expertise that contributes to the decision making process. Public and private insurance interests are also included in our maternal and child health initiatives. Insurance companies, Medicaid, and Medicaid HMOs are represented in our statewide planning and implementation phases. In addition, specialists from across the state and from academic medical centers and hospitals are engaged in our program development and oversight (e.g. universal newborn screening programs and the CYSHCN programs).

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. To accomplish this, VDH is aligning the epidemiologists (e.g. MCH Epis) with the programs across the Life Course model (see Section V, Supporting Documents). 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. VDH has redesigned the agency's public website with a vision of providing the resources for each Virginian to help achieve their optimal health, for a "Live Well" life (http://www.vdh.virginia.gov/livewell). These dashboards and the website are evolving and will continue to be updated.

II.F.6. Public Input

Public input is an ongoing process for Title V in Virginia and started with the Needs Assessment. The following is a review of the extensive input received.

As part of Virginia's 2015 MCH/Title V Needs Assessment, public input was received through multiple mechanisms. The Virginia Department of Health (VDH) held a three-step needs assessment process. Each step contained feedback from key stakeholders, key informants, and citizens of the Commonwealth. Please see the "Needs Assessment" section of the 2017 application for more detail.

Step #1: Stakeholder Meeting

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 in order to identify and discuss critical health issues currently affecting women and children across the state. This was also an opportunity for VDH to not only hear what stakeholders hoped to see addressed over the next five years, but to also learn about the types of resources that are currently needed and that may be needed in the future. Finally, OFHS wanted to gain insight into how special populations in Virginia are faring, on the existence of continuing disparities, and on the ways in which community groups can collaborate with each other and with VDH to begin to effect positive change.

Organizations represented include:

· 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)

Step #2: Key Informant Interviews

As part of the Virginia Department of Health's Maternal and Child Health Needs Assessment, Campbell & Company (C&C) conducted 22 interviews with key stakeholders in the Richmond, VA area in December 2014 and January 2015. The group of individuals interviewed included non-profit executives and leaders of foundations, state and local government officials, and physicians. They 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. The majority of the stakeholders served those in greatest need—specifically Virginia residents living in poverty, 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, as well as 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. They were also asked to provide recommendations to strengthen the role of VDH and other sectors in order to improve collaboration, data collection and sharing.

This final report builds on the top line 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 top line report, there was a great deal of overlap among responses. This report aims to capture not only the key findings from the interviews but also provide additional details on the most relevant emerging themes.

Step #3: Focus Groups

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. Of the six focus groups, four included consumers, and the other two included parents of children and youth with special health care needs. Between January 8 and January 27, 2015, six focus groups were held in key regions across the state of 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)

Next Steps:

Title V and MCH staff continue to collaborate with these stakeholders through our many coalitions, advisory boards, partnerships, and projects for MCH. For example, through the Infant Mortality CoIIN safe sleep initiative, the partnership continues with Sentara, VHHA, OCME, DSS, birth hospitals, DBHDS, families, and community partners to promote the identified state priority need of Safe Sleep.

The Virginia Department for Health (VDH) will put the full application out for further public comment in Town Hall from August 15-September 15, 2016. The executive summary will be placed on the VDH website and the link will be emailed to current MCH partners and stakeholders for comment. Contact information for MCH Title V staff will be included in order to accommodate any questions or requests for a full application. VDH staff will include any public comment received during this period when the 2017 application is reopened for editing.

II.F.7. Technical Assistance

The Virginia Title V program continues to be interested in receiving training on the integration of the life course model into planning and programming. As part of the life course perspective, specific areas of interest include preconception care and quality improvement. Particular emphasis on how to apply the life course model and evaluate its effectiveness would be a requested component of the training. Training modalities of interest include face-to-face interactive trainings and understanding the ways in which the ACA impacts different stakeholders in Virginia.

Under the direction of Dr. Lillian Peake, the Title V Director in 2015, VDH applied for the MCH Workforce Development Center technical assistance program. Virginia was accepted into Cohort 4 and began to plan a project that operationalizes the Virginia vision of the population health approach, systems integration, increased access to care, coordinated care for CYSHCN, and multi-sectoral partnership including family participation from the onset (see Section V, Supporting Documents).

Two of the national performance measures for Virginia are medical home for children with and without special healthcare needs, and transition for children with and without special healthcare needs. Because of the strong foundation with active diverse partnerships and rich family engagement in the Virginia CYSHCN program, Virginia MCH staff decided to propose a project to the MCH Workforce technical assistance initiative that would further the movement towards those two aforementioned National Performance Measures. Partners include American Academy of Pediatrics, DMAS, DOE, DBHDS, local health districts, Family to Family, Partnership for People with Disabilities, Medicaid MCOs, pediatricians, health Systems, Care Connection for Children (CCC) centers, social workers, pediatric specialists, and other community partners.

III. Budget Narrative

	2013		2014	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$12,369,389	$11,657,402	$12,369,389	$12,025,842
Unobligated Balance	$0	$0	$0	$0
State Funds	$9,470,031	$8,743,052	$9,277,042	$9,019,382
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$977,807	$991,958
Program Funds	$500,000	$24,241	$500,000	$0
SubTotal	$22,339,420	$20,424,695	$23,124,238	$22,037,182
Other Federal Funds	$156,035,618	$156,640,893	$145,527,761	
Total	$178,375,038	$177,065,588	$168,651,999	$22,037,182

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.

	2015		2016	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$11,949,178	$10,634,892	$12,025,842	
Unobligated Balance	$0	$0	$0	
State Funds	$8,961,883	$7,976,169	$9,019,382	
Local Funds	$0	$0	$0	
Other Funds	$1,048,412	$1,167,422	$1,152,718	
Program Funds	$25,000	$26,562	$0	
SubTotal	$21,984,473	$19,805,045	$22,197,942	
Other Federal Funds	$151,882,965	$164,569,656	$148,869,827	
Total	$173,867,438	$184,374,701	$171,067,769	

	2017	
	Budgeted	**Expended**
Federal Allocation	$12,072,934	
Unobligated Balance	$0	
State Funds	$9,054,701	
Local Funds	$0	
Other Funds	$1,125,000	
Program Funds	$0	
SubTotal	$22,252,635	
Other Federal Funds	$191,309,215	
Total	$213,561,850	

III.A. Expenditures

Expenditures

Form 2: For FY15, Virginia's Maternal and Child Health program was funded at a total level of $19,805,045 with matching expenditures totaling $9,170,153 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 $9,170,153 Virginia has exceeded this requirement. While Virginia budgeted for $11.9 million in its 2015 application based on prior year expenses, at the time of budget development (July 2014), and as a result of federal budget sequestration, program management had received communications that the 2015 award could be as low as $11 million. As a result, Virginia took significant steps to align planned expenses with the potentially reduced award. Due to turnover and vacancy savings, Virginia only expended $10.6 million, creating the variance between budget and expenditures that is slightly above 10 percent.

Form 3a: For FY15, expenditure data was captured and grouped into categories of people served (Pregnant Women, Infants < 1 year old, etc.). Variances between the budget and actual amounts were a result of the overall reduction in MCH expenses to align planned expenses with available funds.

Form 3b: For FY15, the total expenditures 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 (includes inpatient and outpatient services), dental care (does not include orthodontic services), durable medical equipment and supplies, 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

Budget

The Title V block grant 2017 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, nutrition services, Local Health Department (LHD) agreements, pharmacy and laboratory testing, Fetal/Infant Mortality Review, Newborn screening/follow up, and reducing health problems and risk factors. Other services provided are promotion of health and provision of comprehensive health services, assessment, management of secondary and tertiary care, injury prevention, Child Care Nurse Consultant, Resource Mothers (RM), primary care, school health, family planning (under age 22), teen pregnancy prevention, maternal health (under age 22), laboratory testing, pharmacy, sickle cell services, and dental health.

Population services include policy and procedural oversight concerning women's services, agreements with LHD for family planning services, laboratory testing and pharmacy services. 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 serving the Infant population.

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, pregnant women, mothers, and non-pregnant women over 21 years. About 60 percent of Federal funding is budgeted for CSHCN. Finally, 10 percent of Federal Funding is for Administration.

In addition, Virginia Budgets for match on a 4 to 3 ratio of Federal to State, 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 167 Budget meets the match and MOE amount as follows:

FY17 Budget amount:
Federal amount: $12,072,934
State Match amount: $10,179,701

Administration: VDH's definition of Administrative costs includes management and policy direction, accounting and budgeting services, personnel services and support services.

Additional Federal Funds: The largest Federal Funding comes from the US Department of Agriculture for the Women Infant and Children program and the Special Nutrition program with a Budget of $106,000 for FY15. Virginia has also seen significant growth in its Maternal and Child Home Visiting programs and special nutrition programs such

as the Child and Adult Care Food Program and the Summer Feeding Program.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - VDH DMAS New BAA Final 10 28 2014 .pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - Virginia_TitleV_OrgChart.pdf

Supporting Document #02 - Virginia_MCH_Vision2016.pdf

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Virginia

	FY17 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 12,072,934	
A. Preventive and Primary Care for Children	$ 3,625,934	(30%)
B. Children with Special Health Care Needs	$ 7,240,000	(60%)
C. Title V Administrative Costs	$ 1,207,000	(10%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 9,054,701	
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)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 10,179,701	
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)	$ 22,252,635	
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)	$ 191,309,215	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 213,561,850	

OTHER FEDERAL FUNDS	FY17 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 1,305,215
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	$ 1,020,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Behavioral Risk Factor Surveillance System (BRFSS)	$ 291,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 148,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Public Health Actions-1305 Chronic Disease	$ 347,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	$ 309,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Tobacco Control Programs	$ 1,347,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Youth Risk Behavior Survey (YRBS)	$ 60,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	$ 6,950,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	$ 140,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	$ 1,080,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 263,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 3,595,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Child and Adult Care Food Program (CACFP)	$ 52,250,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 106,000,000

OTHER FEDERAL FUNDS	FY17 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 2,449,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 155,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Children's Oral Healthcare Access Program	$ 246,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Prescription Drug Overdose Program	$ 1,234,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Summer Feeding Program	$ 12,120,000

	FY15 Application Budgeted		FY15 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 11,949,178		$ 10,634,892	
A. Preventive and Primary Care for Children	$ 4,408,703	(36.9%)	$ 3,219,787	(30.3%)
B. Children with Special Health Care Needs	$ 6,436,038	(53.9%)	$ 6,422,382	(60.4%)
C. Title V Administrative Costs	$ 1,104,437	(9.2%)	$ 992,723	(9.3%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0		$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 8,961,883		$ 7,976,169	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 1,048,412		$ 1,167,422	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 25,000		$ 26,562	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 10,035,295		$ 9,170,153	
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)	$ 21,984,473		$ 19,805,045	
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)	$ 151,882,965		$ 164,569,656	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 173,867,438		$ 184,374,701	

OTHER FEDERAL FUNDS	FY15 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 631,185
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	$ 1,197,178
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Behavioral Risk Factor Surveillance System (BRFSS)	$ 98,612
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 116,125
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Public Health Actions-1305 Chronic Disease	$ 295,139
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Tobacco Control Programs	$ 1,091,184
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	$ 291,540
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Youth Risk Behavior Survey (YRBS)	$ 33,839
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	$ 5,715,899
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	$ 170,921
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	$ 992,200
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 155,833
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 3,299,162
US Department of Agriculture (USDA) > Food and Nutrition Services > Child and Adult Care Food Program (CACFP)	$ 48,933,635
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 88,135,564

OTHER FEDERAL FUNDS	FY15 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 67,326
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 2,386,114
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Children's Oral Healthcare Access Program	$ 0
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Prescription Drug Overdose Program	$ 0
US Department of Agriculture (USDA) > Food and Nutrition Services > Summer Feeding Program	$ 10,958,200

Form Notes for Form 2:

None

Field Level Notes for Form 2:

None

Data Alerts:

1.	The value in Line 1, Federal Allocation, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please correct or add a field level note indicating the reason for the discrepancy.
2.	The value in Line 1A, Preventive And Primary Care Expended, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please correct or add a field level note indicating the reason for the discrepancy.
3.	The value in Line 1C, Title V Administrative Costs, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please add a field level note indicating the reason for the discrepancy.
4.	The value in Line 3, State MCH Funds, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please add a field level note indicating the reason for the discrepancy.
5.	The value in Line 5, Other Funds, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please add a field level note indicating the reason for the discrepancy.

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Virginia

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	$ 1,660,788	$ 1,299,883
2. Infants < 1 year	$ 1,421,449	$ 1,062,785
3. Children 1-22 years	$ 946,470	$ 1,189,798
4. CSHCN	$ 8,044,226	$ 7,082,425
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 12,072,933	$ 10,634,891

IB. Non Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	$ 1,245,591	$ 974,912
2. Infants < 1 year	$ 1,066,087	$ 797,089
3. Children 1-22 years	$ 709,853	$ 892,348
4. CSHCN	$ 6,033,169	$ 5,311,819
5. All Others	$ 0	$ 0
Non Federal Total of Individuals Served	$ 9,054,700	$ 7,976,168
Federal State MCH Block Grant Partnership Total	$ 21,127,633	$ 18,611,059

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts:

1.	Children 1 to 22 Years, Application Budgeted does not equal Form 2, Line 1A, preventive and Primary Care for Children Application Budgeted. Please add a field level note to explain.
2.	CSHCN, Application Budgeted does not equal Form 2, Line 1B, Children with Special Health Care Needs, Application Budgeted. Please add a field level note to explain.
3.	Children 1 to 22 Years, Annual Report Expended does not equal Form 2, Line 1A, preventive and Primary Care for Children, Annual Report Expended. Please add a field level note to explain.
4.	CSHCN, Annual Report Expended does not equal Form 2, Line 1B, Children with Special Health Care Needs, Annual Report Expended. Please add a field level note to explain.

Form 3b
Budget and Expenditure Details by Types of Services

State: Virginia

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Direct Services	$ 2,135,724	$ 1,922,378
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 510,814	$ 432,078
B. Preventive and Primary Care Services for Children	$ 510,814	$ 432,078
C. Services for CSHCN	$ 1,114,096	$ 1,058,222
2. Enabling Services	$ 7,666,184	$ 6,601,907
3. Public Health Services and Systems	$ 2,271,026	$ 2,110,607
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		$ 889
Physician/Office Services		$ 841,455
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 1,078,045
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 1,989
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 1,922,378
Federal Total	$ 12,072,934	$ 10,634,892

IIB. Non-Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Direct Services	$ 1,601,793	$ 1,441,783
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 383,110	$ 324,058
B. Preventive and Primary Care Services for Children	$ 383,111	$ 324,058
C. Services for CSHCN	$ 835,572	$ 793,667
2. Enabling Services	$ 5,749,638	$ 4,951,430
3. Public Health Services and Systems	$ 1,703,270	$ 1,582,956
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		$ 667
Physician/Office Services		$ 631,093
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 808,531
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 1,492
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 1,441,783
Non-Federal Total	$ 9,054,701	$ 7,976,169

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: 100,992

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	96,614 (95.7%)	1,597	135	135 (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)	Biotinidase deficiency	Cystic fibrosis
Critical congenital heart disease	Classic galactosemia	Hearing loss		

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 2015

		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	12,649	25.2	0.0	2.6	72.1	0.1
2. Infants < 1 Year of Age	102,674	29.9	0.0	63.1	4.5	2.5
3. Children 1 to 22 Years of Age	41,351	31.2	0.0	6.1	60.2	2.5
4. Children with Special Health Care Needs	7,945	56.7	5.1	33.7	4.5	0.0
5. Others	53,830	17.2	0.0	8.4	73.5	0.9
Total	218,449					

Form Notes for Form 5a:

None

Field Level Notes for Form 5a:

None

Form 5b
Total Recipient Count of Individuals Served by Title V

State: Virginia

Reporting Year 2015

Types Of Individuals Served	Total Served
1. Pregnant Women	12,649
2. Infants < 1 Year of Age	102,674
3. Children 1 to 22 Years of Age	41,351
4. Children with Special Health Care Needs	7,945
5. Others	53,830
Total	218,449

Form Notes for Form 5b:

None

Field Level Notes for Form 5b:

None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Virginia

Reporting Year 2015

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	102,795	66,236	21,267	190	6,549	29	8,458	66
Title V Served	12,956	6,604	2,991	24	437	16	0	2,884
Eligible for Title XIX	30,697	14,997	11,080	43	675	7	3,843	52
2. Total Infants in State	102,795	66,236	21,267	190	6,549	29	8,458	66
Title V Served	102,795	66,236	21,267	190	6,549	29	8,458	66
Eligible for Title XIX	30,697	14,997	11,080	43	675	7	3,843	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	89,333	13,462	0	102,795
Title V Served	7,736	4,360	860	12,956
Eligible for Title XIX	25,023	5,674	0	30,697
2. Total Infants in State	89,333	13,462	0	102,795

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
Title V Served	89,333	13,462	0	102,795
Eligible for Title XIX	25,023	5,674	0	30,697

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	2017 Application Year	2015 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 Services I&R System (211)	VA Statewide Human Services I&R System (211 VA)
3. Name of Contact Person for State MCH "Hotline"	Cornelia Deagle, PhD, MPH	Jennifer O'Brien
4. Contact Person's Telephone Number	(804) 864-7751	(804) 864-7674
5. Number of Calls Received on the State MCH "Hotline"		125,000

B. Other Appropriate Methods	2017 Application Year	2015 Reporting Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address		
4. Number of Hits to the State Title V Program Website		
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, MPH
Title	Division Director
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
Title	CSHCN Director
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	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Virginia

Application Year 2017

No.	Priority Need
1.	Safe Sleep
2.	Breastfeeding
3.	Physical Activity
4.	Tobacco
5.	Medical Home
6.	Transition
7.	Child/Adolescent Injury
8.	Woman/Maternal Health

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.

None

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
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

NOM 1 - Notes:

None

Data Alerts: None

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

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	152.2	4.1 %	1,395	91,677
2012	156.9	4.2 %	1,446	92,136
2011	159.8	4.2 %	1,473	92,190
2010	144.7	4.0 %	1,337	92,389
2009	148.6	4.0 %	1,390	93,526
2008	142.0	3.9 %	1,358	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.

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
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
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
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
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
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
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
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
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
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
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
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
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
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
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: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.9	0.3 %	633	91,680
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
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
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
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	0.9 %	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
2012_2014	9.0	0.7 %	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
2012	40.0 %	0.2 %	20,696	51,786

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
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
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
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)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	26.1	25.9	25.6	25.2	24.9	24.5

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	25.9 %	0.3 %	4,928	19,056
2013	26.3 %	0.3 %	4,591	17,440
2012	28.0 %	0.3 %	6,680	23,840
2011	30.1 %	0.2 %	11,470	38,062
2010	30.6 %	0.2 %	11,496	37,514
2009	30.8 %	0.2 %	11,971	38,874

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

Field Level Notes for Form 10a NPMs:

None

NPM 4 - A) Percent of infants who are ever breastfed

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	81.0	81.5	82.0	82.5	83.0	83.5

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	82.8 %	3.5 %	83,969	101,412
2011	80.5 %	4.2 %		
2010	80.1 %	3.5 %		
2009	79.8 %	2.9 %		
2008	81.4 %	2.4 %		
2007	75.3 %	2.8 %		

Legends:

Indicator has an unweighted denominator <50 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 4 - B) Percent of infants breastfed exclusively through 6 months

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	23.0	23.5	24.0	24.5	25.0	25.5

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	23.6 %	3.6 %	23,645	100,115
2011	22.9 %	4.2 %		
2010	16.6 %	2.8 %		
2009	17.2 %	2.2 %		
2008	15.2 %	1.9 %		
2007	13.7 %	1.9 %		

Legends:

Indicator has an unweighted denominator <50 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	78.5	80.0	82.0	84.0	85.0	86.0

FAD not available for this measure.

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)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	139.0	135.0	132.5	130.0	125.0	122.0

Data Source: State Inpatient Databases (SID) - CHILD

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	87.9	2.9 %	915	1,041,031
2012	96.1	3.0 %	1,035	1,076,691
2011	105.4	3.2 %	1,113	1,056,045
2010	104.7	3.2 %	1,064	1,016,744
2009	106.5	3.3 %	1,077	1,010,863
2008	119.8	3.5 %	1,186	989,821

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

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) (Adolescent Health)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	139.0	135.0	132.5	130.0	125.0	122.0

Data Source: State Inpatient Databases (SID) - ADOLESCENT

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	182.6	4.1 %	1,972	1,079,897
2012	180.5	4.1 %	1,984	1,099,148
2011	192.2	4.2 %	2,071	1,077,687
2010	202.7	4.4 %	2,115	1,043,565
2009	228.0	4.7 %	2,389	1,048,034
2008	238.9	4.8 %	2,497	1,045,037

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day (Child Health)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	50.0	52.5	55.0	57.5	60.0	63.5

Data Source: National Survey of Children's Health (NSCH) - CHILD

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	33.2 %	2.8 %	195,681	589,617
2007	32.9 %	2.6 %	194,030	589,431
2003	30.0 %	2.1 %	172,391	574,580

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day (Child Health) (Adolescent Health)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	50.0	52.5	55.0	57.5	60.0	63.5

Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	19.5 %	2.3 %	124,223	635,789
2007	20.0 %	2.1 %	126,413	631,456
2003	17.9 %	1.7 %	112,928	630,077

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	45.0	47.0	48.0	49.0	50.0	51.5

Data Source: National Survey of Children's Health (NSCH) - CSHCN

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	47.3 %	4.0 %	173,295	366,760
2007	49.7 %	3.4 %	186,971	376,027

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: National Survey of Children's Health (NSCH) - NONCSHCN

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	59.1 %	2.0 %	848,286	1,435,549
2007	61.2 %	1.8 %	856,467	1,399,206

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	40.0	41.0	42.0	43.0	44.0	45.0

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	44.9 %	3.5 %	50,747	113,089
2005_2006	37.8 %	3.1 %	40,436	106,884

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	8.0	7.7	7.5	7.3	7.0	6.8

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	7.8 %	0.1 %	5,726	73,480
2013	8.4 %	0.1 %	6,396	76,009

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

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	23.0	22.4	21.8	21.5	21.0	20.8

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	23.4 %	1.5 %	426,945	1,824,329
2007	25.8 %	1.5 %	468,194	1,818,547
2003	30.2 %	1.3 %	476,796	1,580,062

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	24.5	25.0	25.8	27.0	28.0

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	92.0	92.5	93.0	93.5	94.0

Field Level Notes for Form 10a SPMs:

None

SPM 3 - Infant Mortality Disparity Ratio

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.5	1.3	1.2	1.1	1.0

Field Level Notes for Form 10a SPMs:

None

Form 10a
State Outcome Measures (SOMs)

State: Virginia

SOM 1 - Teen Pregnancy Rate

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	24.5	24.0	23.5	23.0	22.5

Field Level Notes for Form 10a SOMs:

None

SOM 2 - Infant Mortality Rate

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	5.8	5.6	5.5	5.3	5.1

Field Level Notes for Form 10a SOMs:

None

SOM 3 - Maternal Mental Health: Proportion of women who are educated and/or screened during pregnancy or after delivery about depression by a health care worker

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	80.0	81.5	83.0	85.0	87.5

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

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

Field Level Notes for Form 10a ESMs:

None

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	25.0	45.0	60.0	75.0	90.0

Field Level Notes for Form 10a ESMs:

None

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	40.0	55.0	70.0	85.0	100.0

Field Level Notes for Form 10a ESMs:

None

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	50.0	75.0	90.0	95.0	100.0

Field Level Notes for Form 10a ESMs:

None

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	0.0	25.0	40.0	55.0	70.0

Field Level Notes for Form 10a ESMs:

None

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	77,100.0	382,400.0	573,600.0	754,200.0	874,400.0

Field Level Notes for Form 10a ESMs:

None

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

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

Field Level Notes for Form 10a ESMs:

None

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	50.0	65.0	80.0	90.0	100.0

Field Level Notes for Form 10a ESMs:

None

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

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

Field Level Notes for Form 10a ESMs:

None

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

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

Field Level Notes for Form 10a ESMs:

None

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	200.0	350.0	500.0	750.0	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)

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

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

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

<table>
<tr><td>Goal:</td><td>Increase the number of women who attend a postpartum visit with a health care worker 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 health care worker within 6 weeks after getting birth</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>Virginia PRAMS</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

SPM 3 - Infant Mortality Disparity Ratio

Population Domain(s) – Perinatal/Infant Health, Women/Maternal Health, Cross-Cutting/Life Course

Goal:	Eliminate the racial disparity in Virginia's infant morality rate.
Definition:	**Numerator:** Rate of non-white infant moralities **Denominator:** Rate of white infant mortalities **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.

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

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 Rate

Population Domain(s) – Perinatal/Infant Health, Cross-Cutting/Life Course, Children with Special Health Care Needs

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: 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, Perinatal/Infant Health, Adolescent Health, Cross-Cutting/Life Course

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.

Form 10c
Evidence-Based or –Informed Strategy Measure (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

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 4.1 - Proportion of hospital based maternity centers with Virginia Breastfeeding Friendly designation
NPM 4 – A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Goal:	Increase the proportion of women who initiate breastfeeding before hospital discharge by 5% (2020)
Definition:	**Numerator:** Number of hospital based maternity centers with a Virginia Breastfeeding Friendly Designation **Denominator:** Number of hospital based maternity centers **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Virginia Maternity Quality Improvement Collaborative
Significance:	This ESM was identified through the Title V needs assessment, Virginia's Well-being Plan, and Healthy People 2020 (MICH-21).

ESM 4.2 - Proportion of Virginia WIC breastfeeding coordinators certified as IBCLC/CLCs
NPM 4 – A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Goal:	Increase the proportion of women who exclusively breastfeed through 6 months of age by 10% (2020)
Definition:	**Numerator:** Number of Virginia WIC breastfeeding coordinators certified as IBCLC/CLCs **Denominator:** Number of Virginia WIC breastfeeding coordinators **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Virginia WIC
Significance:	This ESM was identified through the Title V needs assessment, Virginia's Well-being Plan, and Healthy People 2020 (MICH-21).

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

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 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

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 8.1 - Number of students enrolled in targeted public schools where staff have received professional development or technical assistance in physical activity.
NPM 8 – Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Goal:	Increase the number of children ages 6-11 and adolescents ages 12-17 who are physically active at least 60 minutes per day
Definition:	**Numerator:** Number of students enrolled in targeted public schools where staff have received professional development or technical assistance in physical activity **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 Prevention and Health Promotion
Significance:	This ESM was identified through the Title V needs assessment, Virginia's Well-being Plan, and Healthy People 2020 (PA-5).

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

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

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

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

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 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

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

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 10d
National Performance Measures (NPMs) (Reporting Year 2014 & 2015)

State: Virginia

Form Notes for Form 10d NPMs and SPMs

None

NPM 01 - The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	107	103	103	160	135
Denominator	107	103	103	160	135
Data Source	Newborn Screening Program	Newborn Screening Program	Virginia Newborn Metabolic Screening Program	Virginia Newborn Metabolic Screening Program	Virginia Newborn Metabolic Screening Program
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2012**
	Field Note: 2012 data from Virginia Newborn Screening Program. Numerator = number receiving appropriate follow-up (linked to appropriate specialist) Denominator = number of confirmed cases Evidence = info from PCP or specialist, oral or written.	
2.	**Field Name:**	**2011**

Field Note:
2011 data from Virginia Newborn Screening Program.
Numerator = number receiving appropriate follow-up (linked to appropriate specialist)
Denominator = number of confirmed cases

Evidence = info from PCP or specialist, oral or written.

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	70.0	77.1	78.0	80.0	80.0
Annual Indicator	77.1	77.1	77.1	77.1	77.1
Numerator					
Denominator					
Data Source	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5. **Field Name:** **2011**

Field Note:
Indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010.

This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	65.0	43.0	43.5	44.0	45.0
Annual Indicator	42.4	42.4	42.4	42.4	42.4
Numerator					
Denominator					
Data Source	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5. **Field Name:** **2011**

Field Note:
Indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010.

This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	75.0	65.2	65.2	67.5	67.5
Annual Indicator	65.2	65.2	65.2	65.2	65.2
Numerator					
Denominator					
Data Source	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5. **Field Name:** **2011**

Field Note:
Indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010.

This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	94.0	67.0	67.0	68.0	68.5
Annual Indicator	67.0	67.0	67.0	67.0	67.0
Numerator					
Denominator					
Data Source	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5. **Field Name:** **2011**

Field Note:
Indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010.

This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts: None

NPM 06 - The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

	2011	2012	2013	2014	2015
Annual Objective	55.0	47.0	48.0	49.0	50.0
Annual Indicator	44.9	44.9	44.9	44.9	44.9
Numerator					
Denominator					
Data Source	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5. **Field Name:** **2011**

Field Note:
Indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010.

This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	88.0	75.0	77.5	77.5	78.0
Annual Indicator	74.2	77.0	71.1	72.6	79.3
Numerator					
Denominator					
Data Source	National Immunization Program	National Immunization Program	National Immunization Program	National Immunization Program	National Immunization Program
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: Data for 2015 is unavailable for this measure. Due to the change in the reported vaccine series (4:3:1:3:3 to 4:3:1:3:3:1) for 2014.	
2.	**Field Name:**	**2014**
	Field Note: Data for 2014 is unavailable for this measure. Due to the change in the reported vaccine series (4:3:1:3:3 to 4:3:1:3:3:1) for 2013.	
3.	**Field Name:**	**2013**
	Field Note: Data for 2013 is unavailable for this measure. Due to the change in the reported vaccine series (4:3:1:3:3 to 4:3:1:3:3:1) for 2012.	
4.	**Field Name:**	**2012**
	Field Note: Data for 2012 is unavailable for this measure. Due to the change in the reported vaccine series (4:3:1:3:3 to 4:3:1:3:3:1) for 2011.	
5.	**Field Name:**	**2011**

Field Note:
Data for 2011 is unavailable for this measure. Due to the change in the reported vaccine series (4:3:1:3:3 to 4:3:1:3:3:1) for 2010.

Data Alerts: None

NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

	2011	2012	2013	2014	2015
Annual Objective	12.0	12.0	10.0	9.8	9.5
Annual Indicator	11.1	10.2	8.0	7.7	7.4
Numerator	1,708	1,559	1,208	1,169	
Denominator	153,220	152,367	151,790	152,796	
Data Source	VA birth data & NCHS pop estimates	VA birth data & NCHS pop estimates	Virginia Vital Records	Virginia Vital Records	Trend Analysis
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: 2015 data not yet available. Entry is an estimate based on performance in previous 5 years.	
2.	**Field Name:**	**2014**
	Field Note: 2014 birth data used for number of births to teens. Denominator entry is an estimate based on US Census population measure.	
3.	**Field Name:**	**2013**
	Field Note: 2013 birth data used for number of births to teens. Denominator entry is an estimate based on US Census population measure.	
4.	**Field Name:**	**2012**
	Field Note: 2012 birth data used for number of births to teens. Denominator entry is an estimate based on US Census population measure.	
5.	**Field Name:**	**2011**
	Field Note: 2011 birth data used for number of births to teens. Denominator entry is an estimate based on previous year.	

Data Alerts: None

NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

	2011	2012	2013	2014	2015
Annual Objective	55.0	50.0	50.0	75.0	75.5
Annual Indicator	49.4	73.6	73.6	73.6	52.0
Numerator	44,567	66,620	66,620	66,620	2,952
Denominator	90,299	90,504	90,504	90,504	5,676
Data Source	Statewide Dental Assessment	Statewide Dental Assessment	Statewide Dental Assessment	Statewide Dental Assessment	Statewide Sentinel Dental Assessment
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

   Field Note:
   Data source is Virginia Statewide 3rd Grade Public School Dental Assessment, 2014/2015. Survey was a sentinel survey of 20 schools from across the Commonwealth. The schools selected for this sentinel survey were primarily in urban/suburban areas of the Commonwealth, possibly leading to an over estimate of dental sealant coverage for the larger weighted sample.

2. **Field Name:** **2014**

   Field Note:
   Data source is Virginia Statewide 3rd Grade Public School Dental Assessment, 2011/2012. Survey was a sentinel survey of 20 schools from across the Commonwealth. The schools selected for this sentinel survey were primarily in urban/suburban areas of the Commonwealth, possibly leading to an over estimate of dental sealant coverage for the larger weighted sample.

3. **Field Name:** **2013**

   Field Note:
   Data source is Virginia Statewide 3rd Grade Public School Dental Assessment, 2011/2012. Survey was a sentinel survey of 20 schools from across the Commonwealth. The schools selected for this sentinel survey were primarily in urban/suburban areas of the Commonwealth, possibly leading to an over estimate of dental sealant coverage for the larger weighted sample.

   A new open mouth survey is slated to be conducted during the 2014/2015 academic year.

4. **Field Name:** **2012**

	Field Note: Data source is Virginia Statewide 3rd Grade Public School Dental Assessment, 2011/2012. Survey was a sentinel survey of 20 schools from across the Commonwealth. The schools selected for this sentinel survey were primarily in urban/suburban areas of the Commonwealth, possibly leading to an over estimate of dental sealant coverage for the larger weighted sample.	
5.	**Field Name:**	**2011**
	Field Note: Estimate for 2010 not yet available. Data source is Virginia Statewide 3rd Grade Public School Dental Assessment, 2009.	

Data Alerts: None

NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

	2011	2012	2013	2014	2015
Annual Objective	1.3	1.0	1.0	1.0	0.8
Annual Indicator	1.6	1.2	1.0	1.4	1.4
Numerator	25	19	15	22	
Denominator	1,539,145	1,545,288	1,555,039	1,556,881	
Data Source	VA Death data & NCHS pop estimates	VA Death data & NCHS pop estimates	Virginia Vital Records	Virginia Vital Records	Trend estimate
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: Data for 2015 not yet available. Entry is an estimate based on trend.	
2.	**Field Name:**	**2014**
	Field Note: Numerator data from 2014 Death Certificate File. Denominator from NCHS population estimates.	
3.	**Field Name:**	**2013**
	Field Note: Numerator data from 2013 Death Certificate File. Denominator from NCHS population estimates.	
4.	**Field Name:**	**2012**
	Field Note: Numerator data from 2012 Death Certificate File. Denominator from NCHS population estimates.	
5.	**Field Name:**	**2011**
	Field Note: Numerator data from 2011 Death Certificate File. Denominator from NCHS population estimates.	

Data Alerts: None

NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.

	2011	2012	2013	2014	2015
Annual Objective	52.0	42.0	50.0	55.0	57.5
Annual Indicator	40.8	48.2	54.6	53.7	53.7
Numerator					
Denominator					
Data Source	National Immunization Program	National Immunization Program	National Immunization Program	National Immunization Program	National Immunization Program
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: 2014 Data not available. Entry is an estimate based on CDC's Breastfeeding National Immunization Data for birth cohort 2012.	
2.	**Field Name:**	**2014**
	Field Note: 2014 Data not available. Entry is an estimate based on CDC's Breastfeeding National Immunization Data for birth cohort 2011.	
3.	**Field Name:**	**2013**
	Field Note: 2013 Data not available. Entry is an estimate based on CDC's Breastfeeding National Immunization Data for birth cohort 2010.	
4.	**Field Name:**	**2012**
	Field Note: 2012 Data not available. Entry is an estimate based on CDC's Breastfeeding National Immunization Data for birth cohort 2009.	
5.	**Field Name:**	**2011**
	Field Note: 2011 Data not available. Entry is an estimate based on CDC's Breastfeeding National Immunization Data for birth cohort 2008.	

Data Alerts: None

NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	95.6	96.1	99.3	97.5	99.3
Numerator	97,990	97,458	99,878	98,476	98,266
Denominator	102,525	101,412	100,618	100,992	99,003
Data Source	Virginia EHDI program & VA birth data	Virginia EHDI program & VA birth data	Virginia EHDI program & VA final birth data	Virginia EHDI program & VA final birth data	Virginia EHDI program & VA provisional birth data
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: Data from the Virginia Early Hearing Detection and Intervention System, 2015 and the number of provisional occurrent births from Virginia Health Statistics, 2015.	
2.	**Field Name:**	**2014**
	Field Note: Data from the Virginia Early Hearing Detection and Intervention System, 2014 and the number of provisional occurrent births from Virginia Health Statistics, 2014.	
3.	**Field Name:**	**2013**
	Field Note: Data from the Virginia Early Hearing Detection and Intervention System, 2013 and the number of occurrent births from Virginia Health Statistics, 2013.	
4.	**Field Name:**	**2012**
	Field Note: Data from the Virginia Early Hearing Detection and Intervention System, 2012, and the number of occurrent births from Virginia Health Statistics, 2012.	
5.	**Field Name:**	**2011**

Field Note:
Data from the Virginia Early Hearing Detection and Intervention System, 2011 and the number of occurrent births from Virginia Health Statistics, 2011.

Data Alerts: None

NPM 13 - Percent of children without health insurance.

	2011	2012	2013	2014	2015
Annual Objective	4.8	8.5	8.0	5.5	5.3
Annual Indicator	8.4	5.9	5.7	5.9	5.9
Numerator	157,488	111,059	107,915	111,705	113,216
Denominator	1,866,712	1,879,030	1,904,597	1,897,097	1,916,790
Data Source	Current Population Survey, US Census Bureau	Current Population Survey, US Census Bureau	Current Population Survey, US Census Bureau	Current Population Survey, US Census Bureau	Current Population Survey, US Census Bureau
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: State survey data not available. Data from the Current Population Survey, U.S. Census Bureau for 2014.	
2.	**Field Name:**	**2014**
	Field Note: State survey data not available. Data from the Current Population Survey, U.S. Census Bureau for 2013.	
3.	**Field Name:**	**2013**
	Field Note: State survey data not available. Data from the Current Population Survey, U.S. Census Bureau for 2012.	
4.	**Field Name:**	**2012**
	Field Note: State survey data not available. Data from the Current Population Survey, U.S. Census Bureau for 2011.	
5.	**Field Name:**	**2011**

Field Note:
State survey data not available.
Data from the Current Population Survey, U.S. Census Bureau for 2010.

Data Alerts: None

NPM 14 - Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

	2011	2012	2013	2014	2015
Annual Objective	22.0	29.0	28.0	27.0	26.0
Annual Indicator	30.0	30.2	27.4	32.1	33.5
Numerator	26,371	26,425	23,009	30,910	27,276
Denominator	87,830	87,589	83,887	96,385	81,417
Data Source	WIC Program	WIC Program	WIC Program	WIC Program	WIC Program
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: Data from VA CrossRoads, FFY2015	
2.	**Field Name:**	**2014**
	Field Note: Data from VA WICNet, 2014	
3.	**Field Name:**	**2013**
	Field Note: Data from VA WICNet, 2013	
4.	**Field Name:**	**2012**
	Field Note: Data from VA WICNet, 2012	
5.	**Field Name:**	**2011**
	Field Note: Data from VA WICNet, 2011	

Data Alerts: None

NPM 15 - Percentage of women who smoke in the last three months of pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	5.5	5.5	5.0	4.5	4.5
Annual Indicator	5.1	5.1	5.3	5.6	6.0
Numerator	5,216	5,214	5,405	5,756	
Denominator	102,525	102,812	101,977	102,795	
Data Source	VA Birth data	VA Birth data	Virginia Vital Records	Virginia Vital Records	Trend Estimate
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: 2014 data not yet available. Entry is an estimate based on performance in previous years and is a measure of women who ever smoked during pregnancy. In 2012, VA transitioned to the 2003 NCHS format of the birth certificate moving forward VA will be able to report the "Percentage of women who smoke in the last three months of pregnancy".	
2.	**Field Name:**	**2013**
	Field Note: 2013 data not yet available. Entry is an estimate based on performance in previous years and is a measure of women who ever smoked during pregnancy. In 2012, VA transitioned to the 2003 NCHS format of the birth certificate moving forward VA will be able to report the "Percentage of women who smoke in the last three months of pregnancy".	
3.	**Field Name:**	**2012**
	Field Note: Entry is an estimate based on performance in previous years and is a measure of women who ever smoked during pregnancy. In 2012, VA transitioned to the 2003 NCHS format of the birth certificate moving forward VA will be able to report the "Percentage of women who smoke in the last three months of pregnancy".	
4.	**Field Name:**	**2011**
	Field Note: 2011 data. Virginia is still using the old birth certificate, so indicator measures women who ever smoked during pregnancy.	

Data Alerts: None

NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

	2011	2012	2013	2014	2015
Annual Objective	5.2	5.5	7.5	7.0	6.5
Annual Indicator	8.3	8.5	7.8	8.6	8.4
Numerator	45	46	42	46	
Denominator	544,275	541,788	537,178	537,108	
Data Source	VA Death data & NCHS pop estimates	VA Death data & NCHS pop estimates	Virginia Vital Records	Virginia Vital Records	Trend estimate
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: Data for 2015 not yet available. Entry is an estimate based on trend.	
2.	**Field Name:**	**2014**
	Field Note: 2014 data from death certificates and 2014 NCHS population estimates.	
3.	**Field Name:**	**2013**
	Field Note: 2013 data from death certificates and 2013 NCHS population estimates.	
4.	**Field Name:**	**2012**
	Field Note: 2012 data from death certificates and 2012 NCHS population estimates.	
5.	**Field Name:**	**2011**
	Field Note: 2011 data from death certificates and 2011 NCHS population estimates.	

Data Alerts: None

NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

	2011	2012	2013	2014	2015
Annual Objective	92.5	85.0	86.0	87.0	88.0
Annual Indicator	89.6	88.1	87.4	87.9	84.9
Numerator	1,221	1,274	1,281	1,276	
Denominator	1,363	1,446	1,465	1,451	
Data Source	VA birth data	VA birth data	Virginia Vital Records	Virginia Vital Records	Trend estimate
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

   Field Note:
   2015 data not available. Entry is an estimate based on trend analysis.

2. **Field Name:** **2014**

   Field Note:
   2014 data from birth certificates and licensure & certification listing of Level III/IV facilities. Invalid birthweights and invalid hospital codes were excluded from the measure.

   For 2005 and forward, stricter criteria was used for determining which hospitals are "facilities for high-risk deliveries and neonates"; based on the state regulations for licensure of hospitals at the specialty and subspecialty levels of infant care (defined for the measure as Level III and Level IV hospitals).

3. **Field Name:** **2013**

   Field Note:
   2013 data from birth certificates and licensure & certification listing of Level III/IV facilities. Invalid birthweights and invalid hospital codes were excluded from the measure.

   For 2005 and forward, stricter criteria was used for determining which hospitals are "facilities for high-risk deliveries and neonates"; based on the state regulations for licensure of hospitals at the specialty and subspecialty levels of infant care (defined for the measure as Level III and Level IV hospitals).

4. **Field Name:** **2012**

Field Note:
2012 data from birth certificates and licensure & certification listing of Level III/IV facilities. Invalid birthweights and invalid hospital codes were excluded from the measure.

For 2005 and forward, stricter criteria was used for determining which hospitals are "facilities for high-risk deliveries and neonates" based on the state regulations for licensure of hospitals at the specialty and subspecialty levels of infant care (defined for the measure as Level III and Level IV hospitals).

5. **Field Name:** **2011**

Field Note:
2011 data from birth certificates and licensure & certification listing of Level III/IV facilities. Invalid birthweights and invalid hospital codes were excluded from the measure.

For 2005 and forward, stricter criteria was used for determining which hospitals are "facilities for high-risk deliveries and neonates" based on the state regulations for licensure of hospitals at the specialty and subspecialty levels of infant care (defined for the measure as Level III and Level IV hospitals).

Data Alerts: None

NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

	2011	2012	2013	2014	2015
Annual Objective	92.0	87.0	87.3	87.5	87.8
Annual Indicator	85.3	83.0	82.9	82.8	84.9
Numerator	84,364	85,364	84,565	85,115	84,100
Denominator	98,943	102,812	101,977	102,795	99,003
Data Source	VA birth data	VA birth data	Virginia VItal Records	Virginia VItal Records	VA Provisional Birth Data
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: 2015 provisional birth certificate data.	
2.	**Field Name:**	**2014**
	Field Note: 2014 birth certificate data.	
3.	**Field Name:**	**2013**
	Field Note: 2013 birth certificate data.	
4.	**Field Name:**	**2012**
	Field Note: 2012 birth certificate data.	
5.	**Field Name:**	**2011**
	Field Note: 2011 birth certificate data.	

Data Alerts: None

Form 10d
State Performance Measures (SPMs) (Reporting Year 2014 & 2015)

State: Virginia

SPM 1 - Percent of infants born preterm (gestational age less than 37 weeks completed)

	2011	2012	2013	2014	2015
Annual Objective	8.0	9.5	9.4	9.3	9.2
Annual Indicator	9.5	9.5	9.4	9.1	9.1
Numerator	9,713	9,744	9,557	9,389	9,017
Denominator	102,525	102,812	101,977	102,795	99,003
Data Source	VA Birth Data	VA Birth Data	Virginia Vital Records	Virginia Vital Records	VA Provisional Birth Data
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2015**
	Field Note: 2015 provisional data.	
2.	**Field Name:**	**2014**
	Field Note: 2014 Final Birth data.	
3.	**Field Name:**	**2013**
	Field Note: 2013 Birth data.	
4.	**Field Name:**	**2012**
	Field Note: 2012 Birth data.	
5.	**Field Name:**	**2011**
	Field Note: 2011 Birth data.	

Data Alerts: None

SPM 2 - Percent of women ages 18-44 who report good/very good/excellent health.

	2011	2012	2013	2014	2015
Annual Objective	95.0	90.0	89.0	90.0	91.0
Annual Indicator	88.4	91.2	91.2	90.6	88.1
Numerator	1,328,776	1,358,883	1,358,883	1,367,563	1,323,830
Denominator	1,503,939	1,489,874	1,489,874	1,509,685	1,503,459
Data Source	Virginia BRFSS	Virginia BRFSS	Virginia BRFSS	Virginia BRFSS	Virginia BRFSS
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2012**
	Field Note: Self-rated health status obtained from the Virginia Behavioral Risk Factor Surveillance System (BRFSS), 2011. Question: Would you say that in general your health is: excellent, very good, good, fair, or poor?	
2.	**Field Name:**	**2011**
	Field Note: Self-rated health status obtained from the Virginia Behavioral Risk Factor Surveillance System (BRFSS), 2011. Question: Would you say that in general your health is: excellent, very good, good, fair, or poor?	

Data Alerts: None

SPM 3 - Percent of 9th-12th graders who have ever been bullied on school property during the past 12 months.

	2011	2012	2013	2014	2015
Annual Objective	15.0	22.0	20.0	20.0	18.0
Annual Indicator	22.0	22.0	20.3	21.9	19.5
Numerator	315	315	291	1,505	1,009
Denominator	1,435	1,435	1,435	6,874	5,171
Data Source	Virginia Youth Survey	Virginia Youth Survey	Virginia Youth Survey	Virginia Youth Survey	Virginia Youth Survey
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2012**
	Field Note: Data from the 2011 Virginia Youth Survey.	
2.	**Field Name:**	**2011**
	Field Note: Data from the 2011 Virginia Youth Survey.	

Data Alerts: None

SPM 4 - The rate of childhood unintentional injury hospitalizations per 100,000 children ages 0-19.

	2011	2012	2013	2014	2015
Annual Objective	129.0	122.5	122.5	120.0	120.0
Annual Indicator	132.0	138.0	119.3	110.0	106.7
Numerator	2,750	2,880	2,497	2,304	
Denominator	2,083,420	2,087,076	2,092,217	2,093,989	
Data Source	VA Hospital Discharge Data	VA Hospital Discharge Data	Virginia Health Information (VHI)	Virginia Health Information (VHI)	Trend Analysis
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2015**
	Field Note: Data for 2015 hospital discharges not yet available.	
2.	**Field Name:**	**2014**
	Field Note: Data from 2014 hospital discharges	
3.	**Field Name:**	**2013**
	Field Note: Data from 2013 hospital discharges	
4.	**Field Name:**	**2012**
	Field Note: Data from 2012 hospital discharges	
5.	**Field Name:**	**2011**
	Field Note: Data from 2011 hospital discharges	

Data Alerts: None

SPM 5 - Percent of low income children (ages 0-5) with dental caries.

	2011	2012	2013	2014	2015
Annual Objective	12.0	18.0	17.0	16.8	16.5
Annual Indicator	18.4	17.2	15.4	14.3	15.8
Numerator	2,094	1,823	1,796	1,732	1,851
Denominator	11,407	10,599	11,670	12,083	11,714
Data Source	Head Start Data	Head Start Data	Head Start Data	Head Start Data	Head Start Data
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2015**
	Field Note: FY15 Head Start Data; State FY 7/1/14-6/30/15	
2.	**Field Name:**	**2014**
	Field Note: FY14 Head Start Data; State FY 7/1/13-6/30/14	
3.	**Field Name:**	**2013**
	Field Note: FY13 Head Start Data; State FY 7/1/12-6/30/13	
4.	**Field Name:**	**2012**
	Field Note: FY12 Head Start Data; State FY 7/1/11-6/30/12	
5.	**Field Name:**	**2011**
	Field Note: FY11 Head Start Data; State FY 7/1/10-6/30/11	

Data Alerts: None

SPM 6 - Percent of low income third grade children with dental caries.

	2011	2012	2013	2014	2015
Annual Objective	20.0	15.0	12.0	11.5	11.0
Annual Indicator	12.4	12.4	12.4	12.4	12.4
Numerator	3,756	3,756	3,756	3,756	3,756
Denominator	30,337	30,337	30,337	30,337	30,337
Data Source	Virginia Free Lunch Program	Virginia Free Lunch Program	Virginia Free Lunch Program	Virginia Free Lunch Program	Virginia Free Lunch Program
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2015**
	Field Note: Data for 2015 not yet available.	
2.	**Field Name:**	**2014**
	Field Note: Data for 2014 not yet available.	
3.	**Field Name:**	**2013**
	Field Note: Data for 2013 not yet available.	
4.	**Field Name:**	**2012**
	Field Note: Data for 2012 from then Virginia Free & Reduced Lunch Program	
5.	**Field Name:**	**2011**
	Field Note: Data for 2011 from then Virginia Free & Reduced Lunch Program	

Data Alerts: None

SPM 7 - Percent of women with a live birth who went to a dentist during pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	50.0	50.0	45.0	47.5	50.0
Annual Indicator	40.1		45.7	49.6	48.1
Numerator	38,709		42,281	47,773	48,064
Denominator	96,483		92,488	96,240	99,883
Data Source	VA PRAMS		Virginia Pregnancy Risk Assessment Monitoring System (PRAMS)	Virginia Pregnancy Risk Assessment Monitoring System (PRAMS)	Virginia Pregnancy Risk Assessment Monitoring System (PRAMS)
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

   Field Note:
   Weighted 2013 Virginia Pregnancy Risk Assessment Monitoring System (PRAMS).

2. **Field Name:** **2014**

   Field Note:
   Weighted 2012 Virginia Pregnancy Risk Assessment Monitoring System (PRAMS).

3. **Field Name:** **2013**

   Field Note:
   Weighted 2011 Virginia Pregnancy Risk Assessment Monitoring System (PRAMS) .

4. **Field Name:** **2012**

   Field Note:
   Weighted 2011 VA PRAMS data not yet available.

5. **Field Name:** **2011**

   Field Note:
   Weighted 2010 VA PRAMS Data

Data Alerts: None

SPM 8 - Percent of children eligible for WIC that are enrolled in WIC, ages 0 to 5.

	2011	2012	2013	2014	2015
Annual Objective	80.0	75.0	77.0	78.0	78.5
Annual Indicator	74.1	76.5	76.7	79.5	68.5
Numerator	125,441	127,132	126,084	130,025	109,374
Denominator	169,394	166,208	164,283	163,534	159,649
Data Source	WIC Program Data	WIC Program Data	WIC Program Data	WIC Program Data	WIC Program Data
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2012**
	Field Note: Data from the WIC "Annual Potential Eligible" projections report, 2012.	
2.	**Field Name:**	**2011**
	Field Note: Data from the WIC "Annual Potential Eligible" projections report, 2011.	

Data Alerts: None

SPM 9 - Percent of eligible children in daycares that participate in the Child and Adult Care Food Program (CACFP).

	2011	2012	2013	2014	2015
Annual Objective	25.0	27.5	40.0	42.5	45.0
Annual Indicator	25.7	37.0	25.8	26.1	29.9
Numerator	69,887	103,447	70,410	72,140	71,006
Denominator	271,422	279,386	272,386	276,283	237,552
Data Source	CACFP, VA Dept of Social Services	CACFP, VA Dept of Social Services	CACFP, VA Dept of Social Services	CACFP, VA Dept of Social Services	CACFP, VA Dept of Social Services
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

Field Note:
Numerator is the number of children ages 0-12 years in daycares that participated in the Child and Adult Care Food Program during 2015.

Denominator is the total licensed capacity for child daycare in Virginia during 2015. Data provided by the Virginia Department of Social Services.

2. **Field Name:** **2014**

Field Note:
Numerator is the number of children ages 0-12 years in daycares that participated in the Child and Adult Care Food Program during 2014.

Denominator is the total licensed capacity for child daycare in Virginia during 2014. Data provided by the Virginia Department of Social Services.

3. **Field Name:** **2013**

Field Note:
Numerator is the number of children ages 0-12 years in daycares that participated in the Child and Adult Care Food Program during 2013.

Denominator is the total licensed capacity for child daycare in Virginia during 2013. Data provided by the Virginia Department of Social Services.

4. **Field Name:** **2012**

Field Note:
Numerator is the number of children ages 0-12 years in daycares that participated in the Child and Adult Care Food Program during 2012.

Denominator is the total licensed capacity for child daycare in Virginia during 2012. Data provided by the Virginia Department of Social Services.

5. **Field Name:** **2011**

Field Note:
Numerator is the number of children ages 0-12 years in daycares that participated in the Child and Adult Care Food Program during 2011.

Denominator is the total licensed capacity for child daycare in Virginia during 2011. Data provided by the Virginia Department of Social Services.

Data Alerts: None

SPM 10 - Percent of eligible children participating in the Summer Food Service Program (SFSP).

	2011	2012	2013	2014	2015
Annual Objective	15.0	12.0	14.0	14.5	15.0
Annual Indicator	11.8	13.8	11.7	11.7	13.5
Numerator	57,905	67,401	60,197	61,079	71,038
Denominator	491,946	489,636	512,752	521,573	525,730
Data Source	SFSP, VA Dept of Education	SFSP, VA Dept of Education	SFSP, VA Dept of Education	SFSP, VA Dept of Education	SFSP, VA Dept of Education
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2012**

   Field Note:
   Numerator data from the 2012 Summer Food Service Program.

   Denominator data provided by the Virginia Department of Education.

2. **Field Name:** **2011**

   Field Note:
   Numerator data from the 2011 Summer Food Service Program.

   Denominator data provided by the Virginia Department of Education.

Data Alerts: None

Form 11
Other State Data

State: Virginia

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the current application/annual report.

State Action Plan Table

State: Virginia

Please click the link below to download a PDF of the full version of the State Action Plan Table.
State Action Plan Table

Abbreviated State Action Plan Table

State: Virginia

Women/Maternal Health

State Priority Needs	NPMs	ESMs	SPMs
Woman/Maternal Health	NPM 2 - Low-Risk Cesarean Delivery	ESM 2.1	
Woman/Maternal Health			SPM 2

Perinatal/Infant Health

State Priority Needs	NPMs	ESMs	SPMs
Safe Sleep	NPM 5 - Safe Sleep	ESM 5.1	
Breastfeeding	NPM 4 - Breastfeeding	ESM 4.1 ESM 4.2	
Woman/Maternal Health			SPM 3

Child Health

State Priority Needs	NPMs	ESMs	SPMs
Child/Adolescent Injury	NPM 7 - Injury Hospitalization	ESM 7.1	
Physical Activity	NPM 8 - Physical Activity	ESM 8.1	

Adolescent Health

State Priority Needs	NPMs	ESMs	SPMs
Physical Activity	NPM 8 - Physical Activity	ESM 8.1	
Child/Adolescent Injury	NPM 7 - Injury Hospitalization	ESM 7.1	

Children with Special Health Care Needs

State Priority Needs	NPMs	ESMs	SPMs
Medical Home	NPM 11 - Medical Home	ESM 11.1 ESM 11.2 ESM 11.3	
Transition	NPM 12 - Transition	ESM 12.1	

Cross-Cutting/Life Course

State Priority Needs	NPMs	ESMs	SPMs
Tobacco	NPM 14 - Smoking	ESM 14.1 ESM 14.2	
Woman/Maternal Health			SPM 1