Maternal and Child Health Services Title V Block Grant

Virginia

FY 2019 Application/ FY 2017 Annual Report

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Table of Contents

I. General Requirements

I.A. Letter of Transmittal

COMMONWEALTH of VIRGINIA

Department of Health

PO BOX 2448
RICHMOND, VA 23218

TTY 7-1-1 OR
1-800-828-1120

July 13, 2018

Michele H. Lawler, M.S., R.D.
Director, Division of State and Community Health
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane, Room 18N33
Rockville, Maryland 20857

Dear Ms. Lawler:

I am pleased to submit Virginia's Maternal and Child Health Services Block Grant 2019 Application / 2017 Annual Report.

Virginia's Application has been submitted through the HRSA Electronic Handbooks (EHBs) in response to grant announcement HRSA-19-072, in accordance with this year's grant guidance.

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

I look forward to working with you and your team during the coming year. Should you or your staff have questions or need additional information regarding our application, you may contact me at (804) 864-7691 or cornelia.deagle@vdh.virginia.gov.

Sincerely,

Cornelia Deagle

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

Enclosure: *Maternal and Child Health Services Title V Block Grant FY19 Application/FY17 Annual Report*

cc: M. Norman Oliver, MD, MA, Acting State Health Commissioner

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2018 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 *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: December 31, 2020.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: December 31, 2020.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Virginia Title V Maternal & Child Health Block Grant

The Title V Maternal and Child Health (MCH) Block Grant is a federal-state partnership program to improve the health of mothers and children, including children and youth with special health care needs. The Virginia Department of Health (VDH) Office of Family Health Services (OFHS) administers the state Title V program.

VDH's mission is to protect the health and promote the well-being of all people in Virginia. Through its flagship brand, *VDHLiveWell*, the OFHS strives to help Virginia become the healthiest state in the nation through strategic focus and distribution of information on programs that strengthen the health of families and communities.

How is the Title V Block Grant used in Virginia?

Title V funds are awarded to each state based on its MCH population. States provide a three-dollar match for every four dollars in federal funding. At least 30% of funds must be used for services and programs for children and 30% for children and youth with special health care needs (CYSHCN). Virginia's Title V funds support state, regional, and local programs; OFHS allocates funding based on state priorities.

Virginia's Maternal & Child Population

Virginia encompasses 42,774 square miles, and is divided into 95 counties and 38 independent cities. The Census Bureau estimates there are approximately 8,310,301 residents living in the state (2012-2016 ACS). Land is divided by the Appalachian Mountains in the west, countryside, rolling hills, growing cities, and the Chesapeake Bay separates the contiguous portion of the state from the Eastern Shore peninsula. In 2016, infants were 1.2% (101,443) of the population (8,411,808). Women age 15-44 years accounted for 19.9% (1,676,203). There were 2,223,450 children and adolescents aged 1-21 years, representing 26.4% of the population. According to the 2016 National Survey of Children's Health, 21.0% of Virginia children aged 0 to 17 (pop. est. 391,428 children) were identified as having special health care needs.

Key Virginia Characteristics

The following represents a snapshot of key Virginia characteristics and health indicators.

- Number of Births[1]: 102,243
- % Preterm births[1]: 9.5%
- % Low weight births[1]: 8.1%
- Infant mortality rate[1] (per 1,000 live births):
  - State: 5.77
  - White: 4.75
  - Black: 10.66
- Number (%) of children <20 years old[2]: 2,092,529 (24.9%)
- % of children <18 years old with special health care needs[3]: 21.0%
- % of births covered by Medicaid[1]: 30.38%
- % of children <18 years old without health insurance[2]: 5%

Assessing State Needs

Every five years, an assessment of maternal and child health (MCH) needs, including needs of CYSHCN, is conducted. VDH MCH programs continuously assess the needs of Virginia's MCH populations through ongoing monitoring and surveillance. Title V programs update the State Action Plan as needed during interim years. The VDH MCH team is implementing a mixed-methods approach for Virginia's upcoming Title V Five-Year Needs Assessment process, with priority given to maximizing the input of internal and external partners and engaging families and consumers in a meaningful way. VDH Title V data needs are met through the State Systems Development Initiative (SSDI), with staff that provide data capacity for informed decision-making. Through SSDI, an MCH dashboard intended to provide timely data is monitored and updated on the VDH data portal. It is the goal of the program to utilize a broad and comprehensive process to identify key priorities for the development and implementation of an action plan that addresses and improves maternal and child health in Virginia, while leveraging resources and partnerships across the state.

State MCH Priority Needs

- Safe Sleep: Increase safe sleep practices for infants.
- Medical Home: Promote the importance of medical home among providers and families.
- Transition: Promote independence and transition of young adults with and without special healthcare needs.
- Child/Adolescent Injury: Reduce injuries, violence, and suicide among Title V populations.
- Woman/Maternal Health: Support the physical and emotional well-being of women and their children.
- Developmental Screening: Support optimal mental health and social-emotional development of all children.
- Oral Health: Increase access to oral health services among pregnant women and children.
- Family Engagement: Foster a culture of family/youth engagement and leadership.

Title V National Performance Measures

Selected National Performance Measures (NPMs):

- NPM5: Safe sleep
- NPM6: Developmental screening
- NPM7: Injury hospitalization
- NPM11: Medical home
- NPM12: Transition
- NPM13: Preventive dental visit

Title V State Performance and Outcome Measures

Identified State Performance Measures (SPMs) and Outcome Measures (SOMs):

- SPM4: Proportion of females age 15-44 years using Tier 1 (most effective) contraceptive methods
- SPM6: Cross-cutting (Family Engagement): Implement and develop report on survey of families served by the VDH Care Connection for Children (CCC) programs
- SOM4: Rate of unintended pregnancy among women of child-bearing age
- SOM5: Infant Mortality Disparity: Infant Mortality Disparity Ratio

Overview of Virginia's MCH Populations

Virginia's Title V plan intends to coordinate MCH activities across funding sources, state agencies, and local/community partners. The MCH program relies on internal and external partners, as well as family and consumer engagement, to ensure impact and effectiveness of services, activities, and strategies.

DOMAIN: Women/Maternal Health

NPM 13.1: Preventive dental visit during pregnancy – Data from the Virginia Pregnancy Risk Assessment

Monitoring System (VA PRAMS) showed that 46.5% of moms had a preventive dental visit during pregnancy (2015). Preventive dental care in pregnancy is recommended by the American College of Obstetricians and Gynecologists (ACOG) to improve lifelong oral hygiene habits and dietary behavior for women and their families.

SPM 4: Unintended pregnancy (SPM 4 and SOM 4) – The proportion of women reporting using a Tier 1 contraceptive method was 31.0% (2015 PRAMS). Tier 1 family planning methods include implants, IUDs, and female or male sterilization. Births resulting from unintended or closely spaced pregnancies are associated with adverse MCH outcomes, such as delayed prenatal care, premature birth, and negative physical and mental health effects (2018 Guttmacher Institute). In Virginia, 49.5% of pregnancies are described by women themselves as unplanned (PRAMS 2015). In 2010, public spending for unplanned pregnancies in Virginia totaled an estimated $507 million (Power to Decide 2018).

Virginia PRAMS: A collaborative project with the CDC that assesses maternal risk and behaviors before, during, and shortly after pregnancy. The VDH OFHS Division of Population Health Data administers the grant. A steering committee, which includes Title V MCH representatives, provides input and support. Virginia's MCH programs use data from PRAMS to inform planning and programming. Data for 2016 will be available in 2018.

DOMAIN: Perinatal/Infant Health

NPM 5: Safe sleep – Sleep-related infant deaths, also called Sudden Unexpected Infant Deaths (SUID), are the leading cause of infant death after the first month of life and the third leading cause of infant death overall. In 2015, the SUID rate in Virginia was 84.2 per 100,000 live births (National Vital Statistics System (NVSS)). The non-Hispanic Black SUID rate was 143.9 per 100,000, compared to 83.5 among non-Hispanic Whites and 56.8 among Hispanics. The American Academy of Pediatrics (AAP) has long recommended the back sleep position to reduce the risk of sleep-related SUIDs. Virginia PRAMS data showed that in 2015, 78.0% of infants were placed to sleep on their backs and 59.9% never or rarely slept in the same bed as the mother or someone else.

Neonatal Abstinence Syndrome: The VDH Maternal & Infant Health Program convenes with the newly formed Virginia Neonatal Perinatal Collaborative (VNPC) to implement and promote quality improvement and evidence-based activities to improve state outcomes. The VNPC has introduced plans to implement the Vermont Oxford Network (VON) NAS Universal Training Program as a tool. A comprehensive approach has been implemented, including several levels of intervention (surveillance to clinical practice improvements).

Newborn Screening: The Virginia Newborn Screening Program includes Early Hearing Detection and Intervention (EHDI), Dried Blood Spot Newborn Screening, education for Critical Congenital Heart Disease (CCHD) pulse oximetry screening, and the Congenital Anomalies Reporting and Education System (VaCARES) Birth Defects Surveillance. With CDC funding support, in May 2017, a Zika Birth Defects Surveillance Coordinator was hired, which enabled Virginia to enhance its surveillance efforts. These enhancements will improve Virginia's capabilities to verify birth defects reported into VaCARES, respond to changing birth defects surveillance needs, and refer infants to CYSHCN programs.

DOMAIN: Child Health

NPM 7.1: Injury hospitalization (ages 0-9 years) – Data from the Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases (SID) showed the rate of hospitalization for non-fatal injury among children was 101.5 per 100,000 in 2015. Among age groups, the annual indicator was 164.7 for children less than one year, 118.1 among

children 1-4 years, and 76.0 among children 5-9 years. Reducing the burden of nonfatal injury can greatly improve the life course trajectory of infants and children resulting in improved quality of life and cost savings.

NPM 11: Medical home (ages 0-11 years) – The National Survey of Children's Health (NSCH) in 2016 showed that 51.6% of children age 0-11 years had a medical home. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions.

NPM 13.2: Preventive dental visit (ages 1-11 years) – The NSCH showed that 77.8% of children age 1-11 years had a preventive dental visit in 2016. Insufficient access to oral health care and effective preventive services affects children's health, education, and ability to prosper. The American Academy of Pediatric Dentistry (AAPD) recommends preventive dental care for all children after the eruption of the first tooth or by age 12 months.

DOMAIN: Adolescent Health

NPM 7.2: Injury hospitalization (ages 10-19 years) – The HCUP- SID showed the rate of hospitalization for non-fatal injury among adolescents was 182.6 per 100,000 in 2015. Among age groups, the annual indicator was 101.7 for those 10-14 years and 261.0 among age 15-19 years.

NPM 11: Medical home (ages 12-17 years) – The NSCH in 2016 showed that 50.2% of adolescents age 12-17 years had a medical home. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions.

NPM 12: Transition (ages 12-17 years) – The 2016 NSCH showed only 8.8% of adolescents age 12-17 years received services necessary to make transitions to adult health care. Healthcare transition focuses on building independent health care skills – including self-advocacy, preparing for the adult model of care, and transferring to new providers. The goal of transition is to optimize health and assist youth in reaching their full potential.

NPM 13.2: Preventive dental visit (ages 12-17 years) – The NSCH showed that 90.9% of children age 12-17 years had a preventive dental visit in 2016. Insufficient access to oral health care and effective preventive services affects children's health, education, and ability to prosper.

DOMAIN: Children with Special Health Care Needs

NPM 11: Medical home (CYSHCN ages 0-17 years) – The 2016 NSCH showed that 42.7% of CYSHCN had a medical home.

NPM 12: Transition (CYSHCN ages 12-17 years) – The 2016 NSCH showed that 18.8% of CYSHCN age 12-17 years received services necessary to make transitions to adult health care. It is important for all youth to be connected to the programs and services they need for adult care, but CYSHCN may face additional challenges when making this transition.

Sources:

1. VDH Division of Health Statistics, 2016
2. National KIDS COUNT, The Annie E. Casey Foundation, 2017
3. National Survey of Children's Health (NSCH), 2016

III.A.2. How Title V Funds Support State MCH Efforts

Title V funds support key infrastructure, including staff within the Division of Child & Family Health (DCFH), Division of Prevention & Health Promotion (DPHP), and Division of Population Health Data. Thirty-five local health districts receive funding for MCH clinical services and education.

Within DCFH, Title V funds are braided with state special funds to support the newborn screening program (including Early Hearing Detection and Intervention). Funds are braided with MIECHV and Healthy Start to support the Early Childhood Health Unit, which administers home visiting programs. The Reproductive Health Unit receives Title X and Sexual Risk Avoidance Education funds, as well as TANF funds (in cooperation with Department of Social Services) for the Resource Mothers program, which supports pregnant/parenting teens. Title V supports the school health and nursing program, which partners closely with the Department of Education. The Maternal & Infant Health Unit receives Title V funds, state funds, and a March of Dimes grant to support our Virginia Neonatal Perinatal Collaborative. Title V invests heavily in the CYSCHN Program, including five Child Development Centers that assess children 0-21 and six Care Coordination for Children centers.

Within DPHP, Title V represents a small portion of categorical funding supporting chronic disease, injury and violence prevention, and oral health programs. Title V funds are braided with CDC funds.

III.A.3. MCH Success Story

The Virginia Children and Youth with Special Health Care Needs (CYSHCN) Program is proud of the state Care Connection for Children network's impact on families.

The INOVA Care Connection for Children (CCC) partnered with children and families who are recipients of Title V-funded services to create a video sharing their stories.

Stories from the video include:

Sabrina (8-year-old girl) and her mother shares how the INOVA CCC team helped with getting a wheelchair, a special car seat, a home care agency, and Medicaid. In addition, Sabrina shares that her mother didn't know how to take care of her unique needs at first, but because of the CCC, now she does.

Ben (teen male) and his family share how they rebuilt their entire support network after moving from another state. Ben's family describes how CCC staff were able to help them because of their connections within the community and their professional expertise.

VDH's partnership with the Department of Education (DOE) in highlighted, with a DOE-funded staff member describing how she works with schools to help families.

Last, a paid parent coordinator explains her work leading family support groups, hosting events, and using her skills

as an interpreter.

Located in Northern Virginia, the INOVA CCC is one of six contracted regional centers across the state of Virginia. Similar services are available at all centers. The Title V federal-state partnership is a critical resource for sustaining this work.

III.B. Overview of the State

Oversight and Authority

Working alongside other state agencies, the Virginia Department of Health (VDH) is the lead state entity in Virginia providing core public health functions and essential services. As stated in the VDH Strategic Plan, the agency's mission is to protect the health and promote the well-being of all people in Virginia; and its vision is to "become the healthiest state in the nation." The agency operates in conjunction with federal efforts to promote and protect the health and well-being of its communities by providing operating programs that include ensuring food and water safety, disease and injury prevention and surveillance, emergency preparedness, health equity, and setting licensure and certification standards.

As the leading public health agency in the state, the central office is located in Richmond, the state's capital. The State Board of Health exists to provide leadership in planning and policy development for the Commonwealth and VDH to implement a coordinated, prevention-oriented program that promotes and protects the health of all Virginians. The agency lead by the State Health Commissioner, with additional oversight from deputy commissioners distributed across four main operating divisions: Public Health & Preparedness, Administration, Community Health Services, and Population Health.

VDH is responsible for the administration of programs carried out with allotments under Title V. The Division of Child and Family Health in the Office of Family Health Services manages the Title V MCH Block Grant program. *VDHLiveWell* is a flagship brand for the Office of Family Health Services (OFHS) to help Virginia become the healthiest state in the nation; through strategic focus and distribution of information on programs that focus on strengthening the health of families and communities, plus risk avoidance tips and information on how certain issues affect public health. The OFHS includes oversight and provision of the Women, Infants, and Children's Nutrition Program (WIC) in the **Division of Community Nutrition**; disease prevention and health promotion in the **Division of Prevention and Health Promotion**; protecting and improving the health of women, infants, children, adolescents, and their families in the **Division of Child and Family Health**; and providing scientific integrity and quality data analysis, reporting, and program evaluation related to these populations in the **Division of Population Health Data**.

Geography

The Commonwealth of Virginia encompasses 42,774 square miles (110,784 km^2), including land and water areas, making it the thirty-fifth largest state by total area. The state is geographically located in the mid-Atlantic area of the United States, between the Atlantic Coast and the Appalachian Mountains. 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. Land is distinctly divided by the Appalachian Mountains in the west, countryside, rolling hills, growing cities, and sandy beaches in the east where the Chesapeake Bay separates the contiguous portion of the Commonwealth from the two-county peninsula of Virginia's Eastern Shore. Many of Virginia's rivers flow into the Chesapeake Bay, including the Potomac, Rappahannock, York, and James.

Population Density & Urbanization

Virginia has 11 Metropolitan Statistical Areas, with Northern Virginia (Washington-Arlington-Alexandria), Hampton Roads (Virginia Beach-Norfolk-Newport News), and Richmond-Petersburg being the three most populous. The

Commonwealth is divided into 133 localities (95 counties and 38 independent cities) with a population density of 206.7 people per square mile. The largest cities are Virginia Beach (449,733), Norfolk (245,724), Chesapeake (233,194), Arlington (226,092), and the state's capital Richmond (216,773). Norfolk forms the urban core of the Hampton Roads metropolitan area, which has a population over 1.6 million people and is the site of the world's largest naval base, Naval Station Norfolk. The City of Alexandria has more people per square mile than any other jurisdiction in Virginia, according to 2016 population estimates. There are over 155,000 people living within the city, for a population density of 10,367 residents/square mile. In contrast, Highland County has the lowest density at 5.338 residents/square mile.

The most populous county and largest jurisdiction in the Commonwealth is Fairfax County in Northern Virginia, with a climbing population of 1.14 million. Fairfax County has a major urban business and shopping center in Tysons Corner, Virginia's largest office market. Neighboring Prince William County (463,023) is Virginia's second most populous county, and is home to Marine Corps Base Quantico, the FBI Academy and Manassas National Battlefield Park. According to an article in the Washington Post, analysis of U.S. Census Bureau data has shown that Prince William County has leapfrogged Virginia Beach to become the second-most-populous jurisdiction in Virginia. Three out of four of the state's largest jurisdictions are now in Northern Virginia, which has accounted for 60 percent of the state's population growth. Loudoun County is the state's fastest-growing jurisdiction. Loudoun gained nearly 84,000 residents for 396,000, surpassing Chesterfield County, which gained 23,700 residents to become the state's fourth-most-populous jurisdiction. The four counties with the largest portions of population 35 and younger were Arlington, Loudoun, Prince William and Stafford, according to 2016 census estimates. Those four Northern Virginia jurisdictions also have the smallest ratios of people 65 and older, the estimates show. This population growth also has come with issues, most notably some of the worst traffic in the country and increasingly overcrowded schools.

Virginia is a place where state averages hide the contrasting stories of its subpopulations. There are approximately 1.2 million residents living within rural areas of the state, compared to over 7.2 million within urban areas. Virginia Department of Health has grouped the Commonwealth's localities into 35 health districts and 5 health regions. The Northern region, composed of Alexandria, Arlington, Fairfax, Loudoun, and Prince William health districts, is densely populated and includes ten of the 30 highest income counties in the United States (USA Today, 2018). Conversely, the Southwest region, made up of Alleghany, Central Virginia, Cumberland Plateau, Lenowisco, Mount Rogers, New River, Pittsylvania/Danville, Roanoke City, and West Piedmont 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. The Central region is composed of Chesterfield, Crater, Chickahominy, Henrico, Piedmont, Richmond City, and Southside health districts. The Northwestern region is made up of Central Shenandoah, Lord Fairfax, Rappahannock, Rappahannock/Rapidan, and Thomas Jefferson health districts. These two regions have a mix of urban, suburban and rural areas. The urban areas are home to large state colleges/universities and are business districts. The suburban areas are more residential than industrial. The rural areas are agricultural. The Eastern region, composed of Chesapeake, Eastern Shore, Hampton, Norfolk City, Peninsula, Portsmouth, Three Rivers, Virginia Beach, Western Tidewater health districts, runs along the east coast (Chesapeake Bay and Atlantic Ocean) and includes the Eastern Shore, a peninsula separated from the mainland by the Chesapeake Bay. The Eastern Shore Health District is very sparsely populated and has a high level of poverty. The Eastern area has the largest concentration of military bases and facilities of any metropolitan area in the world. The coastal area has many bridges and tunnels that create transportation barriers to services. Individuals in the area also experience severe traffic congestion on a daily basis. Occasionally, hurricanes and tropical storms affect the area and can result in flooding and environmental health concerns.

Demographics

Virginia is the 12th most populous state in the U.S., with an estimated population of over 8.4 million people (*PostCensus* population estimates from NVSS).

Race/Ethnicity

Among people reporting one race alone, 63.1 percent identified as non-Hispanic White, 18.9 percent identified as non-Hispanic Black, and 6.0 percent identified as Asian (2012-2016 ACS). There were 8.7 percent of individuals that identified as Hispanic or Latino (of any race). According to the 2010 Census, Virginia ranks tenth in having the highest proportion of individuals who identified as Black or African-American. Within the population, 49.2% are male and 50.8% are female.

There were over 1.6 million women of childbearing age (15-44 years) in 2016, with race and ethnicity composition consisting of 59.1% non-Hispanic white, 21.4% non-Hispanic black, 0.3% non-Hispanic Native American or Alaska Native, 8.6% non-Hispanic Asian, and 10.6% Hispanic (any race) (PostCensus). The Virginia population, like that of the nation, is becoming more racially and ethnically diverse and 11.9% of the population are foreign-born (2012-2016 ACS).

Age

The median age of Virginians is 37.8 years. There are over 1 million Virginian's age 65 and older, with more than half (56%) being female. Women of reproductive age 15-44 accounted for 19.9% (1,676,203). In 2016, there were 2,223,450 children and adolescents aged 1-21 years living in Virginia, representing 26.4% of the population. According to the 2016 National Survey of Children's Health, 21.0% of Virginia children aged 0 to 17 (Pop. Est. 391,428 children) were identified as having special health care needs. There were more males (24.9%) estimated to have a special health care need than females (16.7%).

Educational Attainment

Educational attainment is a predictor of personal wealth and well-being and is directly related to social disparities. In Virginia, 4.6% of the population has less than a 9th grade education, 6.7% have a 9^{th} to 12^{th} grade education with no diploma, 24.5% are high school graduates or equivalent, 21.2% have a bachelor's degree, and 15.7% have a graduate or professional degree. Thirty-six percent (36.9%) of Virginians have a bachelor's degree or higher compared with 30.3% for the U.S.

Economy/Income/Poverty

Virginia's economy is diverse, including local and federal government, military, farming, business, manufacturing, tourism, and healthcare/medical. Virginia has 4.1 million civilian workers, and one-third of the jobs are in the service

sector. The unemployment rate in Virginia was 3.4% in March 2018, below the national rate of 4.1%. The median household income in Virginia is $66,149 compared to $55,322 in the U.S.
Compared to the U.S. population, a lower percentage of Virginians lived in households with incomes below the federal poverty level (11.0% vs. 12.7% for the U.S.) and also a lower percentage of children under age 18 lived in households with incomes below the federal poverty level (12.8% vs. 17.4% for the U.S.). However, wealth varies significantly across the state. The median household income has risen for families in Virginia from $71,600 in 2010 to $82,300 in 2016. This 12.9% increase from 2010 to 2016 is doubled from the 6.0% increase seen from 2007 to 2013. However, the percentage of children living in high-poverty areas jumped, from 14% to 16% from 2010 to 2014 but then fell again back to 14% in 2016.

In 2016, 262,642 Virginia children under 18 years of age were living in poverty. Portions of these children live within five counties/cities: Fairfax County (19,151), Richmond city (15,255), Norfolk City (14,999), Prince William County (11,947) and Virginia Beach City (11,559). These five counties/cities accounted for about 28% of Virginia's population in poverty. Also, counties in Southwest and Appalachian Virginia have high percentages of their own populations in poverty. These counties include: Lee County, with 29.9% of their population in poverty, Harrisonburg City, with 28.4% of their population in poverty, Radford City, with 27.2 percent of their population in poverty and lastly Dickenson County, with 25.6% of their population in poverty. In 2016, the Virginia percent of female-headed households with related children under 18 years with less that a high school degree living below federal poverty level was 43.1% which was slightly below the U.S. population of 49.1%. Thirty six percent of children with special health care needs lived in families with incomes less than 200% of the federal poverty level. This is in comparison to children without special health care needs, of which 32.9 percent are in families with incomes less than 200% of the federal poverty level.

Primary Care Access and Health Insurance Coverage

Based on the 2012-2016 ACS data, 89.3% of Virginians have health insurance of some kind and 94.7 percent of those under age 18 have health insurance. Among the uninsured population, 19.5% are young adults age 25 to 34. Others that are uninsured include 9.1% of the White non-Hispanic population compared to 13.0% of non-Hispanic African Americans, and 25.9% of those with less than a high school education.
In 2017, the Bureau of Labor Statistics reported 4,530 family and general practitioners in Virginia, and 930 obstetricians/ gynecologists. There were 900 pediatricians, 3,030 dentists with 80 of those being specialists, and 160 Oral and Maxillofacial Surgeons in the state. There are needs recognized across the state that can be unique to different areas of the state, such as transportation barriers and availability of providers. There were 90 counties/cities in Virginia designated as Primary Care Health Professional Shortage Areas (HPSAs), 92 in Dental Care, and 99 in Mental Health (HRSA Data Warehouse). Among children that received or needed specialist care but had a problem getting it, 23.8% were CSHCN compared to 16.7% of non-CSHCN.

State Statutes and Other Regulations

The state plan for the Virginia CYSHCN Program is found in the Virginia Administrative Code (VAC). The plan closely mirrors some of the recommendations of AMCHP and the Maternal and Child Health Bureau. In the plan, the Virginia CYSHCN Program is defined along with the program scope and content. The CYSHCN unit includes four programs: Care Connection for Children, Child Development Services Program, Sickle Cell Program, and Bleeding Disorders Program. In addition, the CYSHCN Program connects with newborn screening services in the VAC and has responsibilities in support of newborns confirmed to have certain conditions as described on the newborn

screening panel.

Healthy People 2020 Maternal, Infant, and Child Health Indicators

Indicators	2010	2011	2012	2013	2014	2015	Related HP2020 Goal
Morbidity and Mortality							
Reduce the rate of all infant deaths (within 1 year)[1] (deaths per 1,000 live births)	6.8	6.8	6.5	6.2	5.7	5.9	6.0
Reduce the rate of deaths among children aged 1 to 4 years[2] (deaths per 100,000 population)	21.2	23.2	26.9	20.0	25.0	24.3	26.5
Reduce the rate of deaths among children aged 5 to 9 years[2] (deaths per 100,000 population)	11.9	15.8	9.8	10.3	9.4	12.2	12.4
Reduce the rate of deaths among adolescents aged 10 to 14 years[2] (deaths per 100,000 population)	9.0	12.4	14.3	13.3	12.1	12.1	14.8
Reduce the rate of deaths among adolescents aged 15 to 19 years[2] (deaths per 100,000 population)	44.3	45.9	42.8	39.8	39.8	46.4	54.3
Reduce low birth weight (LBW)[3]	8.2	8.0	8.1	8.0	7.9	7.9	7.8
Reduce total preterm births[3]	10.1	9.5	9.5	9.4	9.2	9.2	9.4
Reduce the rate of maternal mortality[4] (deaths per 100,000 live births)			13.2			15.6	11.4[5]
Pregnancy Health and Behaviors							
Increase the proportion of pregnant women who receive prenatal care beginning in the first trimester[3]	-	-	-	56.1	58.7	69.7	77.9
Increase abstinence from cigarette smoking among pregnant women[3]	-	-	-	68.1	65.6	82.3	98.6
Increase initiation, duration and exclusivity of breastfeeding.							
Percent of mothers who exclusively breastfed their infants at 6 months of age[5]	16.6	22.9	23.6	22.0	21.7		25.5

HP2020: *Healthy People 2020 Goal*

- Maternal Indicator data have been recoded to "Not Reported" for births to mothers residing in a reporting area that used the 1989 U.S. Standard Certificate of Live Birth or did not report the indicator in the specified data year.

Sources:

1. Linked Birth/Infant Death Data Set, CDC/NCHS
2. National Vital Statistics System-Mortality (NVSS-M), CDC/NCHS; Bridged-race Population Estimates, CDC/NCHS and Census
3. National Vital Statistics System-Natality (NVSS-N), CDC/NCHS
4. America's Health Rankings analysis of CDC, National Vital Statistics System, United Health Foundation, AmericasHealthRankings.org, Accessed 10 April 2018.
5. Centers for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition, Physical Activity, and Obesity. Data, Trend and Maps [online]. [accessed May 25, 2018]. URL: https://www.cdc.gov/nccdphp/dnpao/data-trends-maps/index.html.

KIDS COUNT Key Indicators

Compared to other states, Virginia's overall child well-being rank for 2017 was 10

Indicators	Virginia	United States	Rank
Economic Well-Being			*12*
Percent of children in poverty (2015)	15	21	
Percent of children whose parents lack secure employment (2015)	25	29	
Percent of children living in households with a high housing cost burden (2015)	32	33	
Percent of teens (ages 16-19) not attending school and not working (2015)	6	7	
Education Indicators			*7*
Percent of children (ages 3-4) not attending preschool (2013-15)	53	53	
Percent of fourth graders in public school not proficient in reading (2015)	57	65	
Percent of eighth graders in public school not proficient in math (2015)	62	68	
Percent of high school students not graduating on time (2014-15)	14	17	
Health Indicators			*16*
Percent low birth weight babies (2015)	7.9	8.1	
Percent of children without health insurance (2015)	5	5	
Child and teen death rate (per 100,000 children ages 1-19) (2015)	24	25	
Percent of teens (ages 12-17) who abuse alcohol or drugs (2013-14)	5	5	
Family and Community Indicators			*13*
Percent of children in single-parent families (2015)	32	35	
Percent of children in families where the household head lacks a high school diploma (2015)	9	14	
Percent of children living in high-poverty areas (2011-15)	5	14	
Teen birth rate (per 1,000 females ages 15-19) (2015)	17	22	

Source: Annie E. Casey Foundation, 2017 KIDS COUNT Profile, Virginia

III.C. Needs Assessment

FY 2019 Application/FY 2017 Annual Report Update

Ongoing Needs Assessment Activities

VDH MCH programs continuously assess the needs of Virginia's MCH populations through ongoing monitoring and surveillance. Ongoing assessment involves monitoring progress and measures/trends, discussion of work plans and execution, and emerging issues for MCH populations not reflected in the plan. This review (e.g. environmental scans, surveys, formal and informal input from families and stakeholders) informs efforts to adjust and realign to the direction of the Title V program with shifting population and resource needs.

The two ongoing mechanisms that provide data and/or information that inform Title V are: (1) learning from the Division of Population Health Data's (DPHD) ongoing surveillance efforts, including Community Health Assessments (CHAs); and (2) staff participation on state and regional boards and councils. DPHD provides expertise, consultation, and support on epidemiology, data collection, analysis, interpretation, and reporting. DPHD also contributes to statewide MCH needs assessment efforts through their strategic implementation of CHAs and Community Health Improvement Plans (CHIPs) throughout Virginia.

In collaboration with the DPHD MCH Epidemiology Unit, the CYSHCN Program conducts a standardized survey of families of CYSHCN served by regional Care Connection for Children (CCC) Centers. The statewide survey is conducted every 5 years to assess family satisfaction and utilization of services, and to identify areas of program improvement. The survey is scheduled to be completed FY19.

Other ongoing activities include:

1. Maintenance of the public-facing MCH Dashboard
2. Development of data briefs/fact sheets
3. Data sharing and fulfillment of data requests

Emerging Issues and MCH Program Response

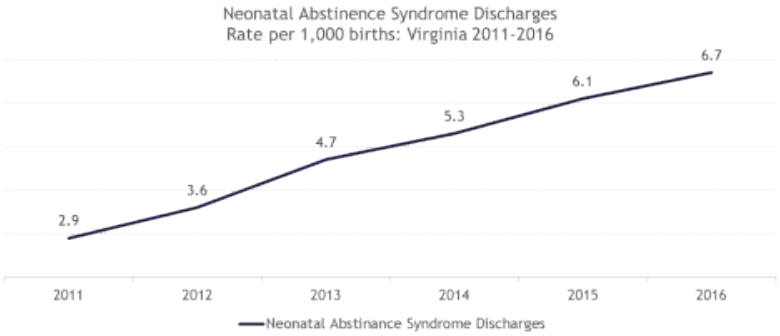
The Title V team remains nimble and flexible to adjust program goals and activities to meet new and emerging health concerns that arise. Significant emerging issues may require realignment of Title V staff scopes of work and the action plan. The following are examples of emerging issues that required realignment.

Maternal/Infant Health

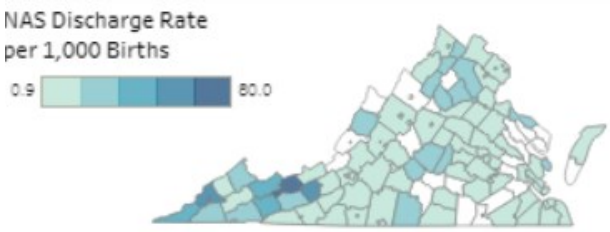
The State Health Commissioner declared opioid addiction a public health emergency in November 2016. The opioid crisis continued to emerge and the scope of the issue became more fully understood in 2017. It became clear that pregnant women with Substance Use Disorder (SUD) and their infants were in need of improved access and coordinated care, and providers needed better understanding of care and available services.

In response, the Maternal Infant Coordinator (funded by Title V) focused her time on the Virginia Neonatal Perinatal Collaborative (VNPC). The VNPC's main goal is to eliminate health disparities and improve outcomes among all women and infants through evidence-based, data driven processes. The VNPC has developed opioid and neonatal abstinence syndrome (NAS) related committees to this effect.

Substance Exposed Infants and NAS: Data from the Virginia Department of Social Services showed that the number of substance exposed infants rose from 742 in 2009 to 1,334 in 2016 (VA DSS 2017). The rate of NAS hospitalizations increased from 2.9 per 1,000 births in 2011 to 6.7 per 1,000 births in 2016 (VA Inpatient Hospitalization). NAS cases counts have posted year-over-year increases for several years; the total number in 2016 was 686 compared to 626 in 2015. Case totals for Quarter 1 of 2017 is 191, compared to 175 in Quarter 1 of 2016.



Southwest Virginia has more infants diagnosed with NAS, but no area of the state is immune. Babies with NAS have an 11-day average length-of-hospital stay, where healthy newborns typically are sent home in 2-3 days (VHHA).



Child Health

Early childhood has been an opportunity for growth in systems and services in Virginia. While there are strong early childhood organizations and proponents for developing a more integrated and coordinated system for young children, Virginia has not dedicated resources to further develop an integrated statewide plan (e.g. health, social services, child development, care and education) since the expiration of the Early Childhood Comprehensive Systems grant. In 2016, the Early Childhood Foundation convened several statewide meetings to spark discussion and collaboration. VDH and Title V were engaged partners. An ongoing environmental scan has identified a gap in universal developmental screening services for young children. According to the National Survey of Children's Health, only 26.8% of children, ages 9 through 35 months, received a developmental screening (2016). Pediatric providers may conduct developmental screening but there is limited documentation or tracking of these services and/or any referrals. Therefore, developmental screening was confirmed as an NPM for Title V, and the work of the Early Childhood Health Consultant (funded by Title V) was adjusted to focus on barriers and challenges related to developmental screening as well as to build knowledge and support for trauma informed care and early childhood social, emotional, and behavioral health for all professionals working with young children.

Health Equity

A focus of the MCH initiative has been, and will continue to be, a reduction in infant mortality and now, maternal mortality; particularly a reduction in the disparity between white and African-American infant and maternal death rates. The African-American infant mortality rate in Virginia remains twice the white rate. The African-American

maternal mortality rate is three-times that of white mothers. To address these disparities, overall MCH efforts are refocusing on contributing factors to mortality such as access to care (e.g., increasing home visiting), family planning (e.g., increased access to highly and moderately effective contraceptives) and maternal/care-giver behaviors (e.g., safe sleep environments and substance use disorder). These efforts are only partially funded by Title V and are supported mostly by other federal grants (e.g., MIECHV, Title X). Virginia is in the process of increasing alignment of the goals and objectives of its various MCH funding streams into a shared "MCH Agenda." This will leverage synergies of collective impact to greater improve the health of women, children and families.

Maternal Mortality: In Virginia, the rate is 15.6 deaths per 100,000 live births (America's Health Rankings 2018). Data shows that white women in Virginia have a rate of 11 deaths per 100,000, and black women have a rate of 36.6.

Safe Sleep: Sleep-related infant deaths, also called Sudden Unexpected Infant Deaths (SUID), are the leading cause of infant death after the first month of life and the third leading cause of infant death overall. In 2014, the Virginia Child Fatality Review Team (led by the VDH Office of the Chief Medical Examiner) released the Sleep-Related Infant Deaths in Virginia report, which reviewed deaths that occurred in 2009. Data from that report showed that 95% of sleep-related deaths were preventable, and that 90% were related to unsafe sleep environment. The report showed that more than 70% of infants were exposed to secondhand smoke, and half of the mothers smoked while pregnant. More than 1 in 5 mothers used alcohol or drugs while pregnant. The same report found that black infants died at a rate more than twice that of white infants.

Title V Program Capacity

Virginia's Title V capacity continues to grow in terms of state leadership, vision, organizational structure and resource mobilization to reach program goals.

Leadership

Since the VDH is within the Executive branch of Virginia's Government, the issues impacting MCH populations have a direct linkage to the Governor and subsequently Secretary of Health and Human services for Virginia. The 2017 Administration, led by Governor Terry McAuliffe, and now the present Governor, Ralph Northam, are very supportive of women's health, children and youth and have initiated several efforts to expand state capacity to improve the health and well-being within these groups. For example, strengthening the early childhood system is of particular interest in Virginia. A large multi-disciplinary effort has begun to coordinate systems of care, share data and track programs addressing early childhood.

Organizational Structure

The Health and Human Services Secretariat oversees the state health and human services agencies (e.g., VDH, Department of Medical Assistance Services, Department of Behavioral health and Developmental Services and Department of Social Services). The Code of Virginia authorizes the VDH to prepare and submit the Title V plan. The Commissioner of Health is authorized to administer the plan and expend the funds. The Shared Administrative Services within Population Health provides fiscal oversight; the Division of Child and Family Health led by the state MCH Title V Director manages the state programs, provides strategic direction and ensures coordination with other state and federal MCH programs. (See organizational chart). The Director of Children and Youth with Special Healthcare Needs program reports to the Title V Director and provides oversight and management of the Child Development Centers, Care Coordination for Children Centers and Bleeding disorders programs in Virginia. The Title V Coordinator is responsible for the day-to-day operations of overseeing grant activities, liaising with program

managers, monitoring grant expenditures, and preparation and submission of the Title V grant.

Agency Capacity

Title V funds are used to improve the health of women, pregnant women, infants, children and adolescents in Virginia. An emphasis is placed on reaching populations with fewer resources, programs and services and those communities most greatly impacted by infant mortality, maternal mortality and the opioid crisis.

Virginia's MCH program, including the CYSHCN program, prioritize quality improvement and sustainability of the statewide coordinated comprehensive system of care that reflects a family-driven, data-informed, community-based approach to care. This comprehensive complex system of care is composed of state agencies, regional partners (the Child Development Centers or CDCs, Care Coordination of Children Centers or CCCs, Health Systems), local partners (e.g., local providers, faith community, businesses, schools etc.) and families.

The VDH infrastructure includes 35 health districts within which are 119 local sites. Each district received an allotment of the federal Title V funds to address the needs of MCH populations in the local communities.

The CYSHCN program includes a network composed of five CDCs and six CCCs. The CDCs provide a range of health and developmental screenings for children 0-21 years of age and referral to treatment. The CCCs provide comprehensive care coordination and wrap-around services to children 0-21 years of age and their families, with an emphasis on providing high quality, cost-efficient comprehensive care.

The Virginia MCH Title V team is composed of nine key staff representing a multi-disciplinary approach to MCH. The skills represented include public health practice, research and service in the areas of data collection and analysis, program development, implementation and evaluation, stakeholder engagement, policy development, community mobilization, clinical services, and care coordination.

- Family Representative: Dana Yarborough, Executive Director of Parent to Parent of Virginia, Family-2-Family Network, Center for Family Involvement.
- Title V/MCH Director: Cornelia Ramsey Deagle, PhD, MSPH, Director of Division of Child and Family Health. Dr. Deagle oversees Newborn Screening including EHDI, Birth Defects, Early Childhood Health including MIECHV and Healthy Start Home Visiting programs, Adolescent and School Health including AEP, CYSHCN including Bleeding Disorders, Family Planning including Title X, and Maternal and Infant Health.
- CYSHCN Director: Marcus Allen, MSPH. Mr. Allen oversees the large state-wide Child Development Centers, Care Connection for Children Centers and Bleeding disorders programs.
- School Health Nursing: Position vacant, to be filled summer 2018.
- Early Childhood Health: Position vacant, to be filled fall 2018.
- Comprehensive Reproductive Health: Emily Yeatts, MSW, MPH. Ms. Yeatts oversees the CRH unit and serves as the Title X Project Director as well as oversees the Abstinence Education Program and Resource Mothers.
- Maternal Infant Health Coordinator/Program Development Director: Shannon Pursell, MPH. Ms. Pursell serves as subject matter expert in Maternal and Infant Health as well as provides TA in MCH program development across MCH populations.
- Operations Director: Carla Hegwood, MPH. Ms. Hegwood oversees the day-to-day activities of Title V as well as development of program budgets.
- MCH Epidemiology Supervisor: Meagan Robinson, DrPH(c), MPH. Ms. Robinson is the lead MCH epidemiologist and supervisor of the MCH Epidemiology Unit. She oversees data needs for the MCH/Title V programs as well as development of MCH dashboards for the state.

Title V Partnerships and Collaborations

Virginia Title V has prioritized increasing diversity and inclusiveness of local partners as well as an emphasis on authentic inclusion of families. Virginia's partnerships are described in the appendix.

Five-Year Needs Assessment Process

The VDH MCH team is implementing a mixed-methods approach for the 5-Year Needs Assessment due in 2020, with a priority to maximize the input of internal and external partners, and engagement of families and consumers in a meaningful way. OFHS has convened a cross-program steering committee that meets monthly to conduct preliminary assessment of data sources and indicators, and perform data gap analysis. VDH Title V data needs are met through the State Systems Development Initiative (SSDI), with staff that provide data capacity for informed decision-making. It is the program's goal to operate in a comprehensive process while leveraging resources and partnerships.

Process

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

Division of Population Health Data

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

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

Boards and Councils

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

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

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

Findings

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

MCH Population Needs

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

Title V Program Capacity

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

Organizational Structure

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

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

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

Agency Capacity

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

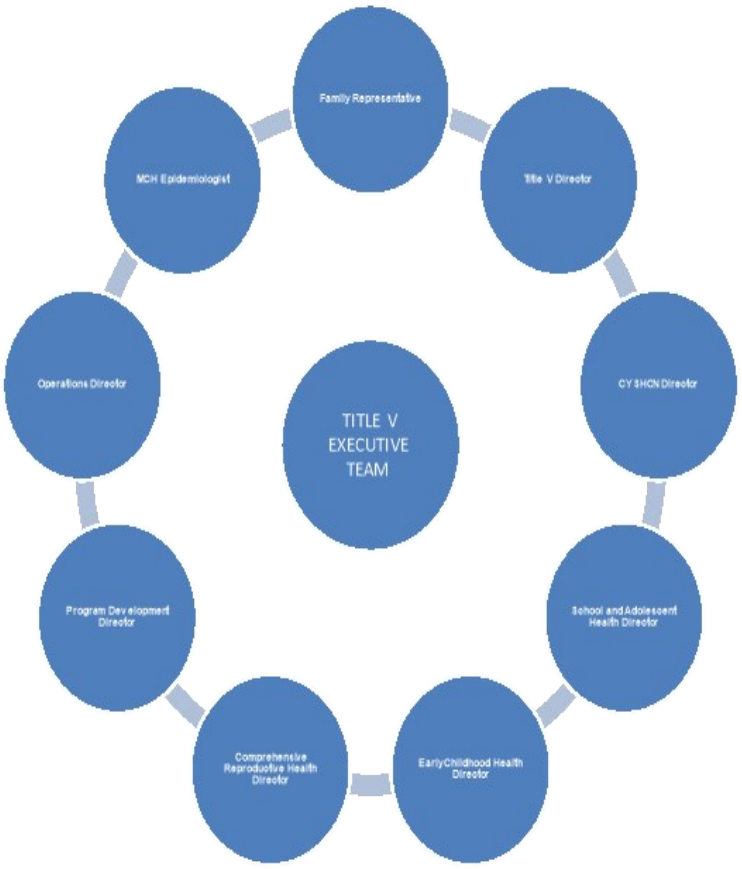
Virginia's MCH and CSHCN programs prioritize maintenance of a statewide system of services that reflects the principles of family-driven, data-informed, comprehensive, community-based, coordinated care. The programs interact with this system on three levels: state agencies and organizations (e.g. headquarters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

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

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

MCH Workforce Development and Capacity

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



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

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

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

School and Adolescent Health Director Janet Wright, BSN, RN, NCSN, oversees school and adolescent health initiatives. Janet is a National Certified School Nurse and serves as the school nurse consultant.

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

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

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

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

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

C. Partnerships, Collaboration, and Coordination

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

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

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

MCHB Investments

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

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

Other Federal Investments

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

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

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

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

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

Other Governmental Agencies

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

Tribes, Tribal Organizations, and Urban Indian Organizations

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

Family/consumer partnership and leadership programs

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

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

The F2F director, Dana Yarbrough, was actively involved in several initiatives and trainings as a core member of the Title V/MCH team.

FY 2017 Application/FY 2015 Annual Report Update

2015-2016 update on Title V Needs Assessment

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

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

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

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

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

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

II.B.1. Process

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

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

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

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

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

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

Stakeholder Meeting Overview

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

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

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

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

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

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

KEY INFORMANT INTERVIEWS

Overview

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

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

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

Consistent Themes

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

FOCUS GROUP

I. **STUDY BACKGROUND AND PURPOSE**

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

1. **Research Objectives**

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

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

2. **Methodology**

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

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

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

Participant Recruitment

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

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

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

II.B.2. Findings

II.B.2.a. MCH Population Needs

General Findings and Themes from Stakeholder Meeting

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

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

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

General Findings and Themes from the Key Informant Interviews

Overall Health Environment and Pressing Health Issues

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

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

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

expressed by many of the respondents included the following:

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

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

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

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

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

Subgroups Who are of Most Concern

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

recession. Other stakeholders named specific groups:

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

Significant Barriers or Gaps

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

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

General Findings from the Focus Groups

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

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

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

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

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

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

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

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

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

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

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

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

2.1 Important Health Issues and Needs - Women

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

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

**Indicates a tie or equal ranking*

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

Mental Health

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

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

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

Nutrition

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

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

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

Breast Cancer

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

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

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

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

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

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

**Indicates a tie or equal ranking*

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

Mental Health

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

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

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

Nutrition

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

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

Obesity and Physical Inactivity

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

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

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

2.2 Barriers/Access to Care

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

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

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

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

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

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

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

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

2.3 Communication Channels/Influencer

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

II.B.2.b Title V Program Capacity

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

III.D. Financial Narrative

	2015		2016	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$11,949,178	$10,634,892	$12,025,842	$12,092,401
State Funds	$8,961,883	$7,976,169	$9,019,382	$9,069,301
Local Funds	$0	$0	$0	$0
Other Funds	$1,048,412	$1,167,422	$1,152,718	$1,182,763
Program Funds	$25,000	$26,562	$0	$183,208
SubTotal	$21,984,473	$19,805,045	$22,197,942	$22,527,673
Other Federal Funds	$151,882,965	$164,569,656	$148,869,827	$170,217,550
Total	$173,867,438	$184,374,701	$171,067,769	$192,745,223

	2017		2018	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$12,072,934	$12,128,653	$12,092,401	
State Funds	$9,054,701	$9,097,551	$9,069,301	
Local Funds	$0	$0	$0	
Other Funds	$1,125,000	$1,146,726	$1,125,000	
Program Funds	$0	$1,295,711	$200,000	
SubTotal	$22,252,635	$23,668,641	$22,486,702	
Other Federal Funds	$191,309,215	$161,040,946	$12,847,299	
Total	$213,561,850	$184,709,587	$35,334,001	

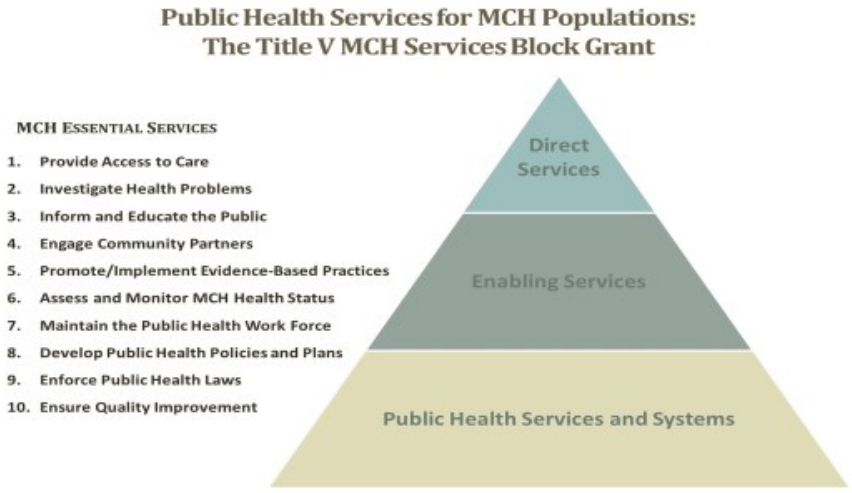
	2019	
	Budgeted	Expended
Federal Allocation	$12,128,653	
State Funds	$9,097,551	
Local Funds	$0	
Other Funds	$1,125,000	
Program Funds	$1,427,400	
SubTotal	$23,778,604	
Other Federal Funds	$16,914,458	
Total	$40,693,062	

III.D.1. Expenditures

Form 2: For FY17, Virginia received a total federal allocation of $12,128,653, with matching expenditures totaling $10,255,513. Virginia expended $9,097,551 of State MCH Funds and $1,146,726 in Other Funds (to perform newborn screening services, as required by the Virginia General Assembly). In addition, a total of $1,295,711 in program income was generated and reinvested in delivery of Title V MCH services. FY17 expenditures for the state-federal Title V partnership totaled $23,668,641. 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 total state match of $11,649,951 (i.e. state, other, and program income funds), Virginia has exceeded this requirement. Variances between the budgeted and expended amounts resulted from receiving a slightly greater federal award (projected based on the FY15 award) and strategic efforts to broaden the impact of Title V initiatives.

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

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



III.D.2. Budget

The Title V MCH Block Grant budget for the FY19 application provides funds for maternal and child health (MCH) services, primary care for children and adolescents, and preventive and maintenance services to children with special health care needs (CSHCN). Preventive and primary care services include policy and procedural oversight, local health department (LHD) agreements, pharmacy and laboratory testing, newborn screening and referral for follow up (non-Title V funds; see Other Funds below), and reducing health problems and risk factors. Other services provided include population-based maternal and child health systems coordination, e.g. cross-coordination of providers, specialists, school systems, government agencies, and community partners. Employing appropriate and culturally relevant communication strategies is an increasing priority to better connect with priority MCH communities and “meet people where they are” (e.g. web-based community outreach and education through social media, the VDH online data portal, online training modules for families and health care providers).

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

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

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

In addition, Virginia budgets for match on a 4-to-3 ratio of federal to state funds, keeping in mind the maintenance of effort (MOE). Sec. 505 (a)(4) requires that states maintain the level of funds provided (match) solely by the state for MCH health programs at a level at least equal to the level provided by the state in fiscal year 1989. Virginia's MOE is $8,718,003. The FY19 budget meets the match and MOE amount as follows:

FY19 Budget Amount
Federal amount: $12,128,653
State Match amount: $11,649,951

Administration costs include management, policy direction, accounting and budgeting services, personnel services, and support services.

For FY19, the Virginia Department of Health’s Office of Family Health Services has reviewed all federal investments relevant to the MCH state and national priorities that are received. We narrowed the criteria for inclusion in the state’s MCH budget (as reported on line 11 of Form 2) to more clearly define the fiscal landscape for Virginia’s MCH population. This will maximize opportunities to leverage different funding streams to meet Title V goals and objectives and also accurately demonstrate how Title V funds are used to support state priorities and complement the state’s investment.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Virginia

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

Leadership Roles

The families and children we serve spearhead the leadership of the Maternal and Child Health effort in Virginia. It is a priority to engage families in all of the work that we do not only in the Children and Youth with Special Healthcare Needs program but in all of our programs.

The names and title of key Title V staff are listed below:

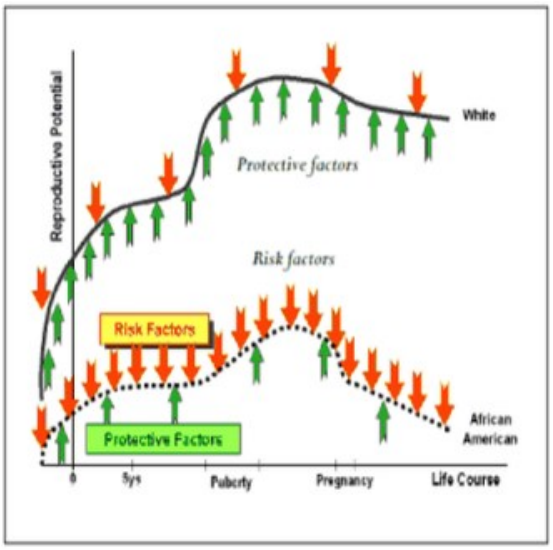
- Children and Families of Virginia
- Dana Yarbrough - Center for Family Involvement (Lead Family Representative)
- Marcus Allen, MPH - CYSHCN Director
- Carla Hegwood, MPH – Title V Grant Coordinator
- Meagan Robinson, MPH – Lead MCH Epidemiologist
- Shannon Pursell, MPH – Maternal & Infant Health Coordinator
- Shamaree Cromartie, MPH – Blood Disorders Program Coordinator
- Vacant – Early Childhood Health Unit Supervisor
- Vacant – School & Adolescent Health Coordinator
- Heather Board, MPH – Director Prevention and Health Promotion
- Lisa Wooten, MPH, BSN, RN – Injury and Violence Prevention Supervisor
- Katie Lafon – Director of Administration
- Cornelia Deagle, PhD, MSPH – Title V MCH Director
- Vanessa Walker-Harris, MD – Director, Office of Family Health Services
- Jackie Figgs – Executive Secretary, Division of Child & Family Health and Title V

The majority of MCH programs and services are within the Division of Child and Family Health (DCFH) within the Office of Family Health Services in the Virginia Department of Health. The Division includes newborn screening (including EHDI), Early Childhood Health and Home Visiting, Adolescent Health, CYSHCN, Family Planning, and Maternal and Infant Health. The Title V MCH Director reports to the Director of the Office of Family Health Services. The Division of Prevention and Health Promotion (DPHP) contributes expertise injury and violence prevention, oral health and health behavior (e.g., nutrition, exercise, physical activity and tobacco), and the Director of DPHP reports to the Director of the Office of Family Health Services.

This multi-disciplinary team leads the Title V work in collaboration with many community partners (as indicated throughout the grant application). There has been particular emphasis on the coordination of activities across programs in the effort to fulfill the vision as depicted below.

Framework and Strategic Approach

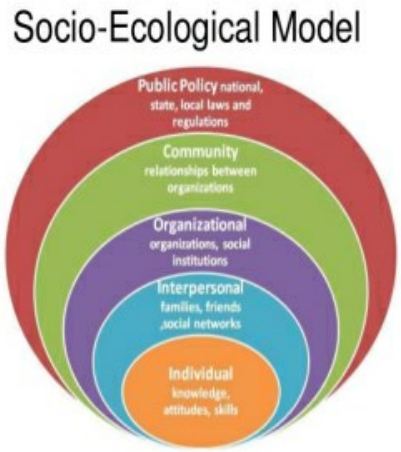
The framework for Title V in Virginia (and for larger MCH efforts) is the life course model.



The life course model provides an explanation of the human experience of life that is developed through research and observation. It demonstrates how individuals progress through their life (or life course) and the impacts of healthy (or protective) factors and the impacts of unhealthy (or risk) factors on their health status. This model is useful because it shows how the beginning of life and the experiences of infancy and early childhood are important factors in the health of adolescents and subsequently adults. Each phase of life is not independent but rather is dependent upon earlier experiences and also influences the following phases of life. For example, infancy is impacted by the pregnancy and then the health status and experiences in infancy influence the early childhood health and wellbeing.

The Virginia MCH effort adopted the life course model as the framework because it represents the inter-connectedness of the state Title V programs and aligns the transformation of Title V. By using a life course mode, the staff has been able to work to identify key areas of coordination and the protective factors (e.g., high quality pregnancy and postpartum care) as well as the gaps in our program network and the risk factors (e.g., need for transition of CYSHCN from adolescence to adulthood).

The other framework or model that is part of the foundation of the Virginia effort is the ecological model. The children and families we serve do not live in isolation but rather live within complex systems of families, social networks, organizations, communities and the larger state and national system(s).



In order to maximize the impacts of our MCH programs, the programs need to address all levels within the ecological model from the individual mother and her family, to her work place or school, her community and finally including the policies that contribute to or hinder her health.

The strategic approaches to improving the health and wellbeing of the populations within the Maternal and Child Health space are to maximize family involvement and utilize a population health approach. This also aligns with the ecological model described above. We try to include individuals, families, partner organizations that serve the MCH populations and larger community partners (e.g., Medicaid) in the planning and implementation of programs and services funded by Title V.

We engage families as much as possible in our planning and decision-making. Next, we look at the available statistical data to inform our plans. These two strategies ensure that we understand the lived experiences of our children and families and understand their priorities for health as well as ground our decisions in the evidence (data). We are currently exploring ways to include families in our evaluation strategies not only to provide us with feedback but also to provide input into the questions we ask, methodologies we use and the interpretation of results.

By looking at each population domain within Title V and incorporating family-driven and data informed decisions, Virginia is not only “meeting” families where they are in addressing their needs but also including strategies that families prioritize.

Family & Community Health Across The State (Family Driven-Data Informed, Regions) and Quality Health Care Services

The Title V leadership in Virginia achieves success through our collaborations and partnerships to improve the health of the MCH populations. Sometimes we are the conveners for projects (e.g., Medical Neighborhood, MIECHV Home Visiting, Newborn Screening), and at other times, Title V Leadership is an engaged participant (e.g., CHIP, Early Childhood Care and Development). The largest MCH effort that has begun in Virginia is the Virginia Neonatal Perinatal Collaborative (VNPC). The Maternal Infant Health Coordinator is one of five leaders in MCH who came together in the form of a Steering Committee to launch this large complex initiative. Other members of the Title V team are also engaged in some of the committee work as well.

Family engagement is a priority in Virginia. The CYSHCN program has embraced the *National Consensus Standards for Systems of Care for Children and Youth with Special Healthcare Needs* and is implementing

elements including family leadership in the CYSHCN program (as well as overall Title V). In addition, the CYSHCN program is actively looking for unique new roles for family members to extend beyond advising the program to strategic planning, partnering for grant development and workforce development.

The Virginia Title V staff is dedicated to identifying and implementing evidence-based practices. Interestingly, some of the MCH programs in Virginia have been “home grown” and were developed many years ago when evidence-based programs were not available. For example, approximately 30 years ago, Resource Mothers program was developed. Several of our localities identified the need for greater support services for teen mothers. There were no teen focused maternal health programs nor were there wrap around care coordination programs for young mothers. In response to that need, the Title V staff developed Resource Mothers, a mentoring and peer support program for pregnant teens and their babies. This program utilized community health workers and matched a young mother to a community health worker who would support the mother, identify educational opportunities and work with the young mother to achieve educational vocational and employment goals. The program is still going and now we are adopting a new evidence-based curricula to use with the young mothers in order to continue to support the mothers and also achieve even better health and social outcomes for both mother and baby. Our MIECHV and Loving Steps home visiting programs are utilizing evidence-based home visiting programs and have strong evaluation components to assure success.

The MCH effort in Virginia touches on the three main functions of Public health: assessment, assurance and policy development. The MCH Epi team is partially funded by Title V and provides programmatic evaluation, survey and surveillance support to each Title V program. In addition, data “dashboards” are being developed and are available on the VDH websites for families, community partners, state agencies, healthcare providers and community members to use to inform their programs and decision-making. Title V also funds services in the local health districts and supplements other locality efforts such as education and outreach for the MCH populations. While our clinical services are small, the local health districts do provide some safety net services in prenatal care and provide many referrals for women’s services and child health. The MCH policy development area has been very active over the last few years in Virginia. While there are no advocacy activities, all Title V staff are involved in providing relevant research findings, data and evidence-based practices to inform our General Assembly each winter.

III.E.2.b. Supportive Administrative Systems and Processes

III.E.2.b.i. MCH Workforce Development

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

Current Capacity of Workforce

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

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

MCH Workforce Needs

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

Title V-Funded Workforce Development Efforts

Title V funds are invested in retaining a qualified Title V program staff and providing access to training and growth opportunities for families and external partners.

Funds help to sustain a skilled MCH workforce in Virginia by providing training to staff within the state health department (e.g. program coordinators, epidemiology and evaluation staff, administrative staff) and within local health districts (e.g. public health nurses, home visitors).

Funds are also allocated to conducting a variety of workforce development activities for families and other Title V partners outside of VDH (e.g. physicians, school nurses, oral health staff, care coordinators at contract CSHCN centers).

Examples of key workforce development activities completed in FY17 and planned in FY19 include:

Oral Health

In FY17, 160 dental providers participated in VDH-sponsored continuing education courses regarding the oral health care of ISHCN, young children, and/or perinatal/pregnant women. In addition, the ISHCN program coordinator provided various oral health education courses regarding care of ISHCN and young children attended by 219 lay health workers/home visitors/family educators, 49 medical professionals, and 106 Head Start staff members.

Unintended Pregnancy

In FY19, VDH proposes to train all Resource Mothers staff in the evidence-based teen pregnancy prevention program AIM4TM. This training will give Community Health Workers the skills to empower teens with the knowledge to prevent unintended pregnancies while being sensitive to the specific needs of teen parents. Incorporating AIM4TM into Resource Mothers, a program that has been implemented by Community Health Workers in Virginia for several decades, offers Community Health Workers the opportunity to make a positive impact on teen parents and their families.

Child/Adolescent Injury

The VDH Injury and Violence Prevention Program works to increase the number of stakeholders who employ best and promising practices for reducing injury related deaths, injuries, and hospitalizations. Stakeholders are provided technical assistance in the 9 American Public Health Association Injury Prevention Core Competencies. In addition, Virginia is working to implement a sustainable model for delivering ongoing education to the primary and specialty prescribers in a Project ECHO© Neonatal Abstinence Syndrome Case Management Learning Lab series. Using simple videoconferencing technology, Medicaid prescribers connect to a community of learners with free continuing education credit, opportunity to present actual present actual patient cases, in a de-identified format, and receive specialty input from a panel of experts.

CSHCN Unit

In FY17, the CYSHCN program focused on the following workforce development activities:

- A contract was executed with UVA to create medical home and transition modules. These modules will be available online for practitioners for free in the state of Virginia with the goal of increasing knowledge and promotion of the importance of these two MCH priorities;
- MCH leadership is working with Medicaid Managed Care Organizations to explore the possibility of entering into contractual agreements to help pay for care coordination services provided by the CYSHCN program to Medicaid recipients. Staff are presently working very closely with one particular MCO to execute a business associate agreement and contract. Once completed and if it is successful, the process of collecting reimbursement will be piloted in one region with the hopes of duplicating it statewide and with multiple MCOs;
- The CYSHCN program held the first ever statewide CYSHCN Meeting and invited program staff from the CCC, CDC, Bleeding Disorders, and Sickle Cell Program. The purpose of the meeting was to share program specific data and to encourage greater collaboration among programs. The Virginia Department of Education and our family partner from the Partnership for People with Disabilities spoke at the event;
- In January of 2018, the last health department run CCC center in Southwest Virginia transitioned to management by a private contractor. The University of Virginia now manages the center and will continue the clinical work it does in the region with the desire to possibly expand telemedicine and other clinical services for CYSHCN;
- The CYSHCN program shared the LEND module that was created on early identification of autism to the CCCs and CDCs;
- Care coordinators with the CCCs were encouraged to maintain or to become certified case managers with assistance from Title V to pay for the training costs;
- The Southwest Virginia CCC staff took the SEEK model training and SEEK was presented at one of the

regularly held CCC directors meeting. The CCC in the Tidewater region is working on getting staff trained in SEEK and promoting SEEK among providers in the health system;

- UVA published several articles in professional journals related to the evaluation of the CDC that they did for the CYSHCN program in 2016.

III.E.2.b.ii. Family Partnership

In FY19, CYSHCN program leadership will continue several strong family support partnerships on behalf of VDH. Staff will serve on the Virginia Department of Education Family Engagement Network (FEN), attend the FEN statewide conference, and rely heavily on the long standing partnership with Virginia Commonwealth University's, Partnership for People with Disabilities (PPD). PPD houses Family 2 Family and the VA LEND Program. Staff from PPD will continue to serve as trusted advisors to help the CYSHCN program move several initiatives forward. Examples include the development of the medical home and transition modules and implementation of a statewide parent survey of the CCC program.

The CCC program will continue to employ parent coordinators as staff to actively engage families to offer resources and support. In addition to providing general support, parent coordinators in various regions across the Commonwealth will work to:

- Maintain center resource lists;
- Create newsletters;
- Lead educational activities and trainings; and
- Support families to overcome barriers to care.

The CCC program also plans to conduct a very extensive parent survey to obtain data regarding patient satisfaction. The survey will focus on some of the key overall system outcomes for CYSHCN. The data will be used to highlight what the program is doing well and to identify areas for growth.

The CDCs will provide assessments of children suspected of having developmental and/or behavioral conditions and families will be an active part of each evaluation. Parents will receive a report that details the results of the assessment their child received and the diagnosis will be explained to them in detail. Center staff members will refer families to clinical and non-clinical resources for assistance and share the report with other providers as approved by each family.

The VBDP program manager will continue to work with the Virginia Hemophilia Foundation to educate families regarding emergency department, emergency medical services, and dental services. Nursing staff will help families learn how to self-infuse at home and social work staff will continue to support families regarding keeping or obtaining adequate insurance. Patient Services Incorporated will maintain its partnership with VDH to provide extensive insurance case management support for families who need insurance premium assistance.

All sickle cell centers will provide education and genetic counseling to families at their initial clinical visit. Families will be educated on inheritance patterns and the potential for having additional children with sickle cell disease. Patients of childbearing age will receive the same education and will be encouraged to know the trait status of partners for family planning. Center social workers will address issues of family support, health insurance, and other factors by conducting psychosocial assessments.

III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts

The Virginia Department of Health (VDH) has received SSDI funding for nearly fifteen years and received funding for the new five-year period beginning FY2018. During that time, the state has made significant improvements in MCH surveillance capacity, enhancing the ability of the Virginia's Title V Maternal and Child Health (MCH) programming to have timely access to relevant data in order to allow for informed decision-making and resource allocation. The Virginia SSDI has linked several datasets to facilitate cross program data analysis. Data are used to evaluate programs, for surveillance of public health trends, and for program and policy decision making. The Virginia SSDI program recognizes the importance of availability and accuracy of data to support all Virginia MCH programs, including the Title V MCH Block Grant. Virginia has adopted the federally required Tier 2 goals:

1. Build and expand state MCH data capacity to support the Title V MCH Block Grant program activities and contribute to data-driven decision making in MCH programs, including assessment, planning, implementation, and evaluation;
2. Advance the development and utilization of linked information systems between key MCH datasets in the state; and
3. Provide data support to states participating in quality improvement activities (Virginia Infant Mortality Collaborative Improvement and Innovation Network and the Virginia Neonatal Perinatal Collaborative)

The MCH data capacity of the Office of Family Health Services (OFHS) has made substantial progress in meeting its Data, Information, and Knowledge needs greatly due to SSDI funding support. The OFHS Data Mart provides access to timely, cleaned, and standardized data. Multiple linked datasets are also accessible through the Data Mart. MCH indicators, including Title V MCH Block Grant indicators based on Vital Records and other data available in the OFHS Data Mart, are available to OFHS staff.

OFHS Data Mart (Data Access). The Virginia SSDI team continues to invest in the maintenance and expansion of the OFHS Data Mart, a linkage to the VDH Office of Information Management (OIM) Data Warehouse, to ensure continued access to complete statistical data files of birth, death, fetal death, linked birth-infant death, and intentional terminations of pregnancy data. The Oracle-based server allows OFHS epidemiology staff to access timely, cleaned, and standardized Vital Records data. The Virginia SSDI team continues to renegotiate and renew an office-wide Memoranda of Agreement (MOA) between the VDH Office of Vital Records & Health Statistics and VDH OFHS annually. Additionally, the Virginia SSDI team annually renews a MOA with the VDH OIM to continue supporting the OFHS in data access efforts. A complete list of datasets, years available, and frequency of updates is in Table 1.

Table 1. OFHS Data Availability, May 2018.

Dataset	Years Available	Updated
Behavioral Risk Factor Surveillance System (BRFSS)	1989-2016	Annually
Birth Certificate	1960-2017	Weekly
Birth Defects Registry	1985-2017	Monthly
Death Certificate	1990-2017	Bi-monthly
Early Hearing Detection and Intervention	2002-2017	Monthly
Fetal Death	1990-2017	Bi-monthly
Intentional Termination of Pregnancy (ITOP)	1990-2017	Annually
Linked Birth-Infant Death	1990-2016	Annually
National Center for Health Statistics (NCHS) Bridged Race Population Estimates	1990-2017	Annually
Newborn Screening	2004-2016	Monthly
Pregnancy Risk Assessment Monitoring System (PRAMS)	2007-2015	Annually
Virginia Hospital Information (VHI) Inpatient Hospital Discharge	1996-2017	Quarterly
Virginia Youth Survey Data (YRBS)	2009, 11, 13, 15	Biennially
WIC	2002-2016	Annually

By storing multiple years of key datasets in a central location, OFHS has greatly improved efficiency. Data loading, cleaning, and standardization are no longer repeated by staff in different divisions. Trend data are much easier to compute now that all years of data are in a single table. The client-server architecture allows users to leverage the power of a server with the ease of use of familiar front-end client software (e.g., SAS or Microsoft Access). Timeliness, accuracy, and replicability of data have also substantially improved.

Data Linkage. Data linkage continues to be a major focus of the Virginia SSDI project. Birth and infant death data are linked by the Division of Vital Records annually and are also in the OFHS Data Mart. Linkage of birth data to WIC eligibility, Medicaid eligibility, and newborn screening data was also established for the first time in Virginia by SSDI staff. Staff has also developed sophisticated data standardization and data linkage protocols based on a combination of deterministic and probabilistic methods using SAS and Microsoft Office. The following tables depict birth linkages to datasets (Table 2) and level of access to datasets (Table 3).

Table 2. OFHS Linked Datasets, May 2018.

Dataset	Years Available
Maternally linked pregnancy history data (fetal deaths and live births linked)	1990-2016
PRAMS survey data (linked to births)	2007-2015 weighted data
WIC – births	2000-2016
Medicaid eligibility – births	2008-2016
Birth defects data – births	2002-2016 birth years
Hearing screening data – births	2002-2016 birth years
Newborn screening – births	2004-2016
Geocoded births and deaths	1990-2015

Table 3. Level of Access

Dataset	Level of Access
Vital Records Birth	4
Vital Records Death	4
Medicaid	3
WIC	3
Newborn Bloodspot Screening	4
Newborn Hearing Screening	4
Hospital Discharge Data	4
Birth Defects Surveillance Database	4
Immunization	3
PRAMS or PRAMS-like Data	4
Vital Records Birth Linked with Vital Records Death	4
Vital Records Birth Linked with Medicaid	2
Vital Records Birth Linked with WIC	4
Vital Records Birth Linked with Newborn Bloodspot Screening	4
Vital Records Birth Linked with Newborn Hearing Screening	4
Vital Records Birth Linked with Hospital Discharge Data	1
Vital Records Birth Linked with Birth Defects Surveillance Database	4
Vital Records Birth Linked with Immunization	3

1 = No Access, Legislatively Prohibited 3 = Access through Portal or Application
2 = No Access, Working to Gain Access 4 = Direct Access to All Data Elements

The Virginia SSDI team currently has the data capacity to report on 23 of the 24 data elements that compose the Minimum/National Dataset (M/NDS), 7 of the 8 data elements that compose the Core/National Dataset (C/NDS), and all 13 data elements that compose the Core/State Dataset (C/SDS). The two data elements of the Minimum and Core Datasets that the Virginia SSDI team is not currently collecting include:

M/NDS
- Access to Health Insurance (Percentage of children/adolescents who have access to a health insurance)

C/NDS
- Access to Medical Home (Percentage of children/adolescents who have access to a medical home)

The Virginia SSDI team is reinitiating conversations with the Department of Medical Assistance Services (DMAS) to acquire access to Medicaid claim data through an MOA. The Virginia SSDI is able to access information through

the Virginia Immunization Information System (VIIS) and the All Payers Claim Database (APCD). The VIIS provides a statewide, reliable Immunization Information System. The APCD is managed by the Virginia Health Information organization and provides statewide payer data from the 10 major health insurance companies. Both the VIIS and the APCD are accessible by portal or application.

Data Dissemination. The Virginia SSDI released to the public a series of Maternal and Child Health indicators over 10 years at the locality level through a Tableau dashboard. This demonstrated a huge step in getting MCH data into local health department and public hands. The program used 2006-2015 vital statistics data, 2011-2015 BRFSS, and other data sources, calculated MCH indicators, and created a Tableau Dashboard that can be found at http://www.vdh.virginia.gov/data/maternal-child-health/. A strategy is in development for making PRAMS data available on the portal as well. MCH indicators include total births, preterm birth, low birth weight, late or no prenatal care, maternal smoking during pregnancy, infant deaths, and teen pregnancy. The dashboards are used by health districts in the community health assessment (CHA) process and by the public and academia for general direction.

MCH Data Infrastructure

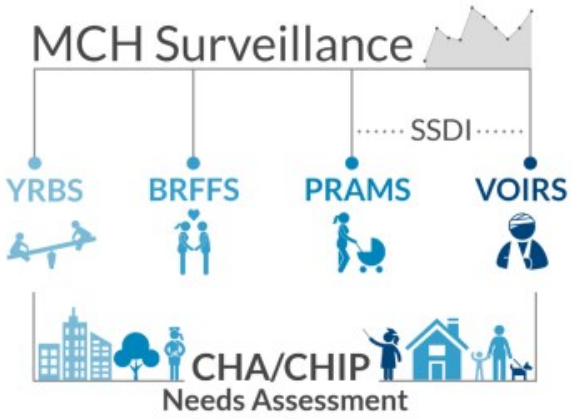
The OFHS Division of Population Health Data (DPHD) provides employees with a peer group for cross-training and problem solving, as well as opportunities for career advancement and emphasis on learning. The keys to achieving SSDI/MCH data goals and objectives fits within this vision through the existence of a centralized MCH epidemiology unit and by leveraging data systems and other resources.

Centralized Epidemiology Unit. The DPHD leads surveillance, analysis, evaluation, and policy review within OFHS. Staff are organized by role classification and subject matter. The MCH Epidemiology Unit consists of an MCH Epidemiology Lead & Supervisor, a Perinatal Epidemiologist, a Newborn Screening Epidemiologist, and two program evaluators. The MCH Epidemiology Lead & Supervisor/SSDI Project Director directly oversees data and information efforts related to maternal and child health, while supporting the Title V MCH Block grant and programs, including the Maternal and Infant Health Program and the Children and Youth with Special Health Care Needs Program. The Perinatal Epidemiologist supports the Title X Family Planning services, the Pregnancy Risk Assessment Monitoring System (PRAMS), and other perinatal and women's health initiatives. The Newborn Screening Epidemiologist supports the Early Hearing Detection and Intervention Program and Newborn Genetic Screening Program. Program evaluators within the unit support MCH programs regarding home-visiting, child and adolescent health, and support needs assessment activities.

Leveraging data systems and other resources. The Office of Information Management at the Virginia Department of Health maintains a Data Warehouse, which coordinates much of the basic data loading and cleaning functions formerly performed by SSDI project staff in the OFHS Data Mart. As datasets shift to the Data Warehouse, more time is available to SSDI staff to focus on the knowledge and action portions of the public health assessment process.

The peer group style of the DPHD allows the MCH Epidemiology Unit to cross-collaborate with data systems that are managed within the division, including the Youth Risk Behavior Survey (YRBS), the Behavioral Risk Surveillance System (BRFSS), the Virginia Online Injury Reporting System (VOIRS) and Opioid Addiction Dashboards, and PRAMS. The YRBS includes oversampling for eight localities, providing local level data. The BRFSS will continue to collect the adverse childhood experiences (ACE) module and is currently administering the full family planning module. PRAMS has begun oversampling for two Virginia health districts. VOIRS is a query/table builder on the VDH

external website for injury hospitalization and death. The Opioid Addiction dashboard is updated quarterly and includes information for neonatal abstinence syndrome (NAS). All of these surveillance sources are used to inform Community Health Assessments, Health Improvement profiles, and other needs assessment activities.



Students, interns, and fellows are another resource that SSDI project staff utilize. Summer internships by MPH students from local universities and the MCHB Graduate Student Internship Program (GSIP) have helped OFHS move from the “information” to “knowledge” portion of the public health assessment process by completing thoughtful projects addressing key topics current staff did not have time to explore in detail. MPH students from Virginia Commonwealth University’s Public Health Practice track are able to spend an entire semester on a capstone experience that could also lead to policy or program actions. CSTE Applied Epidemiology Fellows are placed for 2 years and help to support the MCH epidemiology effort in Virginia. CSTE Fellows have been sought out to assist particularly with the knowledge to action and evaluation portions of the public health assessment process.

III.E.2.b.iv. Health Care Delivery System

The MCH program works very closely with the Virginia Medicaid program in several areas including planning, monitoring, and program support. The MCH Division at the Virginia Department of Medical Assistance Services (DMAS) works closely with the Title V team on planning programs. At the same time, the Title V team invited the DMAS MCH team to participate in all program planning activities particularly for prenatal care and CYSHCN programs.

DMAS staff have been included in discussions regarding reimbursement for the expansion of our Home Visiting programs in the local health districts with particular emphasis on the BabyCare program (a Virginia Medicaid Reimbursement schedule for prenatal care), which enrolls women as early as possible in their pregnancy and follows the woman and infant through the baby's second birthday. Staff provide education, support, and home visits. DMAS also continues to be a key partner in the Medical Neighborhood initiative, which is an effort to improve the coordinated care for CYSHCN and their families through care coordination and support (see CSHCN application and annual report for details).

In 2017, the MCH Title V Director was invited to be a member of the proposal review team to select the MCOs for the state Medallion 4 Medicaid awards. The MCH Title V Director serves as a voting member of the Children's Health Insurance Advisory Committee and participates in subcommittees and activities. This group regularly reviews health statistics and DMAS program data and advises on service and program improvements. This group also provides background information and research regarding child health policy within DMAS as well as state code.

Finally, regarding direct service, the prenatal care provided in the local health districts is reimbursed by Medicaid for eligible patients as is the BabyCare program. The state Title V program are actively working with DMAS to determine best strategies moving forward to cover the cost of the care coordination provided by our Care Connection with Children program. The CYSHCN Director has met with the DMAS MCOs and attended several meetings to explore opportunities. The CYSHCN Director works directly with leaders in DMAS regarding waivers and healthcare delivery for CYSHCN particularly as changes are occurring at the state and federal levels affecting the coverage for the MCH populations. The MOU with DMAS attached to this application provides more information on the breadth of VDH-DMAS partnerships.

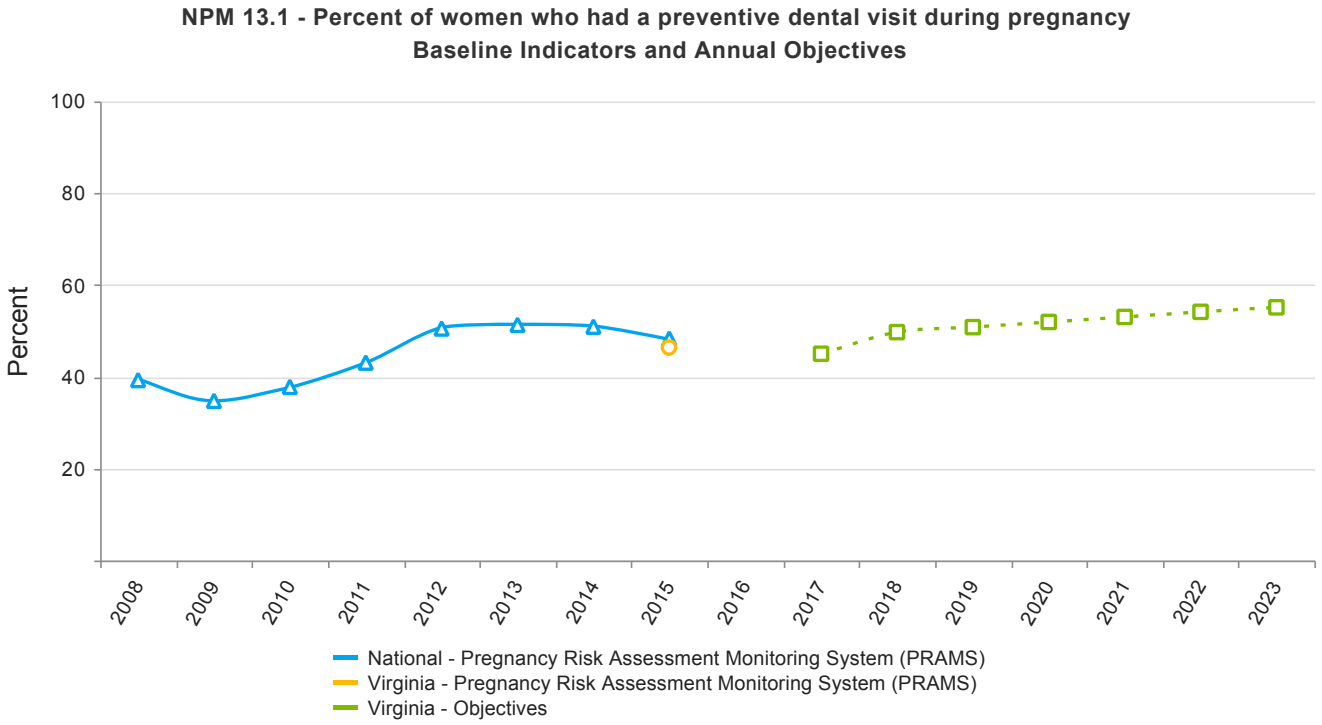
III.E.2.c State Action Plan Narrative by Domain

Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2016	9.9 %	NPM 13.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	92.9 %	NPM 13.1

National Performance Measures



Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2017
Annual Objective	45
Annual Indicator	46.5
Numerator	44,225
Denominator	95,088
Data Source	PRAMS
Data Source Year	2015

State Provided Data		
	2016	2017
Annual Objective		45
Annual Indicator	43.6	
Numerator		
Denominator		
Data Source	PRAMS	
Data Source Year	2010-2011	
Provisional or Final ?	Provisional	

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	49.7	50.8	51.9	53.0	54.1	55.1

Evidence-Based or –Informed Strategy Measures

ESM 13.1.1 - Completion of action plan identifying strategies and partners for addressing top 3 MCH population oral health needs in Virginia

Measure Status:	Inactive - Completed

State Provided Data	
	2017
Annual Objective	No
Annual Indicator	Yes
Numerator	
Denominator	
Data Source	Dental Staff program data
Data Source Year	2017
Provisional or Final ?	Final

ESM 13.1.2 - Number of Regional Oral Health Alliances that implemented work plans to increase dental visits among pregnant women

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	6.0	6.0	6.0	6.0	6.0

State Performance Measures

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

Measure Status:	Active

State Provided Data	
	2017
Annual Objective	2.6
Annual Indicator	31
Numerator	
Denominator	
Data Source	VA PRAMS
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	33.3	34.1	34.9	35.7	36.4	37.2

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

Measure Status:	Inactive - Due to a shift in VDH Title V priorities and initiatives, including agency programs outside of Title V funding that are taking on this priority.

State Provided Data	
	2017
Annual Objective	
Annual Indicator	7.1
Numerator	447
Denominator	6,338
Data Source	VDH - Maternal/Infant-Health Stats/Pop Health Data
Data Source Year	2016
Provisional or Final ?	Provisional

State Outcome Measures

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

Measure Status:	Inactive - Due to a shift in VDH Title V priorities and initiatives, including agency programs outside of Title V funding that are taking on this priority.

State Provided Data		
	2016	2017
Annual Objective		80
Annual Indicator	79.2	70.9
Numerator		
Denominator		
Data Source	PRAMS	PRAMS
Data Source Year	2014	2015
Provisional or Final ?	Final	Final

SOM 4 - Unintended Pregnancy: Percent of unintended pregnancy among all women of child-bearing age

Measure Status:	Inactive - Unintended pregnancy efforts will be linked to only SPM; unable to link both SOM and SPM within state action plan.

State Provided Data	
	2017
Annual Objective	40
Annual Indicator	49.5
Numerator	
Denominator	
Data Source	PRAMS
Data Source Year	2015
Provisional or Final ?	Final

State Action Plan Table

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

Priority Need

Oral Health: Increase access to oral health services for pregnant women and children.

NPM

NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy

Objectives

By June 30, 2020, increase the percent of women who had a dental visit during pregnancy from 46.5% (PRAMS 2015) to 51.9%.

Strategies

Provide preventive dental services for pregnant women.

Foster network of 6 regional Oral Health Alliances to conduct regional needs assessments and implement systems change and data-sharing initiatives to improve the oral health of all Virginians, with emphasis on pregnant women and children 1-17.

ESMs	Status
ESM 13.1.1 - Completion of action plan identifying strategies and partners for addressing top 3 MCH population oral health needs in Virginia	Inactive
ESM 13.1.2 - Number of Regional Oral Health Alliances that implemented work plans to increase dental visits among pregnant women	Active

NOMs

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

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

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

Priority Need

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

SPM

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

Objectives

By June 30, 2020, reduce the rate of unintended pregnancies for all women of child-bearing age (ages 15-44) from 49.5% (PRAMS 2016) to 47%.

Strategies

Provide staff support and technical assistance to 17 LHDs to reduce the rate of unintended pregnancy.

Work with community stakeholders to remove policy, financial, and training barriers to LARC utilization.

Strategies within the FY17 Women's/Maternal Health workplan were implemented by the Division of Child and Family Health's Maternal and Infant Health (MIH) Unit and the Division of Prevention and Health Promotion's Injury and Violence Prevention Program (IVPP). Complementary efforts were implemented by Office of the Chief Medical Examiner and the Virginia Neonatal Perinatal Collaborative. Activities completed during the reporting period are detailed below.

NPM 2: Low-Risk Cesarean Delivery

Strategies and related evidence-based/informed strategy measures proposed in the FY17 workplan included:

- *Strategy 1: Partner with the American College of Obstetricians and Gynecologists (ACOG), Virginia Hospital and Healthcare Association (VHHA), and March of Dimes (MOD) to adopt best practices and provide education to labor and delivery hospitals and obstetrics providers.*
- *Strategy 2: Partner with insurance companies and the Virginia Department of Medical Assistance Services (DMAS) to reduce low-risk cesarean deliveries by implementing policies that withhold reimbursement to providers who allow non-medically necessary low-risk cesarean delivery.*
- *ESM 2.1 - Proportion of birthing hospitals who have adopted a policy to reduce low risk cesarean deliveries*

Through partnerships with VHHA and MOD, the Commonwealth was successful in reducing early elective delivery (EED) to a rate below 2%, which is a national goal. Through quarterly submission of data to VHHA for surveillance, policy changes, and education, Virginia was able to significantly reduce the rate of EED. This was accomplished in partnership with VHHA, MOD, and the Virginia chapter of ACOG. Additional work surrounding low-risk cesarean delivery has been slow as education is still needed on the differences between EED and low-risk cesarean delivery among providers and public health stakeholders. Lack of a shared understanding of differences in definitions and drivers of EED and low-risk cesarean delivery was a challenge. Education and training to clarify that these terms aren't interchangeable is still needed to address these priorities and implement best practices specific to low-risk cesarean delivery.

The first ESM created under NPM 2 proposed to track birthing hospital policies on low-risk cesarean deliveries (ESM 2.1); for the FY18 application, a second ESM was proposed to track completion of a report identifying hospitals for focused EED reduction and ongoing quality improvement interventions (ESM 2.2). However, successes in reducing EED rates and the emergence of the VNPC led to a shift in state priorities and removal of NPM 2 from the state workplan the end of FY17.

Virginia became an Alliance for Innovation on Maternal Health (AIM) state in 2017. The VNPC's Maternal Hemorrhage Workgroup is currently implementing the Maternal Hemorrhage patient safety bundle. Virginia has been also selected as a pilot state to roll-out the Obstetric Care for Women with Opioid Use Disorder (OUD) patient safety bundle under the Maternal OUD workgroup. The VNPC's Improving Perinatal Outcomes Advisory Committee is devoted to identifying key problems in obstetric care and outcomes, designing quality improvement projects to address these problems, supervising implementation of projects, and then summarizing and reporting on project data, with primary cesarean being one of the key areas of interest.

More details on the VNPC can be found within the *Other Programmatic Activities* section below.

SPM: Maternal Mental Health

Strategies and the related state performance measure proposed in the FY17 workplan included:

- *Strategy 1: Partner with ACOG and the Association of Women's Health, Obstetric and Neonatal Nurses (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.*
- *Strategy 2: 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.*
- *Strategy 3: Develop a training module for health care providers to educate on best practices for mental health services of pregnant/postpartum women.*
- *SPM - Proportion of women who attend a postpartum visit with a health care worker within 6 weeks after getting birth*

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. 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. But recognizing that according to PRAMS in 2014, only 42% of women reported attending a post-partum visit, looking at other avenues to have women screened is essential. In partnership with Medicaid, moms can be screened at baby's well-baby visit through their second birthday and the provider can be reimbursed by Medicaid for the screening. While there is still much work to be done with maternal mental health, the majority of this work will be in partnership with the VNPC moving forward as they are in the process of adding a Maternal Mental Health Workgroup to address this more globally across the state, across disciplines, and across systems.

Other Programmatic Activities

Office of the Chief Medical Examiner

Maternal mortality review is co-led by VDH Office of the Chief Medical Examiner (OCME) and the Office of Family Health Services. Letters to members are co-signed by Dr. Melanie Rouse and Dr. Vanessa Walker Harris.

OCME also leads the state's child fatality review team.

Title V funds contribute to OCME staffing support for both maternal and child fatality review. In addition, Title V-funded and non-Title V-funded OFHS staff serve on both review teams.

Virginia Neonatal Perinatal Collaborative

As detailed in the FY18/16 application and annual report, the Virginia Neonatal Perinatal Collaborative (VNPC) exists to ensure that every mother has the best possible perinatal care and every infant cared for in Virginia has the best possible start to life. The VNPC believes in an evidence-based, data-driven collaborative process that involves care providers for women, infants and families as well as state and local leaders. The VNPC believes that working together now will create a stronger, healthier Virginia in the future.

The goals of the VNPC are:

- To provide assistance to hospitals and obstetric providers in performing quality improvement initiatives designed to improve pregnancy outcomes, including decreasing the preterm birth rate to Healthy People 2030 Goals and to decrease maternal mortality by 50%;
- To enhance the quality of state-wide perinatal data and to provide hospital-specific data back to participating hospitals promptly so as to accomplish quality improvement goals;
- To provide assistance to hospitals and newborn care providers in performing quality improvement initiatives designed to improve neonatal outcomes, including decreasing morbidity and mortality as well as decreasing length of stay;
- To inform and involve the community, including health care providers, nurses, ancillary medical staff, payers, hospital administrators, and, most importantly, patients in efforts to make Virginia the safest and best place to deliver babies; and
- To narrow the racial and ethnic disparities with the achievement of health equity in pregnancy and neonatal outcomes.

The VNPC is led by:

- Chair: Donald Dudley, M.D., William T. Moore Professor and Director, Division of Maternal-Fetal Medicine at University of Virginia
- Co-Chair: Joseph El Khoury, M.D., Asst. Professor of Pediatrics, Medical Director, Neonatal Transport Team, Virginia Commonwealth University
- VHHA representative: Joan Williamson RN, MN, CPHQ, CPPS
- March of Dimes representative: Marie Pokraka MSN, RN, IBCLC
- Virginia Department of Health representative: Shannon Pursell, MPH
- National Association of Neonatal Nurse Practitioners representative: Barbara Snapp, DNP, NNP-BC

In addition, the VNPC's Executive Leadership Committee includes a member/representative from each of these professional organizations: Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), American College of Nurse-Midwives (ACNM), American Congress of Obstetricians and Gynecologists (ACOG), American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP), Managed Care Organization (MCO), Insurance Company, Department of Medical Assistance Services (DMAS), Office of Secretary of Health and Human Resources (OSHHR), and a Family Representative.

In FY17, the MIH Coordinator supported VNPC infrastructure development. The VNPC was formally launched in June 2017 to help improve pregnancy and birth outcomes by advancing evidence-based clinical best practices to enhance the quality of care provided to pregnant women and infants. This joint initiative is a result of cooperation from several leading health care organizations, clinicians, and stakeholders. In October 2017, the MIH Coordinator supported coordination of the first statewide meeting of the VNPC, which brought together obstetric, neonatal, and other practitioners as well as members of the health care community, state agencies and stakeholders with a focus on improving maternal and infant health outcomes. The meeting drew close to 250 attendees, including representation from eight local health departments.

Once formed, input from VNPC stakeholders was leveraged to prioritize five initial projects. The collaborative will employ evidence-based strategies and quality improvement bundles from the Vermont Oxford Network for NAS and Antibiotic Stewardship in the NICU and from AIM on Obstetric Hemorrhage and Maternal Opioid Use Disorder. In collaboration with MOD, the VNPC will also work to identify and reduce barriers related to administering 17P.

These five projects have not been included in the FY19 Title V state action plan, as ownership will remain with the VNPC; however, Virginia will continue to report annually on the VNPC as a key effort supported by the Title V-funded

MIH Coordinator.

Injury and Violence Prevention Program

Prevention of opioid poisonings as a result of misuse, overuse, and abuse continues to be a growing focus throughout Virginia. There are several drivers to this public health issue, which continue to escalate this epidemic, including the problematic practice of opioid case management, prescribing, and dispensing among healthcare providers.

In FY17, the IVPP used Centers for Disease Control and Prevention (CDC) Prescription Drug Overdose Prevention for States grant funding to partner with the Virginia Department of Medical Assistance Services (DMAS) to host a series of 31 statewide healthcare provider trainings utilizing the Providers Clinical Support System for Medication Assisted Treatment (PCSS-MAT). Content also included Virginia specific education for current and potential Virginia Medicaid members. These trainings increased the number of physicians who are knowledgeable about and qualified to prescribe buprenorphine to their patients with opioid use disorder. After completing the trainings, eligible providers received continuing medical education units and were eligible for their DEA waiver. Over 1,000 broad-spectrum healthcare providers received education during the training sessions.

Women/Maternal Health - Application Year

The Office of Family Health Services administers a number of programs and initiatives serving women and infants. Leadership of Title V-funded efforts for women's and maternal health is shared by the Division of Child and Family Health's Reproductive Health Unit and Maternal and Infant Health Unit and the Division of Prevention and Health Promotion's Dental Health Program. These entities and their proposed activities for the upcoming grant period are detailed below.

Reproductive Health Unit

The Division of Child and Family Health's Reproductive Health Unit is led by Emily Yeatts, MSW, MPH (Reproductive Health Unit Supervisor). The unit includes the following programs:

- Title X Family Planning (Title X): Clinical family planning programs consistent with Title X requirements and Quality Family Planning Services as defined by the CDC;
- Adolescent Health (Abstinence Education Grant, Title V): Positive youth development programs that build protective factors among participants that will make them less likely to initiate sexual activity; and
- Resource Mothers (TANF, Title V): Adolescent health program providing support services to pregnant and parenting teens and their families.

Maternal & Infant Health Unit

The Division of Child and Family Health's Maternal and Infant Health Unit is led by Shannon Pursell, MPH (Maternal and Infant Health Coordinator).

The unit has a hub-and-spoke structure consisting of a subject matter expert housed within VDH's Central Office who works closely with staff at 35 local health districts (LHDs), the Virginia Neonatal Perinatal Collaborative (VNPC), the Maternal Mortality Review team, and an array of state and local community partners. Current Title V priorities for maternal and infant health include access to prenatal care, tobacco cessation for pregnant women, and addressing the opioid crisis for MCH populations.

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

Dental Health Program

The Division of Prevention and Health Promotion's Dental Health Unit is led by Tonya McRae Adiches, RDH (Dental Health Programs Manager). Non-MCH funds support preventive dental services for MCH populations.

The Dental Health Unit collaborates with Title V to:

- Foster regional alliances and implement local initiatives to improve access to dental care for children and pregnant women;
- Promote medical and dental integration in safety-net settings;
- Increase public awareness and engagement around oral health by disseminating data, research, and promising practices; and
- Support workforce development and training for medical and dental providers, lay professionals, home visitors, and caregivers serving individuals with special health care needs (ISHCN).

State Priority: Women's/Maternal Health
FY19 Performance Measure: SPM 4 – Unintended Pregnancy: Proportion of females ages 15-44 using Tier 1 (most effective) contraceptive methods

Objective: By June 30, 2020, reduce the rate of unintended pregnancies for all women of child-bearing age (ages 15-44) from 49.5% (PRAMS 2016) to 47%.

Strategy 1: Work with community stakeholders to remove policy, financial, and training barriers to LARC utilization.

The LARC Stakeholder Workgroup is a network of agencies working towards reducing unintended pregnancies among women of childbearing age and increasing access to quality comprehensive family planning services. This workgroup was developed to increase access to the moderately and most effective contraceptive methods, including immediate post-partum LARC (long acting reversible contraceptives). The workgroup works to remove policy barriers to LARC access in both inpatient and outpatient settings, facilitate provider trainings and operational support for programs offering LARCs, and support public education initiatives. The workgroup is facilitated by VDH, and group members include state agencies, Medicaid, private payers, hospital systems, nonprofit health centers, maternal and child health organizations, and individuals.

Current participating agencies are: ACOG, Aetna, Anthem, Carilion, DMAS, Inova, Kaiser Permanente, Office of the Governor, March of Dimes, Merck, Planned Parenthood Advocates of Virginia, Planned Parenthood South Atlantic, Sentara, UVA, Virginia Academy of Family Physicians, VAHP, VCU, and Virginia Premier (a large Virginia-based insurance carrier).

Activities proposed for the upcoming grant period include the following:

- Facilitate quarterly meetings.
- Develop, implement, and evaluate at least three initiatives designed to increase access to quality family planning services and that are responsive to community needs. Proposed initiatives include the following:
    - Coordinate at least one training for providers to increase knowledge and skills related to LARCs.
    - Provide feedback regarding a public education campaign to increase knowledge about LARCs.
    - Offer information to private payers regarding the benefits of unbundling delivery costs to allow for reimbursement of immediate postpartum LARCs.

All Workgroup activities will contribute to the overall goal to reduce unintended pregnancy rates among women of childbearing age and increase access to the most effective contraceptive methods, including LARCs.

Strategy 2: Provide staff support and technical assistance to 17 LHDs to reduce the rate of unintended pregnancy.

Unintended pregnancy is being addressed through Title X and Title V in the LHDs by supporting staff in the family planning clinics. Education and outreach to reach more women particularly in underserved communities is also conducted (e.g., health fairs, TA, community events). In addition, a pilot project to conduct education and training for providers with the goal of increasing overall access to LARCs is also being implemented.

Thirty-three LHDs receive Title X funds to support the provision of clinical family planning services. The Reproductive

Health Unit provides oversight of the Title X family planning program and provides continuous technical assistance in order to ensure that the program is meeting the needs of vulnerable populations.

State Priority: Oral Health
FY19 Performance Measure: NPM 13.1 - Percent of women who had a dental visit during pregnancy

OBJECTIVE: By June 30, 2020, increase the percent of women who had a dental visit during pregnancy from 46.5% (PRAMS 2015) to 51.9%.

Strategy 1: Provide preventive dental services for pregnant women.

The Virginia Oral Health Coalition (VaOHC) supports VDH by collaborating on various grant-funded initiatives, including convening a safety-net medical and dental learning collaborative. Through work with partners, MCH funds will allow 2 safety-net sites to thoroughly integrate medical and dental clinics with a focus on coordinated care for pregnant women that includes dental care during pregnancy. Integration results, best practices, and success stories will be used to develop communications to share with other safety-net sites to be used in their integration efforts.

In addition, with non-MCH funds, VDH will provide oral health risk assessments and screenings, fluoride varnish applications, oral health counseling, and dental referrals for pregnant women in various unconventional, non-dental settings.

Strategy 2: Foster network of 6 regional Oral Health Alliances to conduct regional needs assessments and implement systems change and data-sharing initiatives to improve the oral health of all Virginians, with emphasis on pregnant women and children 1-17.

VDH will partner with the VaOHC to provide backbone support and facilitative leadership training to 6 Regional Alliances (South Hampton Roads, Northern Virginia, Richmond/Petersburg, Southside, Central Virginia, and Southwest Virginia) to conduct regional oral health needs assessments, develop and implement regional project workplans, and share region-specific data among state and local partners. Staffs will also work together to develop and disseminate communications, to include 4 white papers addressing MCH populations.

This strategy is aligned with the following evidence-based strategy measure:

- ESM 13.2 - Number of Regional Oral Health Alliances that implemented work plans to increase dental visits among pregnant women

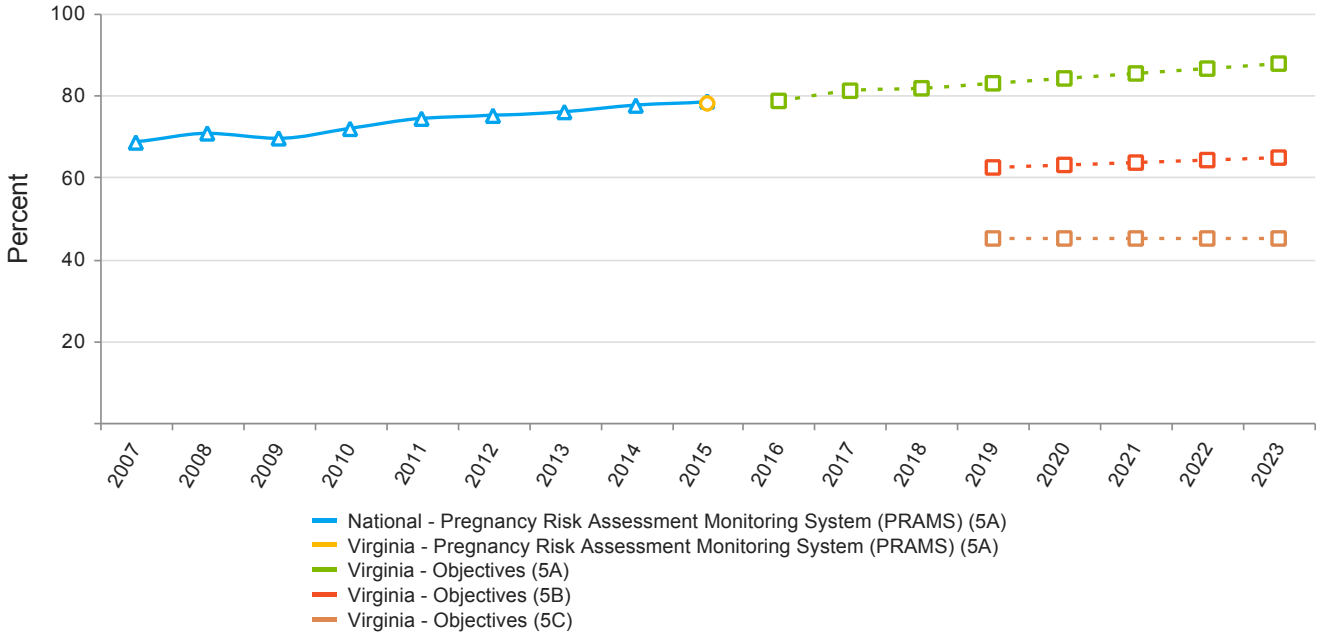
Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2015	5.9	NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2015	2.0	NPM 5
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2015	84.2	NPM 5

National Performance Measures

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding
Baseline Indicators and Annual Objectives



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

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2017
Annual Objective	81
Annual Indicator	78.0
Numerator	73,007
Denominator	93,567
Data Source	PRAMS
Data Source Year	2015

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	81.6	82.8	84.0	85.2	86.4	87.6

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

FAD for this measure is not available for the State.

State Provided Data	
	2017
Annual Objective	
Annual Indicator	59.9
Numerator	
Denominator	
Data Source	VA PRAMS
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	62.3	62.9	63.5	64.1	64.7

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

FAD for this measure is not available for the State.

State Provided Data	
	2017
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	VA PRAMS
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	45.0	45.0	45.0	45.0	45.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data	
	2017
Annual Objective	150
Annual Indicator	1,373
Numerator	
Denominator	
Data Source	VDH-OFHS Communications Specialist
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	200.0	250.0	300.0	350.0	400.0	450.0

ESM 5.3 - Number of individuals counseled/educated about Safe Sleep environments

Measure Status:	Active

State Provided Data	
	2017
Annual Objective	
Annual Indicator	9,924
Numerator	
Denominator	
Data Source	Maternal/Infant Health Program - LHD Reports
Data Source Year	2017
Provisional or Final ?	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	10,000.0	10,000.0	10,000.0	10,000.0	10,000.0	10,000.0

ESM 5.4 - Number of providers (home-visitors, doctors, nurses, health educators, etc.) educated about Safe Sleep environments and resources provided at www.safesleepva.com

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	500.0	500.0	500.0	500.0	500.0

ESM 5.5 - Interdisciplinary Workforce Development - Number of Local Health Departments (LHD) attending VDH technical assistance for safe sleep environment.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	35.0	35.0	35.0	35.0	35.0

ESM 5.6 - Interdisciplinary Workforce Development - Number of home visitors completing Early Impact Virginia training modules that discuss safe sleep environment.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	375.0	400.0	425.0	450.0	475.0

State Performance Measures

SPM 3 - Infant Mortality Disparity: Infant Mortality Disparity Ratio

Measure Status:	Inactive - Inactive - Due to shift in priorities and initiatives, including agency programs outside of Title V funding, this measure has been shifted to an SOM

State Provided Data		
	2016	2017
Annual Objective		1.6
Annual Indicator	2.1	2.3
Numerator	10.3	10.5
Denominator	4.9	4.5
Data Source	VDH - Division of Population Health Data	VDH - Division of Population Health Data
Data Source Year	2015	2016
Provisional or Final ?	Final	Provisional

State Outcome Measures

SOM 2 - Infant Mortality Disparity: Infant Mortality Rate

Measure Status:	Inactive - Due to a shift in VDH Title V priorities and initiatives, including agency programs outside of Title V funding that are taking on this priority.

State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	5.9	5.8
Numerator		
Denominator		
Data Source	NVSS-Linked Birth/Infant Death Records	Health Statistics, Population Health Data
Data Source Year	2015	2016
Provisional or Final ?	Final	Provisional

State Action Plan Table

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

Priority Need

Safe Sleep: Increase safe sleep practices for infants.

NPM

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Objectives

By June 30, 2020, increase (a) the percent of infants placed to sleep on their backs from 78% (PRAMS 2015) to 84% and (b) the percent of infants placed to sleep on a separate approved sleep surface from 59.9% (PRAMS 2015) to 62.9%.

Strategies

Provide staff support and technical assistance to 24 LHDs to promote safe sleep practices.

Provide staff support and training to home visitors on promotion of safe sleep practices.

ESMs	Status
ESM 5.1 - Proportion of partnering hospitals who have implemented a standardized safe sleep curriculum	Inactive
ESM 5.2 - Number of visits to the SafeSleepVA.com website	Active
ESM 5.3 - Number of individuals counseled/educated about Safe Sleep environments	Active
ESM 5.4 - Number of providers (home-visitors, doctors, nurses, health educators, etc.) educated about Safe Sleep environments and resources provided at www.safesleepva.com	Active
ESM 5.5 - Interdisciplinary Workforce Development - Number of Local Health Departments (LHD) attending VDH technical assistance for safe sleep environment.	Active
ESM 5.6 - Interdisciplinary Workforce Development - Number of home visitors completing Early Impact Virginia training modules that discuss safe sleep environment.	Active

NOMs

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

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

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

Perinatal/Infant Health - Annual Report

Strategies within the FY17 Perinatal/Infant Health workplan were implemented by the Division of Child and Family Health's Maternal and Infant Health (MIH) Unit and the Division of Prevention and Health Promotion's Injury and Violence Prevention Program (IVPP). Complementary efforts were implemented by the Early Childhood Health Unit, the Office of the Chief Medical Examiner, and Newborn Screening Program. Activities completed during the reporting period are detailed below.

NPM 5: Safe Sleep

Strategies and the related state performance measure proposed in the FY17 workplan included:

- *Strategy 1: 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.*
- *Strategy 2: Evaluate changes in policy and procedures in partnering hospitals to promote safe sleep practices.*
- *Strategy 3: Collaborate with OCME to establish a standard definition and investigation mechanism for classifying sleep related deaths.*
- *ESM 5.1 - Proportion of partnering hospitals who have implemented a standardized safe sleep curriculum*

MIH Unit and Local Health Districts

The Virginia Department of Health is composed of a Central Office located in Richmond and 35 LHDs (local health districts) with 119 sites across the state that provide clinical and population-based public health programs and services. Each of the 35 LHDs receives an allocation of Title V funding based on the birth rate.

The MIH coordinator worked closely with LHDs to promote community engagement, education and training and disseminate the safe sleep messaging. Almost 20 LHDs were engaged in these efforts, helping to develop the SafeSleepVa.com website and ensuring that the resources remain up-to-date and appropriate for their parents and caregivers that they are referring to the website. Several LHDs also began providing safe sleep education concurrently with their IVPP Low-Income Safety Seat Distribution and Education Program (LISSDEP) or their smoking cessation counseling services. Many of the LHDs began reaching out to their local day care providers and began a train-the-trainer program in their day care facilities, ensuring that staff are educated about safe sleep and then encouraging them to have the same discussion with the parents and caregivers.

The FY17 workplan proposed tracking implementation of a safe sleep curriculum among hospitals (ESM 5.1). In FY18, the focus of safe sleep activities shifted from hospitals to Title V-funded LHDs and their partners. Two new ESMs were proposed in the FY18 workplan (ESM 5.2 tracks the number of visits to the SafeSleepVA.com website; ESM 5.3 tracks the number of partners who have implemented a quality improvement plan for standardization of safe sleep messaging). ESMs in the FY19 workplan further refines tracking of LHD activities.

Injury and Violence Prevention Program

In FY17, the Division of Prevention and Health Promotion's IVPP used non-Title V funds to serve as a member and workgroup co-chair of the *National Institute of Children's Health Quality-Virginia Department of Health Safe Sleep Collaborative Improvement and Innovation Network (CoIIN) to Reduce Infant Mortality*, an initiative to decrease the instances of sudden unexpected infant death (SUID) rates and reduce racial disparities in sleep-related deaths.

During the course of the CoIIN extension, the IVPP partnered with the Division of Child and Family Health, along with vested acute and community stakeholders, to develop: 1) a quality improvement (QI) acute hospital postpartum observation tool, designed to provide nursing QI professionals with data linking evidence-based safe sleep practices of infants while under the care of postpartum nurses; 2) a hospital policy toolkit, outlining the model for safe sleep practices among infants prior to post birth discharge for dissemination among maternity hospitals; 3) a safe sleep communication plan, outlining messages for the general public; and 4) an internal environmental scan, analyzing agency practices among divisions for implementation of initiatives. Work commenced at the end of the CoIIN and continued through final data reporting by the MCH epidemiology team.

In FY17, the IVPP also used Centers for Disease Control and Prevention (CDC) Core State Violence and Injury Prevention Program (Core SVIPP) grant funding to develop a continuing education curriculum in partnership with the Virginia Nurses Association, equipping nursing professionals with best practices for educating newborn caregivers and families in safe sleep practices. An online training platform has been developed to host training modules and is ready for release in the fall of 2018.

In FY17, the IVPP, supported by CDC Preventive Health and Health Services Block Grant funding, partnered with the Virginia Department of Social Services and other stakeholders on several workgroups to address child welfare issues as part of the Three Branch Institute. A safe sleep workgroup was convened focused on designing a plan for dissemination of Baby Boxes, an alternative sleep environment for infant to promote safe sleeping environments. IVPP developed a risk mitigation communication outreach plan, informing new parents and caregivers of the need to follow AAP recommendations if they chose to use the product. This included the development of a user-friendly parent, caregiver, and stakeholder website. The IVPP constructed website content to include infant sleep-related death statewide burden, risk and protective factors, American Academy of Pediatrics New Safe Sleep Recommendations to Protect Against Sleep-Related Infant Deaths (SIDS), and strategies for addressing myths. In addition, the IVPP worked directly with the Virginia Department of Social Services to provide input to its constructed Baby Box media and education plan.

Early Childhood Health Unit

In FY17, block grant funds also provided partial salary support for the Early Childhood Health Supervisor to identify shared metrics of interest between the Maternal Infant Early Childhood Home Visiting (MIECVH) grant and Title V as well as opportunities to collaborate on Title V-funded initiatives serving women, infants, and children (namely safe sleep, developmental screening, and maternal substance use).

The MIECHV grant is a federally funded program that aims to (a) expand implementation of evidence-based home visiting services into at-risk communities and (b) enhance the early childhood system of care to ensure availability and accessibility of community-based services for families. During FY17, MIECHV-funded evidence-based home visiting services were provided to more than 1,200 families in 18 organizations serving 44 communities in Virginia. In addition, MIECHV funded centralized intake and referral in 2 communities, and statewide training, technical assistance, professional development, and sustainability efforts. No FY17 Title V funds supported these efforts beyond the partial salary support noted above.

However, it is noteworthy that infant safe sleep was a new MIECHV performance measure in FY17. This was the first year that Virginia collected infant safe sleep data for MIECHV sites. Data showed that 74.9% of infants enrolled in MIECHV home visiting during FY17 were always placed to sleep on their backs, without bed sharing or soft bedding. Interest in improving infant safe sleep at MIECHV sites informed the proposed FY19 workplan activities.

NPM 4: Breastfeeding

Strategies and related evidence-based/informed strategy measures proposed in the FY17 workplan included:

- *Strategy 1: 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.*
- *Strategy 2: 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.*
- *Strategy 3: 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.*
- *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*

Most FY17 breastfeeding efforts were coordinated through the Virginia Maternity Care Quality Improvement Collaborative (VMQIC). Efforts have since been made to align work of the VMQIC under the Virginia Neonatal Perinatal Collaborative (VNPC) to maximize synergies and sustain the work, as detailed below.

Virginia Maternity Care Quality Improvement Collaborative (VMQIC)

Development of the VMQIC was initiated by the Virginia Breastfeeding Advisory Committee (VBAC). The VBAC works to improve the duration of breastfeeding and provides a statewide organizational vehicle for communication, collaboration, and coordination of services throughout the Commonwealth of Virginia. VBAC members served as subject matter experts and faculty for the VMQIC. The VMQIC was funded through the State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health FOA (CDC-RFA-DP13-1305), a 5-year cooperative agreement with the Centers for Disease Control and Prevention (CDC). The effort was a joint undertaking of the Office of Family Health Services (OFHS) Division of Community Nutrition-WIC (DCN-WIC) and Division of Prevention and Health Promotion. The VMQIC provided technical assistance and education to Virginia's maternity facilities regarding quality improvement in infant and maternity care practices.

From 2013 to 2018, the VMQIC hosted 6 statewide summits inclusive of at least 3 key decision-making staff, developed a host website for maternity care facilities to share ideas and data regarding the 10 Steps to Successful Breastfeeding, and provided technical support and education through monthly webinars, and working groups.

The goal of the VMQIC was for 30 of Virginia's maternity facilities to achieve 4 of 5 stars from the Virginia Maternity Center Breastfeeding-Friendly Designation Program (which is equivalent to 8 of the Ten Steps to Successful Breastfeeding) by June 2018. By May 2018, 11 facilities achieved 4 or 5 stars, eight additional facilities have applied and received a lesser number of stars.

Additional goals of the Collaborative included:

- 45+ (of 55) maternity facilities will be enrolled in the collaborative by September, 2015 (Status: accomplished,

61 facilities participated)

- Virginia's state-level mPINC score will increase from 76 (2013) to 82 by in the 2017 survey (Status: the 2015 score was 80, the 2017 report is still pending); and
- 8+ participating maternity facilities will achieve Baby-Friendly USA Designation by July 1, 2018 (Status: 7 Virginia facilities achieved that goal).

Virginia Maternity Care Breastfeeding-Friendly Designation

In FY17, the committee met twice to review very comprehensive applications from hospitals interested in the Virginia Maternity Center Breastfeeding-Friendly Designation Program. The program recognizes hospital breastfeeding best practices, including patient education and support, availability of lactation consultants, nursing education, etc.

The five-star program awards a star for every two steps achieved in the "Ten Steps to Successful Breastfeeding" as defined by the World Health Organization (WHO) and Baby Friendly USA:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff;
2. Train all health care staff in skills necessary to implement this policy;
3. Inform all pregnant women about the benefits and management of breastfeeding;
4. Help all mothers initiate breastfeeding within one hour of birth;
5. Show mothers how to breastfeed and maintain lactation even if they should be separated from their infants;
6. Give newborns no food or drink other than breastmilk, unless medically indicated;
7. Practice rooming-in allow mothers and infants to remain together-24 hours per day;
8. Encourage breastfeeding on demand;
9. Give no artificial teats or pacifiers; and
10. Foster breast-feeding support groups and refer mothers to them on discharge from the hospital or clinic.

A list of awardees can be found here, along with more details on recognition criteria. Eight hospitals have completed all ten steps to receive five stars, three hospitals have received four stars, one hospital has received three stars, two hospitals have received two stars, and three hospitals have received one star.

Ongoing Program Efforts

As detailed in the FY18 application / FY16 annual report, the breastfeeding NPM was removed from the Title V workplan at the end of FY17. Efforts aligned with ESM 4.2 (workforce development metric for WIC breastfeeding coordinators) were discontinued because certification of breastfeeding coordinators fell under the oversight of WIC, which separately funds other agency breastfeeding promotion activities.

However, the Title V team recognizes that breastfeeding as a best practice for safe sleep, NAS treatment, ensuring a strong start for children, and a number of key maternal and infant health outcomes.

The Title V program will continue to support and report annually on breastfeeding efforts.

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

The Title V Director also chairs the review team for Virginia Maternity Center Breastfeeding-Friendly Designation Program, with support from the MIH Coordinator.

Other agency efforts to promote breastfeeding are detailed on the VDH breastfeeding website.

SPM: Infant Mortality Disparity Ratio

Strategies and related evidence-based/informed strategy measures proposed in the FY17 workplan included:

- *Strategy 1: Collaborate with FQHC, text4baby, and other community partners to expand the number of safety net providers of prenatal care services to vulnerable populations.*
- *Strategy 2: 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.*
- *Strategy 3: Collaborate with OCME to establish a standard definition and investigation mechanism for classifying sleep-related deaths.*
- *SPM - Infant Mortality Disparity Ratio*

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

VDH continues to work with community partners and stakeholders to eliminate the racial/ethnic disparities in Virginia's infant mortality rates, by aligning efforts in the Virginia Plan for Well-Being. VDH's ongoing partnership with OCME and the Infant Mortality Review Committee to monitor infant mortality, examine leading causes of infant deaths, and determine statewide strategies for infant mortality reduction will continue.

While this SPM has been removed for FY19, VDH will continue efforts in collaboration with the VNPC to eliminate the racial/ethnic disparities in Virginia's infant mortality rates.

Other Programmatic Activities

Office of the Chief Medical Examiner

Maternal mortality review is co-led by VDH Office of the Chief Medical Examiner (OCME) and the Office of Family Health Services. Letters to members are co-signed by Dr. Melanie Rouse and Dr. Vanessa Walker Harris.

OCME also leads the state's child fatality review team.

Title V funds contribute to OCME staffing support for both maternal and child fatality review. In addition, Title V-funded and non-Title V-funded OFHS staff serve on both review teams.

In FY17, the state child fatality review team reviewed cases of overdose poison deaths to infants and children up to age 17 that occurred in Virginia during the five-year period between 2009-2013. During this time, 41 infants, children, and adolescents died as a result poisoning in Virginia. After reviewing the circumstances of child overdose fatalities, the team identified two distinct child populations at risk: 1) teenagers who died as a result of suicidal or

accidental drug overdose, and 2) infants and young children age six and under who died after unintentionally ingesting a fatal substance when left unsupervised, or after a caregiver administered medication to manage the child's behavior or sleeplessness. Prescription drugs were identified as the main contributor to child poisoning deaths, causing or contributing to more than two-thirds of these overdoses.

Additional details about the child fatality review team, along with data and reports, can be found here.

Newborn Screening

Virginia's Newborn Screening Program includes Dried Blood Spot Newborn Screening, Critical Congenital Heart Disease Screening, Virginia Congenital Anomalies Reporting and Education System (VaCARES) Birth Defects Surveillance, and the Virginia Early Hearing Detection and Intervention (EHDI) Program. Special revenue funds from the Division of Consolidated Lab Services sustain the dried blood spot screening program. Other programs receive CDC and HRSA funding. Title V funds provide partial support for the EHDI Program and VaCARES registry birth defect projects.

Early Hearing Detection and Intervention

The EDHI Program received supplemental HRSA funding. The overall goal of HRSA funding is to continue activities that develop a comprehensive and well-coordinated statewide system of care which is targeted towards ensuring that newborns and infants receive appropriate and timely services related to hearing loss screening, diagnosis and care. Enhancing collaborations with key stakeholders, such as other state agencies, healthcare providers and family support organizations, allow the program to meet the objectives of the 1-3-6 EHDI principals, increasing health professionals' engagement within and knowledge of the EHDI system, improving access to early intervention services and language acquisition and increasing family engagement, partnership, and leadership within Virginia.

Injury and Violence Prevention Program

Opioid misuse, overuse, and abuse continues to be a growing problem throughout Virginia. Directly related to this public health epidemic is the increasing number of newborns and infants diagnosed with neonatal abstinence syndrome (NAS). In FY17, the Injury and Violence Prevention Epidemiologist, partially supported with Title V funds, regularly analyzed and reported rates of neonatal abstinence syndrome.

Activities implemented by the Injury and Violence Prevention Program in recent years not only target the prevention of overdose deaths but also include the prevention of NAS and efforts to reduce the increased risk of intentional injury/child abuse/neglect among the perinatal/infant population with a NAS diagnosis. Information specific to these efforts are detailed in the Women's/Maternal Health and Child Health sections of the annual report.

Perinatal/Infant Health - Application Year

The Office of Family Health Services administers a number of programs and initiatives serving women and infants. Leadership of Title V-funded efforts for perinatal and infant health is shared by the Division of Child and Family Health's Maternal and Infant Health Unit and the Early Childhood Health Unit. These entities and their proposed activities for the upcoming grant period are detailed below.

Maternal and Infant Health Unit

The Division of Child and Family Health's Maternal and Infant Health Unit is led by Shannon Pursell, MPH (Maternal and Infant Health Coordinator).

The unit has a hub-and-spoke structure consisting of a subject matter expert housed within VDH's Central Office who works closely with staff at 35 local health districts (LHDs), the Virginia Neonatal Perinatal Collaborative (VNPC), the Maternal Mortality Review team, and an array of state and local community partners. Current Title V priorities for maternal and infant health include access to prenatal care, tobacco cessation for pregnant women, and addressing the opioid crisis for MCH populations.

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

Early Childhood Health Unit

The Division of Child and Family Health's Early Childhood Health Unit administers the agency's home visiting programs. The unit supervisor position is currently vacant. The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant is a federally funded program that aims to a) expand implementation of evidence-based home visiting services into at-risk communities and b) enhance the early childhood system of care to ensure availability and accessibility of community-based services for families.

State Priority: Safe Sleep

FY19 Performance Measure: NPM 5 – A) Percent of infants placed to sleep on their backs, B) Percent of infants placed to sleep on a separate approved sleep surface, C) Percent of infants placed to sleep without soft objects or loose bedding

Objectives:

- By June 30, 2020, increase the percent of infants placed to sleep on their backs from 78% (PRAMS 2015) to 84%.
- By June 30, 2020, increase the percent of infants placed to sleep on a separate approved sleep surface from 59.9% (PRAMS 2015) to 62.9%.

Strategy 1: Provide staff support and technical assistance to 24 LHDs to promote safe sleep practices.

In FY19, the MIH Coordinator will continue to provide TA to the 24 LHDs that have identified safe sleep as one of their top five local priorities. Activities will include staff education, community outreach, and capacity-building to promote safe sleep practices.

The MIH Coordinator will continue to partner with Early Impact Virginia, local health districts, March of Dimes,

Virginia Neonatal Perinatal Collaborative (VNPC), and community partners to promote and educate the public about safe sleep through SafeSleepVA.com (a statewide website providing educational materials, training, and other resources for providers and parents about safe sleep).

In addition, MIH Coordinator will work closely with the VNPC as the Improving Neonatal Outcomes Advisory committee adds a subcommittee to focus specifically on safe sleep working closely with the 54 birth hospitals across the Commonwealth to educate and promote safe sleep efforts. This group is also collaborating on a safe sleep campaign to develop large floor stickers with the American Academy of Pediatrics guidelines. The floor stickers will be placed throughout local communities across Virginia educating the public about safe sleep (e.g. local DMVs, grocery stores, pharmacies, etc.).

Strategy 2: Provide staff support and training to home visitors on promotion of safe sleep practices.

In FY19, the Early Childhood Health Unit will partner more closely with Title V staff to enhance safe sleep promotion practices among home visitors.

Infant safe sleep was a new MIECHV performance measure in FY17. This was the first year that Virginia collected infant safe sleep data for MIECHV sites.

In FY19, MIECHV will continue funding evidence-based home visiting services to 18 organizations serving 44 communities, with support for centralized intake, statewide training, TA, professional development, and sustainability. As part of professional development activities and through a contract with James Madison University, MIECHV will fund the development of an infant safe sleep training module. Completion of this module will be required of all MIECHV-funded home visitors, and will be available nationwide on the Institute for the Advancement of Family Support Professionals (IAFSP, http://www.iafsp.org). Virginia is collaborating with Iowa in the development of the IAFSP through a MIECHV Innovation Grant.

In FY19, the Early Childhood Unit will leverage Title V funding to assess the extent to which safe sleep is addressed by VDH home visiting programs. This includes assessing safe sleep curricula currently utilized by home visiting programs at MIECHV sites (3 LHDs and 15 community sites), Healthy Start sites (2 LHDs and the Eastern Virginia Medical School), and Resource Mothers sites (5 LHDs and 1 community site). Partial salary support will be provided for the Early Childhood Health Unit Supervisor to carry out this work. Gaps in knowledge and practice related to safe sleep promotion will be addressed through training modules in partnership with Early Impact Virginia, the central organization that represents all of the home visiting model programs in Virginia.

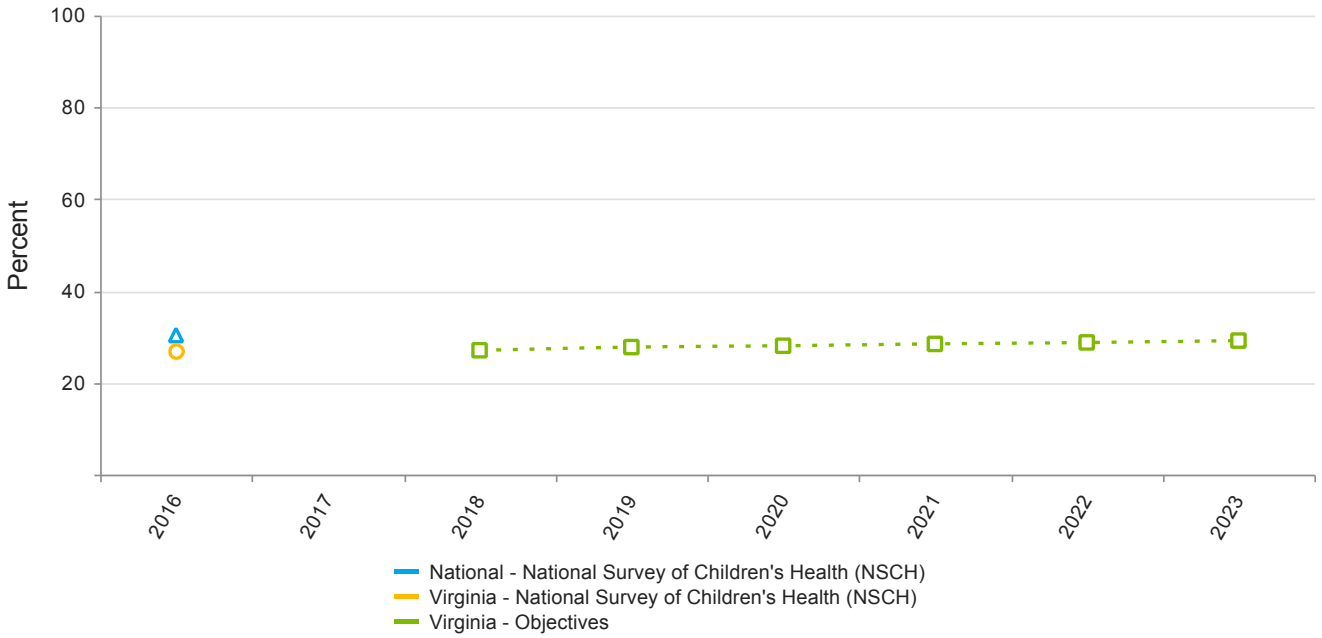
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available	NPM 6
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2016	9.9 %	NPM 13.2
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	NVSS-2016	15.6	NPM 7.1
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2016	30.4	NPM 7.1
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2014_2016	10.6	NPM 7.1
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2014_2016	9.8	NPM 7.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	92.9 %	NPM 6 NPM 13.2

National Performance Measures

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
Baseline Indicators and Annual Objectives



Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	**2017**
Annual Objective		
Annual Indicator		26.8
Numerator		67,562
Denominator		252,334
Data Source		NSCH
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	27.1	27.8	28.1	28.5	28.8	29.2

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data	
	2017
Annual Objective	7
Annual Indicator	150
Numerator	
Denominator	
Data Source	VDH Division of Child and Family Health
Data Source Year	2016-2017
Provisional or Final ?	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	15.0	20.0	25.0	35.0	50.0	100.0

ESM 6.2 - Number of hits to the VDH web pages by individuals seeking information about the importance of regular developmental screening and Bright Futures

Measure Status:	Active

State Provided Data	
	2017
Annual Objective	100
Annual Indicator	0
Numerator	
Denominator	
Data Source	VDH Division of Child and Family Health
Data Source Year	2016-2017
Provisional or Final ?	Provisional

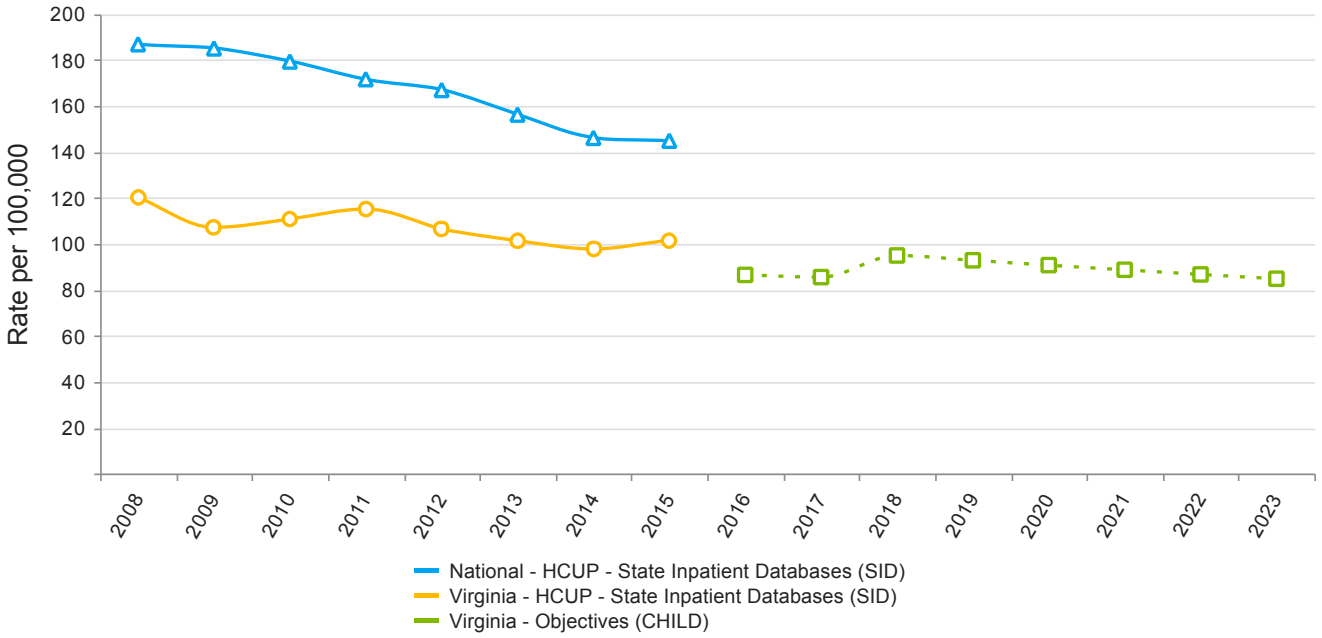
Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	125.0	200.0	250.0	300.0	350.0	400.0

ESM 6.3 - Completion of actionable 2-year plan (FY19-FY20) for strengthening the comprehensive, complex developmental screening system of care for children 0-8

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	Yes	Yes	Yes	Yes	Yes

NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9
Baseline Indicators and Annual Objectives



Federally Available Data		
Data Source: HCUP - State Inpatient Databases (SID)		
	2016	**2017**
Annual Objective	86.5	85.5
Annual Indicator	87.0	101.5
Numerator	899	785
Denominator	1,033,738	773,528
Data Source	SID-CHILD	SID-CHILD
Data Source Year	2014	2015

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	94.9	92.8	90.7	88.7	86.7	84.8

Evidence-Based or –Informed Strategy Measures

ESM 7.1.1 - Proportion of maternity centers with prenatal courses including Virginia's injury prevention curriculum

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		0
Annual Indicator	0	0
Numerator	0	0
Denominator	60	60
Data Source	Office of Family Health Services, VDH	Office of Family Health Services, VDH
Data Source Year	2016	2017
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	10.0	15.0	20.0	25.0	30.0	35.0

ESM 7.1.2 - Number of child safety seats disseminated through the LISSDEP network

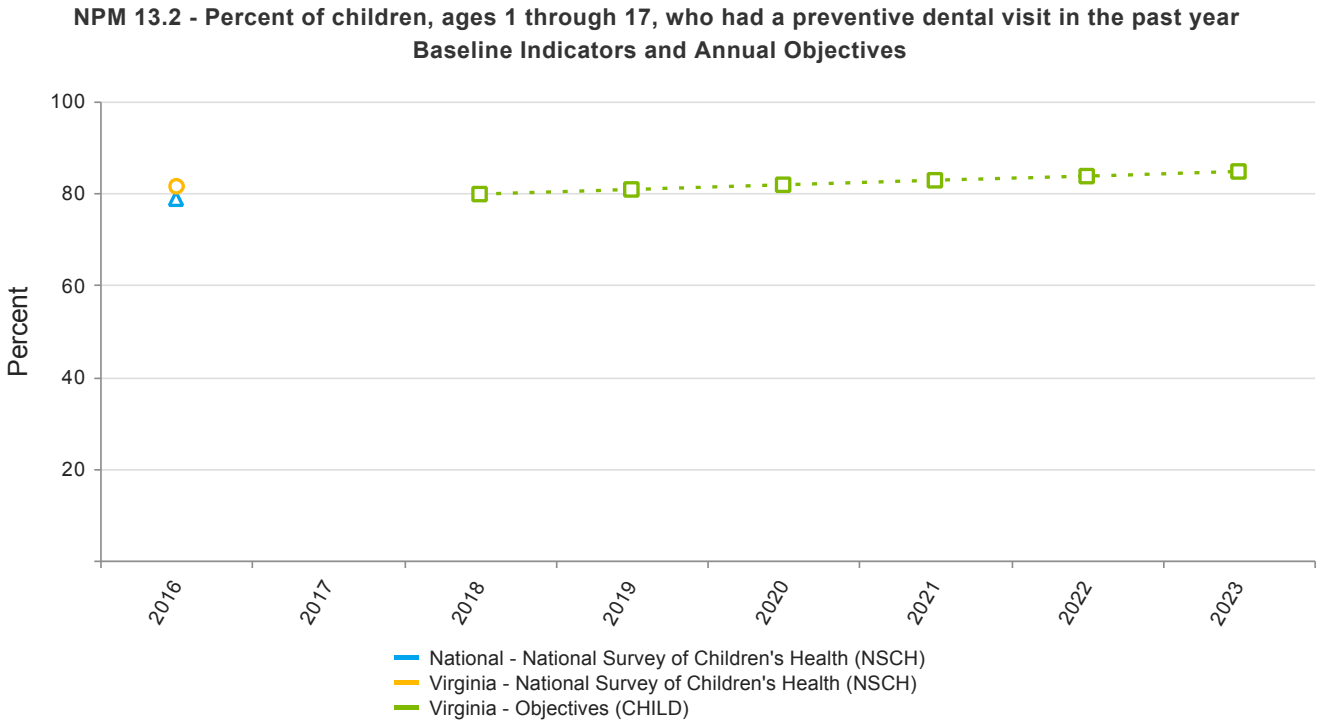
Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	2,549.0	2,549.0	2,549.0	2,549.0	2,549.0

ESM 7.1.3 - Number of healthcare providers receiving Project ECHO content in reducing the impact of NAS

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	25.0	30.0	35.0	40.0	45.0



NPM 13.2 - Child Health

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	**2017**
Annual Objective		
Annual Indicator		81.4
Numerator		1,407,907
Denominator		1,729,004
Data Source		NSCH
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	77.8	77.8
Numerator		
Denominator		
Data Source	NSCH	NSCH
Data Source Year	2016	2016
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	79.7	80.7	81.7	82.7	83.6	84.6

Evidence-Based or –Informed Strategy Measures

ESM 13.2.1 - Number of Regional Oral Health Alliances that implemented work plans to increase dental visits among children (ages 0-11 years) and adolescents (ages 12-17 years)

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	6.0	6.0	6.0	6.0	6.0

State Action Plan Table

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

Priority Need

Oral Health: Increase access to oral health services for pregnant women and children.

NPM

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Objectives

By June 30, 2020, increase the percent of children (ages 1 through 11) who had a preventive dental visit in the past year from 77.8% (National Survey of Children's Health (NSCH) – NONCSHCN 2016) to 81.7%.

Strategies

Provide preventive dental services to children 1-17 with and without special health care needs.

Foster network of 6 regional Oral Health Alliances to conduct regional needs assessments and implement systems change and data-sharing initiatives to improve the oral health of all Virginians, with emphasis on pregnant women and children 1-17.

ESMs	Status
ESM 13.2.1 - Number of Regional Oral Health Alliances that implemented work plans to increase dental visits among children (ages 0-11 years) and adolescents (ages 12-17 years)	Active

NOMs

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

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

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

Priority Need

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

NPM

NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Objectives

By June 30, 2020, decrease the rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 from 101.5 (HCUP - State Inpatient Databases (SID) 2015) to 90.7.

Strategies

Provide an injury prevention curriculum to maternity hospitals.

Eliminate financial barriers to safety devices by equipping income-eligible families with child safety seats through the Low Income Safety Seat Distribution and Education Program.

Equip healthcare providers with primary prevention skills for reducing Neonatal Abstinence Syndrome through the evidence-based model Project ECHO ®.

ESMs	Status
ESM 7.1.1 - Proportion of maternity centers with prenatal courses including Virginia's injury prevention curriculum	Active
ESM 7.1.2 - Number of child safety seats disseminated through the LISSDEP network	Active
ESM 7.1.3 - Number of healthcare providers receiving Project ECHO content in reducing the impact of NAS	Active

NOMs

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

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

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

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

State Action Plan Table (Virginia) - Child Health - Entry 3

Priority Need

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

NPM

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Objectives

By June 30, 2020, increase the percent of children (ages 10-71 months) receiving a developmental screening using a parent-completed screening tool from 26.8% (NSCH 2016) to 28.1%.

Strategies

Through early childhood partnerships, support ongoing work force development through training, technical assistance, professional development and education with evidence-based tools for LHDs and their community partners.

Provide messages for families and the community about the importance of ongoing screening, monitoring, referral and follow-up of child development using social media.

Strengthen the continuum of child health care infrastructure for screening, assessment, referral, and follow-up for developmental screening.

ESMs	Status
ESM 6.1 - Number of LHDs, community partners, and providers receiving developmental screening resources, training, or TA	Active
ESM 6.2 - Number of hits to the VDH web pages by individuals seeking information about the importance of regular developmental screening and Bright Futures	Active
ESM 6.3 - Completion of actionable 2-year plan (FY19-FY20) for strengthening the comprehensive, complex developmental screening system of care for children 0-8	Active

NOMs

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

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Strategies within the FY17 Child Health workplan were implemented by the Division of Prevention and Health Promotion's Injury and Violence Prevention Program (IVPP) and Chronic Disease Unit. Complementary efforts were implemented by the Office of the Chief Medical Examiner. Activities completed during the reporting period are detailed below.

NPM 7: Injury Hospitalization

Strategies and related evidence-based/informed strategy measures proposed in the FY17 workplan included:

- *Strategy 1: 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.*
- *Strategy 2: 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.*
- *ESM 7.1 - Proportion of maternity centers with prenatal courses including Virginia's injury prevention curriculum*

In FY17, the IVPP used the Centers for Disease Control and Prevention (CDC) Preventive Health and Health Services Block Grant to develop Project Patience, an initiative supporting statewide delivery of prenatal and postpartum education on child maltreatment and infant injury prevention. Project Patience focuses on providing technical assistance to maternity hospitals and community comprehensive maternity case management programs. Priority populations include mothers of NAS infants and pregnant women at risk for or with a history of addiction. The goals are to engage, inform, and educate key stakeholders and to leverage infrastructure partnerships to address child maltreatment and injury prevention among substance-exposed infants. Staff constructed a technical assistance, communications and dissemination, and evaluation plan for driving efforts in program implementation. Project Patience activities are included in the state Title V FY19 action plan and will be funded by Title V.

In FY17, the IVPP used CDC Core State Violence and Injury Prevention Program (Core SVIPP) grant funding to partner with the Division of Child and Family Health's Children with Special Health Care Needs Program and the Southwest Care Connection for Children (SWCCC) site to implement the 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, and enhance children's health, development, and safety while also working to prevent child maltreatment. All SWCCC staff members received continuing education units; however, due to program structure changes within SWCCC, the center declined further technical assistance. As a result, in FY18, the IVPP began implementation of the SEEK program in Children's Hospital of Kings Daughters CCC site through activities supported by Core SVIPP funds.

In FY17, the Injury and Violence Epidemiologist, partially funded by MCH Title V, maintained the Virginia Online Injury Reporting System (VOIRS), which provides the public with data on deaths and hospitalizations attributable to injury. VOIRS allows quick and easy access to basic injury data and enables users to customize data reports on various types of injury hospitalizations and deaths. Data are available for both intentional and unintentional injuries, and some demographic and geographic information is included to allow for more detailed analysis. The Injury and Violence

Epidemiologist routinely responded to data requests from constituents that could not be addressed through the VOIRS system.

Project ECHO

In November 2016, the State Health Commissioner declared opioid misuse, overuse and abuse a public health emergency in Virginia. There are several drivers to this public health issue which continue to escalate this epidemic, including the problematic practice of opioid case management, prescribing, and dispensing among healthcare providers. To equip healthcare providers with the knowledge and tools necessary to treat patients at risk for misuse, Virginia has enacted laws mandating continuing medical education for providers regarding proper prescribing, addiction, and addiction treatment. However, varying models facilitated by many stakeholders and medical/clinical training programs often do not contain Virginia state specific scope of practice content, statewide resources, integrated care content, and clinical networking needed by practitioners. Virginia providers continue to face the challenge of limited networking, limited access to consultative services, barriers for attending live education sessions, travel restraints, inability for time away from patient care, and knowledge to effectively implement an addiction disease management business delivery model. These limitations will continue to impact the burden of increased admissions, emergency room visits, and limited access to effective primary care.

Opioid overdose prevention efforts by the Injury and Violence Prevention Program (IVPP) have included support for provider education. However, long-term sustainability for continuing opioid case management medical provider education is limited due to cost and staffing capacity. As part of the solution, the IVPP has begun implementing a sustainable model for delivering ongoing education to the primary and specialty prescribers using the Project ECHO© model. Using simple videoconferencing technology, providers connect to a community of learners with free continuing education credit and the opportunity to present actual patient cases, in a de-identified format, and receive specialty input from a panel of experts. Research conducted by the University of New Mexico has shown that access to care has improved in primary health settings for patients with prescribers participating in the Project ECHO model.

As part of the opioid epidemic, the IVPP recognizes that newborns born to substance-abusing caregivers are at particular risk not only for the effects of neonatal abstinence syndrome but also unintentional and intentional injury following discharge from the hospital. Therefore, supported by Title V funds, the IVPP has partnered with the University of Virginia to develop and launch a Project ECHO© Neonatal Abstinence Syndrome Case Management Learning Lab series which will also include injury prevention modules to reduce injury-related hospitalizations among this population of children. Outcomes that demonstrate how the practice, program, or activity addressed the problem will reflect policy and practice changes, reduced gaps in care, and reduction of the impact of neonatal abstinence syndrome.

Project ECHO is a new strategy for the state Title V action plan for the FY19 application.

NPM 8: Physical Activity

Strategies and related evidence-based/informed strategy measures proposed in the FY17 workplan included:

- *Strategy 1: Partner with physical education and activity specialists to conduct tailored Comprehensive School Physical Activity Program (CSPAP) training within the 15 targeted school divisions.*
- *Strategy 2: 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.

- *Strategy 3: 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.*
- *ESM 8.1 - Number of students enrolled in targeted public schools where staff have received professional development or technical assistance in physical activity.*

In FY17, VDH supported local schools by promoting the establishment of wellness councils and healthy nutrition and physical activity environments. VDH and partners reached 206 school staff statewide by providing professional development, tailored technical assistance, resources, and tools to update and implement local school wellness policies. Additionally, school nurses were empowered through professional development to identify and manage students with chronic health conditions with a particular focus on asthma, epilepsy/seizure disorders, obesity, diabetes, food allergies, and poor oral health. Finally, VDH supported the Virginia Department of Education's online repository of curricula and resources to help implement Virginia's 2015 Health and Physical Education Standards of Learning. All School Health efforts were focused on helping Virginia schools adopt policies and practices to encourage children to: make healthy nutrition choices; achieve the recommended amount of daily physical activity; and prevent and/or manage the daily challenges from chronic health conditions.

Other Programmatic Activities

Office of the Chief Medical Examiner

Maternal mortality review is co-led by VDH Office of the Chief Medical Examiner (OCME) and the Office of Family Health Services. Letters to members are co-signed by Dr. Melanie Rouse and Dr. Vanessa Walker Harris.

OCME also leads the state's child fatality review team.

Title V funds contribute to OCME staffing support for both maternal and child fatality review. In addition, Title V-funded and non-Title V-funded OFHS staff serve on both review teams.

In FY17, the state child fatality review team reviewed cases of overdose poison deaths to infants and children up to age 17 that occurred in Virginia during the five-year period between 2009-2013. During this time, 41 infants, children, and adolescents died as a result poisoning in Virginia. After reviewing the circumstances of child overdose fatalities, the team identified two distinct child populations at risk: 1) teenagers who died as a result of suicidal or accidental drug overdose, and 2) infants and young children age six and under who died after unintentionally ingesting a fatal substance when left unsupervised, or after a caregiver administered medication to manage the child's behavior or sleeplessness. Prescription drugs were identified as the main contributor to child poisoning deaths, causing or contributing to more than two-thirds of these overdoses.

Additional details about the child fatality review team, along with data and reports, can be found here.

Child Health - Application Year

The Office of Family Health Services administers a number of programs and initiatives serving children. Leadership of Title V-funded efforts for child health is shared by the Dental Health Program, Injury and Violence Prevention Program, Early Childhood Health Unit, and Children with Special Healthcare Needs Program. These entities and their proposed activities for the upcoming grant period are detailed below.

State Priority: Oral Health

FY19 Performance Measure: NPM 13.2 – Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

OBJECTIVE: By June 30, 2020, increase the percent of children (ages 1 through 11) who had a preventive dental visit in the past year from 77.8% (National Survey of Children's Health – NONCSHCN 2016) to 81.7%.

Dental Health Program

The Division of Prevention and Health Promotion (DPHP)'s Dental Health Unit is led by Tonya McRae Adiches, RDH (Dental Health Programs Manager). Non-MCH funds support preventive dental services for MCH populations. The Dental Health Unit collaborates with Title V to:

- Foster regional alliances and implement local initiatives to improve access to dental care for children and pregnant women;
- Promote medical and dental integration in safety-net settings;
- Increase public awareness and engagement around oral health by disseminating data, research, and promising practices; and
- Support workforce development and training for medical and dental providers, lay professionals, home visitors, and caregivers serving ISHCN.

Strategy 1: Provide preventive dental services to children 1-17 with and without special health care needs.

This strategy includes maintaining a web-based listing of dental providers who report serving individuals with special health care needs (ISHCN) and children under three years of age for referral from VDH clinical programs and the general public; providing fluoride varnish and oral screenings at Southwest Care Connection for Children (SWCCC) pediatric medical specialty clinics, an extension of the Bright Smiles for Babies program which provides fluoride varnish; educating medical and dental professionals, lay health workers, case workers, teachers, families, and individuals about oral health care for ISHCN through presentations, exhibit booths, and educational materials; and developing cooperative relationships with other organizations and advocates to disseminate oral health information.

In addition, with non-MCH funding, VDH will provide oral screenings, and preventive dental sealants and fluoride varnish to preschool and school-aged children. Additionally, staff will provide oral health risk assessments and screenings, fluoride varnish applications, oral health counseling for parents, and dental referrals in WIC and well-child clinics in local health departments; and train early childhood professionals and VDH clinical providers to promote the importance of oral health during pregnancy, inter-conception, and early childhood.

Strategy 2: Foster network of 6 regional Oral Health Alliances to conduct regional needs assessments and implement systems change and data-sharing initiatives to improve the oral health of all Virginians, with emphasis on pregnant women and children 1-17.

VDH will partner with the Virginia Oral Health Coalition (VaOHC) to provide backbone support and facilitative

leadership training to 6 Regional Alliances (South Hampton Roads, Northern Virginia, Richmond/Petersburg, Southside, Central Virginia, and Southwest Virginia) to conduct regional oral health needs assessments, develop and implement regional project workplans, and share region-specific data among state and local partners. Staffs will also work together to develop and disseminate communications, to include 4 white papers addressing MCH populations.

State Priority: Child/Adolescent Injury
FY19 Performance Measure: NPM 7 – Rate of hospitalization for non-fatal injury per 100,000 children ages 0-9

OBJECTIVE: By June 30, 2020, decrease the rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 from 101.5 (HCUP - State Inpatient Databases (SID) 2015) to 90.7.

Injury and Violence Prevention Program

DPHP's Injury and Violence Prevention (IVP) Program is led by Lisa Wooten, MPH, BSN, RN (Injury and Violence Prevention Program Supervisor). The IVP Program supports promising and best practice activities at the local level that address leading or emerging injury issues. Unintentional injuries continue to be a leading cause of death in the US and Virginia. Although death is the most severe result of injury, it represents only part of the problem. The majority of those who incur injuries survive, and often endure life-long mental, physical, and financial problems as a result of prolonged rehabilitation, hospitalization, loss of productivity, or stress to victim, family, and other caregivers. Despite its immense burden, injuries are largely preventable. Per the socioecological model, the IVP will aim to implement multi-level interventions (e.g. individual, relationship, community, societal) in order to effectively move the needle.

Strategy 1: Provide an injury prevention curriculum to maternity hospitals.

In FY19, the Injury and Violence Prevention Program will continue Project Patience, an initiative supporting statewide delivery of prenatal and postpartum education on child maltreatment and infant injury prevention. Project Patience focuses on providing technical assistance to maternity hospitals and community comprehensive maternity case management programs.

Strategy 2: Eliminate financial barriers to safety devices by equipping income-eligible families with child safety seats through the Low Income Safety Seat Distribution and Education Program.

The proper use of child safety seats and booster seats is required for all children under the age of eight by Virginia Code 46.2-1095. Pursuant to VA code 46.2-1098, VDH coordinated the Low-Income Safety Seat Distribution and Education Program (LISSDEP) to provide safety seats through a network of 154 dissemination sites statewide to indigent families through revenue derived from fines collected from violations of the CPS law. LISSDEP helps to remove financial barriers and increase access to safety devices and proper education for reducing motor vehicle-related injuries. In FY19, local health departments operating as LISSDEP distribution sites will leverage funding from the Child Restraint Special Device Fund and Federal Highway Safety Fund with Title V funds to support program Coordination and child passenger safety education for indigent families that addressed the proper usage and installation of safety seats.

Strategy 3: Equip healthcare providers with the primary prevention skills in reducing Neonatal Abstinence Syndrome through evidence-based models.

The misuse of prescription opiates among women of childbearing age is a major concern. Rates of Neonatal

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

In support of equipping healthcare providers with the skills to provide opioid case management and for the reduction of NAS, the IVP Program will leverage Title V funds with other funding in FY19 to continue the facilitation of Virginia specific Project ECHO© healthcare provider training learning labs on best practices in caring for the childbearing age client exposed to substances.

About Project ECHO

Opioid overdose prevention efforts by the Injury and Violence Prevention Program (IVPP) have included support for provider education. However, long-term sustainability for continuing opioid case management medical provider education is limited due to cost and staffing capacity. As part of the solution, the IVPP has begun implementing a sustainable model for delivering ongoing education to the primary and specialty prescribers using the Project ECHO© model. Using simple videoconferencing technology, providers connect to a community of learners with free continuing education credit and the opportunity to present actual present actual patient cases, in a de-identified format, and receive specialty input from a panel of experts. Research conducted by the University of New Mexico has shown that access to care has improved in primary health settings for patients with prescribers participating in the Project ECHO model.

As part of the opioid epidemic, the IVPP recognizes that newborns born to substance-abusing caregivers are at particular risk not only for the effects of neonatal abstinence syndrome but also unintentional and intentional injury following discharge from the hospital. Therefore, supported by Title V funds, the IVPP has partnered with the University of Virginia to develop and launch a Project ECHO© Neonatal Abstinence Syndrome Case Management Learning Lab series which will also include injury prevention modules to reduce injury-related hospitalizations among this population of children. Outcomes that demonstrate how the practice, program, or activity addressed the problem will reflect policy and practice changes, reduced gaps in care, and reduction of the impact of Neonatal Abstinence Syndrome.

Investing in Project ECHO is a new Title V strategy for the FY19 application.

State Priority: Developmental Screening
FY19 Performance Measure: NPM 6 - Percent of children, ages 9-35 months, who received a developmental screening using a parent-completed screening tool in the past year

OBJECTIVE: By June 30, 2020, increase the percent of children (ages 10-71 months) receiving a developmental screening using a parent-completed screening tool from 26.8% (NSCH 2016) to 28.1%.

Early Childhood Health Unit

The Division of Child and Family Health's Early Childhood Health (ECH) Unit administers the agency's home visiting programs. The unit supervisor position is currently vacant. Developmental screening initiatives fall within this unit, led by Bethany Geldmaker, PhD, PNP (ECH Consultant).

Developmental screening represents an emerging priority for the state Title V program. Two ESMs have been developed to reflect planned FY18 efforts aligned with this priority. These efforts are jointly expected to support implementation of the Bright Futures guidelines and to encourage a more comprehensive, coordinated approach to providing child health care at the community level.

Strategy 1: Through early childhood partnerships, support ongoing work force development through training, technical assistance, professional development and education with evidence-based tools for LHDs and their community partners.

In FY19, the ECH Consultant will work to assure LHD staff maintain up-to-date knowledge and skills to provide developmental screenings using the revised ASQ3 and ASQSE2 and make referrals when indicated. District staff (including nurses and home visitors) will have access to an annual training and to referrals to additional state and local ASQ and ASQSE training resources. The ECH Consultant will provide ongoing consultation to LHD staff on proper use of evidence-based screening tools (e.g., scoring, interpreting results, communicating with families, referrals) and track the number of staff trained.

Strategy 2: Provide messages for families and the community about the importance of ongoing screening, monitoring, referral and follow-up of child development using social media.

In FY19, the ECH Consultant will revise and implement the communication plan developed in 2018, to include updates to existing VDH child health webpages to provide current, relevant, consumer-friendly information about comprehensive child health and developmental screening (based on Bright Futures). This plan will include social media marketing. Information about the Children and Youth with Special Healthcare Needs (CYSHCN) Program's Child Development Centers will be incorporated to increase parent and provider knowledge regarding developmental screening resources and importance. Staff will support family engagement and peer education by engaging partners such as Early Intervention, Early Impact Virginia, Partnership for People with Disabilities, and the Child Development Centers to tailor messaging and select resource materials (e.g. 'Know the Signs, Act Early' materials). The number of hits to the webpage before implemented (2018 baseline) and after implementation of the communication plan will be tracked.

Strategy 3: Strengthen the continuum of child health care infrastructure for screening, assessment, referral, and follow-up for developmental screening.

The ECH Consultant will work with partners to prepare a FY18 developmental screening environmental scan report. Building on findings, VDH will convene partners to develop statewide strategies to improve developmental screening rates. To strengthen the screen-assess-refer continuum, the Child Development Centers will be invited to participate in this effort.

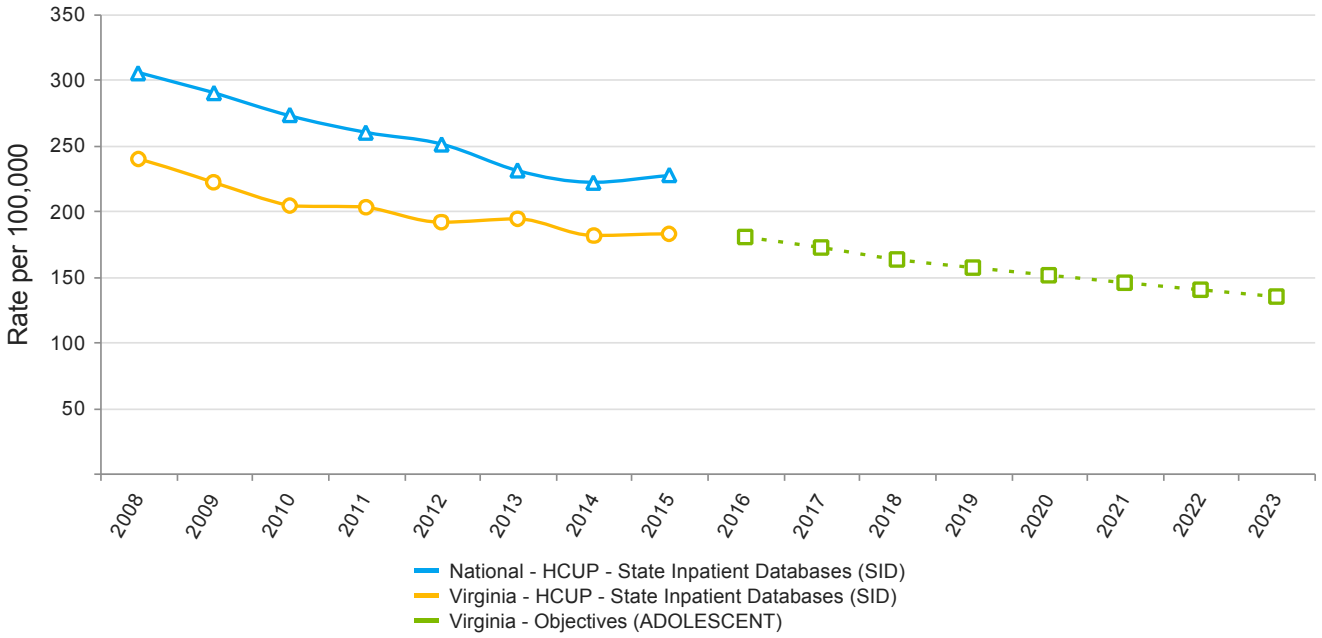
Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2016	9.9 %	NPM 13.2
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	NVSS-2016	15.6	NPM 7.2
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2016	30.4	NPM 7.2
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2014_2016	10.6	NPM 7.2
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2014_2016	9.8	NPM 7.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	92.9 %	NPM 13.2

National Performance Measures

NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19
Baseline Indicators and Annual Objectives



Federally Available Data		
Data Source: HCUP - State Inpatient Databases (SID)		
	2016	**2017**
Annual Objective	180	172
Annual Indicator	172.4	182.6
Numerator	1,826	1,451
Denominator	1,059,470	794,656
Data Source	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2014	2015

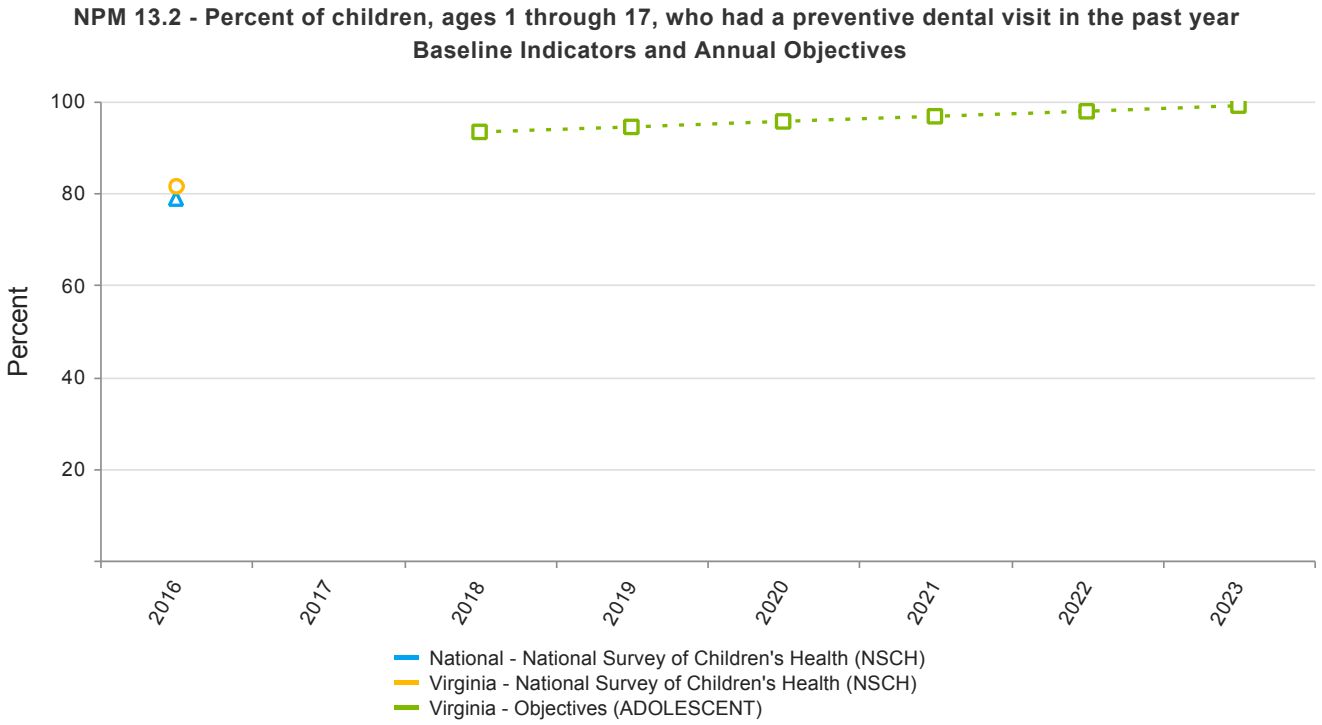
Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	162.9	156.8	151.0	145.3	139.9	134.7

Evidence-Based or –Informed Strategy Measures

ESM 7.2.1 - Number of gatekeepers trained in the prevention of suicide among youth

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	10.0	10.0	10.0	10.0	10.0



NPM 13.2 - Adolescent Health

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	**2017**
Annual Objective		
Annual Indicator		81.4
Numerator		1,407,907
Denominator		1,729,004
Data Source		NSCH
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	90.9	90.9
Numerator		
Denominator		
Data Source	NSCH	NSCH
Data Source Year	2016	2016
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	93.2	94.3	95.5	96.6	97.7	98.9

Evidence-Based or –Informed Strategy Measures

ESM 13.2.1 - Number of Regional Oral Health Alliances that implemented work plans to increase dental visits among children (ages 0-11 years) and adolescents (ages 12-17 years)

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	6.0	6.0	6.0	6.0	6.0

State Performance Measures

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

Measure Status:	Active

State Provided Data	
	2017
Annual Objective	2.6
Annual Indicator	31
Numerator	
Denominator	
Data Source	VA PRAMS
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	33.3	34.1	34.9	35.7	36.4	37.2

State Outcome Measures

SOM 4 - Unintended Pregnancy: Percent of unintended pregnancy among all women of child-bearing age

Measure Status:	Inactive - Unintended pregnancy efforts will be linked to only SPM; unable to link both SOM and SPM within state action plan.

State Provided Data	
	2017
Annual Objective	40
Annual Indicator	49.5
Numerator	
Denominator	
Data Source	PRAMS
Data Source Year	2015
Provisional or Final ?	Final

State Action Plan Table

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

Priority Need
Oral Health: Increase access to oral health services for pregnant women and children.

NPM
NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Objectives
By June 30, 2020, increase the percent of children (ages 12 through 17) who had a preventive dental visit in the past year from 90.9% (National Survey of Children's Health (NSCH) – NONCSHCN 2016) to 95.5%.

Strategies
Provide preventive dental services to children 1-17 with and without special health care needs.
Foster network of 6 regional Oral Health Alliances to conduct regional needs assessments and implement systems change and data-sharing initiatives to improve the oral health of all Virginians, with emphasis on pregnant women and children 1-17.

ESMs	Status
ESM 13.2.1 - Number of Regional Oral Health Alliances that implemented work plans to increase dental visits among children (ages 0-11 years) and adolescents (ages 12-17 years)	Active

NOMs
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

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

Priority Need

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

NPM

NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Objectives

By June 30, 2020, decrease the rate of hospitalization for non-fatal injury per 100,000 children ages 10 to 19 from 172.4 to 171.1 (SID-Adolescent).

Strategies

Provide suicide prevention trainings to professionals interacting with youth and adolescents.

ESMs	Status
ESM 7.2.1 - Number of gatekeepers trained in the prevention of suicide among youth	Active

NOMs

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

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

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

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

State Action Plan Table (Virginia) - Adolescent Health - Entry 3

Priority Need

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

SPM

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

Objectives

By June 30, 2020, reduce the rate of unintended pregnancies for all women of child-bearing age (ages 15-44) from 49.5% (PRAMS 2016) to 47%.

Strategies

Increase capacity of youth serving agencies to implement AIM 4 Teen Moms (AIM4TM), an evidence-based pregnancy prevention programs designed for parenting teens.

Strategies within the FY17 Adolescent Health workplan were implemented by the Division of Prevention and Health Promotion's Injury and Violence Prevention Program (IVPP) and Chronic Disease Unit. Complementary efforts were implemented by the Dental Health Unit and the Office of the Chief Medical Examiner. Activities completed during the reporting period are detailed below.

NPM 7: Injury Hospitalization

Strategies and related evidence-based/informed strategy measures proposed in the FY17 workplan included:

- *Strategy 1: 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.*

In FY17, the Injury and Violence Epidemiologist, partially funded with MCH Title V funds, maintained the Virginia Online Injury Reporting System (VOIRS), which provides the public with data on deaths and hospitalizations attributable to injury. VOIRS allows quick and easy access to basic injury data and enables users to customize data reports on various types of injury hospitalizations and deaths. Data are available for both intentional and unintentional injuries, and some demographic and geographic information is included to allow for more detailed analysis. The Injury and Violence Epidemiologist routinely responded to data requests from constituents that could not be addressed through the VOIRS system.

Using state general funds, the Injury and Violence Prevention Program supported the Campus Suicide Prevention Center of Virginia directed by James Madison University. The Center's mission is to reduce risk for suicide across Virginia's higher education settings. The Center serves all 15 public, 24 private, and 33 community colleges and universities located within Virginia with consultation, training, and suicide prevention resources. Supported activities included formation of the Virginia Campus Coalition inclusive of 6 colleges and universities; providing best practice and evidence-based training in identifying and responding to individuals in distress to students, faculty, staff and administration; coordination of Healthy Minds Study data collection and interpretation; and promotion of web-based resources for creating and maintaining triage protocols. During FY17, the center also continued to support and guide the development of a strategic plan for colleges and universities to address and promote the mental health of all students.

NPM 8: Physical Activity

Strategies and related evidence-based/informed strategy measures proposed in the FY17 workplan included:

- *Strategy 1: Partner with physical education and activity specialists to conduct tailored Comprehensive School Physical Activity Program (CSPAP) training within the 15 targeted school divisions.*
- *Strategy 2: 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.*
- *Strategy 3: 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.

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

In FY17, VDH supported local schools by promoting the establishment of wellness councils and healthy nutrition and physical activity environments. VDH and partners reached 206 school staff statewide by providing professional development, tailored technical assistance, resources, and tools to update and implement local school wellness policies. Additionally, school nurses were empowered through professional development to identify and manage students with chronic health conditions with a particular focus on asthma, epilepsy/seizure disorders, obesity, diabetes, food allergies, and poor oral health. Finally, VDH supported the Virginia Department of Education's online repository of curricula and resources to help implement Virginia's 2015 Health and Physical Education Standards of Learning. All School Health efforts were focused on helping Virginia schools adopt policies and practices to encourage children to: make healthy nutrition choices; achieve the recommended amount of daily physical activity; and prevent and/or manage the daily challenges from chronic health conditions.

Other Programmatic Activities

Dental Health Program

During the reporting period, the Division of Prevention and Health Promotion’s Dental Health Program served pregnant women and children (including children and youth with special healthcare needs).

Through a partnership with the Southwest Care Connection for Children (SWCCC) in 3 southwestern Virginia counties, a VDH remote-supervised dental hygienist provided oral screenings and varnish for 188 individuals with special healthcare needs (ISHCN), dental referrals for 129 ISHCN, and oral health education for 187 parents/caregivers. Also during this timeframe, 160 dental providers participated in VDH-sponsored continuing education courses regarding the oral health care of ISHCN, young children, and/or perinatal/pregnant women. In addition, the ISHCN program coordinator provided various oral health education courses regarding care of ISHCN and young children attended by 219 lay health workers/home visitors/family educators, 49 medical professionals, and 106 Head Start staff members. Medical and dental integration efforts included continued collaboration between clinics and drafting of initial documents regarding integration processes.

Planning for FY18 and FY19 work with the Virginia Oral Health Coalition and is detailed in the FY19 application. Regional alliances convened regularly and have developed short-term goals, as well as lists of data needs and a plan for obtaining the needed data through surveys. Of particular relevance, one alliance has made tremendous progress on developing an outreach initiative for pediatricians in the region who see the highest volume of Medicaid-enrolled children. The group has drafted a set of basic questions to interview pediatricians regarding their oral health knowledge and referral practices and has begun to create a toolkit of oral health information/resources for pediatricians to address the oral health of young children and pregnant women.

With non-MCH Funds, VDH dental teams continue to provide sealants and fluoride varnish to very young and school age children.

Office of the Chief Medical Examiner

Maternal mortality review is co-led by VDH Office of the Chief Medical Examiner (OCME) and the Office of Family Health Services.

OCME also leads the state's child fatality review team.

Title V funds contribute to OCME staffing support for both maternal and child fatality review. In addition, Title V-funded and non-Title V-funded OFHS staff serve on both review teams.

In FY17, the state child fatality review team reviewed cases of overdose poison deaths to infants and children up to age 17 that occurred in Virginia during the five-year period between 2009-2013. During this time, 41 infants, children, and adolescents died as a result poisoning in Virginia. After reviewing the circumstances of child overdose fatalities, the team identified two distinct child populations at risk: 1) teenagers who died as a result of suicidal or accidental drug overdose, and 2) infants and young children age six and under who died after unintentionally ingesting a fatal substance when left unsupervised, or after a caregiver administered medication to manage the child's behavior or sleeplessness. Prescription drugs were identified as the main contributor to child poisoning deaths, causing or contributing to more than two-thirds of these overdoses.

Additional details about the child fatality review team, along with data and reports, can be found here.

Adolescent Health - Application Year

The Office of Family Health Services administers a number of programs and initiatives serving adolescents. Leadership of Title V-funded efforts for adolescent health is shared by the Dental Health Program, Injury and Violence Prevention Program, Reproductive Health Unit, and Children with Special Healthcare Needs Program. These entities and their proposed activities for the upcoming grant period are detailed below.

State Priority: Oral Health

FY19 Performance Measure: NPM 13.2 –Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

OBJECTIVE: By June 30, 2020, increase the percent of children (ages 1 through 11) who had a preventive dental visit in the past year from 77.8% (National Survey of Children's Health – NONCSHCN 2016) to 81.7%.

Dental Health Program

The Division of Prevention and Health Promotion (DPHP)'s Dental Health Unit is led by Tonya McRae Adiches, RDH (Dental Health Programs Manager). Non-MCH funds support preventive dental services for MCH populations. The Dental Health Unit collaborates with Title V to:

- Foster regional alliances and implement local initiatives to improve access to dental care for children and pregnant women;
- Promote medical and dental integration in safety-net settings;
- Increase public awareness and engagement around oral health by disseminating data, research, and promising practices; and
- Support workforce development and training for medical and dental providers, lay professionals, home visitors, and caregivers serving ISHCN.

Strategy 1: Provide preventive dental services to children 1-17 with and without special health care needs.

This strategy includes maintaining a web-based listing of dental providers who report serving ISCHN and children under three years of age for referral from VDH clinical programs and the general public; providing fluoride varnish and oral screenings at South West Care Connection for Children pediatric medical specialty clinics (SWCCC), an extension of the Bright Smiles for Babies program; educating medical and dental professionals, lay health workers, case workers, teachers, families, and individuals about oral health care for ISHCN through presentations, exhibit booths, and educational materials; and developing cooperative relationships with other organizations and advocates to disseminate oral health information.

In addition, with non-MCH funding, VDH will provide oral screenings, and preventive dental sealants and fluoride varnish to preschool and school-aged children. Additionally, staff will provide oral health risk assessments and screenings, fluoride varnish applications, oral health counseling for parents, and dental referrals in WIC and well-child clinics in local health departments; and train early childhood professionals and VDH clinical providers to promote the importance of oral health during pregnancy, interconception, and early childhood.

Strategy 2: Foster network of 6 regional Oral Health Alliances to conduct regional needs assessments and implement systems change and data-sharing initiatives to improve the oral health of all Virginians, with emphasis on pregnant women and children 1-17.

VDH will partner with the Virginia Oral Health Coalition (VaOHC) to provide backbone support and facilitative

leadership training to 6 Regional Alliances (South Hampton Roads, Northern Virginia, Richmond/Petersburg, Southside, Central Virginia, and Southwest Virginia) to conduct regional oral health needs assessments, develop and implement regional project workplans, and share region-specific data among state and local partners. Staffs will also work together to develop and disseminate communications, to include 4 white papers addressing MCH populations.

State Priority: Child/Adolescent Injury
FY19 Performance Measure: NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 adolescents 10-19

OBJECTIVE: By June 30, 2020, decrease the rate of hospitalization for non-fatal injury per 100,000 children ages 10 to 19 from 182.6 (HCUP - State Inpatient Databases (SID) 2015) to 151.

Injury and Violence Prevention Program

DPHP's Injury and Violence Prevention (IVP) Program is led by Lisa Wooten, MPH, BSN, RN (Injury and Violence Prevention Program Supervisor). The IVP Program supports promising and best practice activities at the local level that address leading or emerging injury issues. Unintentional injuries continue to be a leading cause of death in the US and Virginia. Although death is the most severe result of injury, it represents only part of the problem. The majority of those who incur injuries survive, and often endure life-long mental, physical, and financial problems as a result of prolonged rehabilitation, hospitalization, loss of productivity, or stress to victim, family, and other caregivers. Despite its immense burden, injuries are largely preventable. Per the socioecological model, the IVP will aim to implement multi-level interventions (e.g. individual, relationship, community, societal) in order to effectively move the needle.

Strategy 1: Provide suicide prevention trainings to professionals interacting with youth and adolescents.

Reduction of suicide deaths is a continuing priority. However, death statistics vastly underestimate the burden of intentional self-harm injuries in youth. The VDH Suicide Prevention Program is housed in the Division of Prevention and Health Promotion (DPHP), within the Injury and Violence Prevention Program (IVPP). Primary efforts to address youth suicide under this program have focused on training youth serving professionals and organizations to comprehensively screen for suicide risk and refer affected youth to immediate care. Additionally, the program has worked with college and university campuses throughout Virginia to develop suicide prevention plans that would address risk for students in those settings and strengthen community systems to address campus mental health

In FY19, efforts will include continuing assistance to the statewide Campus Suicide Prevention Center, which is designed to provide technical assistance to university and college campuses through cohort infrastructure and address risk and protective factors for acts of suicide specific to college age adolescents and young adults; and increase the number of youth serving stakeholders for employing best practices in youth suicide prevention. These activities will leverage existing partnerships to improve access to injury prevention education and promote workforce competency in injury prevention best practices.

State Priority: Women's/Maternal Health
FY19 Performance Measure: SPM 4 – Unintended Pregnancy: Proportion of females ages 15-44 using Tier 1 (most effective) contraceptive methods

Objective: By June 30, 2020, reduce the rate of unintended pregnancies for all women of child-bearing age (ages 15-44) from 49.5% (PRAMS 2016) to 47%.

Reproductive Health Unit

The Division of Child and Family Health's Reproductive Health Unit is led by Emily Yeatts, MSW, MPH (Reproductive Health Unit Supervisor). The unit includes the following programs:

- Title X Family Planning (Title X): Clinical family planning programs consistent with Title X requirements and Quality Family Planning Services as defined by the CDC
- Adolescent Health (Abstinence Education Grant, Title V): Positive youth development programs that build protective factors among participants that will make them less likely to initiate sexual activity
- Resource Mothers (TANF, Title V): Adolescent health program providing support services to pregnant and parenting teens and their families

Strategy 1: Increase capacity of youth serving agencies to implement AIM 4 Teen Moms (AIM4TM), an evidence-based pregnancy prevention programs designed for parenting teens.

Resource Mothers is a program developed by VDH for pregnant and parenting teens and their families. Community Health Workers have been offering this program to teens for several decades, and services include home visiting, education, developmental screenings, and referrals. The goals of the Resource Mothers program include preventing rapid repeat unintended pregnancy, reducing infant mortality, and improving maternal and child health outcomes.

In order to incorporate evidence-based teen pregnancy prevention work into the Resource Mothers program, VDH proposes to train all Resource Mothers in the evidence-based model AIM for Teen Moms (AIM4TM). AIM4TM was developed by the Children's Hospital of Los Angeles and designed specifically to meet the needs of parenting teens. AIM4TM has been recognized by the Office of Adolescent Health as an evidence-based teen pregnancy prevention program and employs a strengths-based approach.
During FY19, VDH intends to launch the AIM4TM program for teens enrolled in Resource Mothers, and using the information gathered during this pilot program, develop a strategy for expanding this program to other youth-serving agencies. In order to ensure the success of the AIM4TM pilot program, VDH intends to monitor local implementation sites to ensure that the program is implemented with fidelity. In order to expand programs available to pregnant and parenting teens, VDH intends to offer at least one training for community agencies about AIM4TM.

Children with Special Health Care Needs

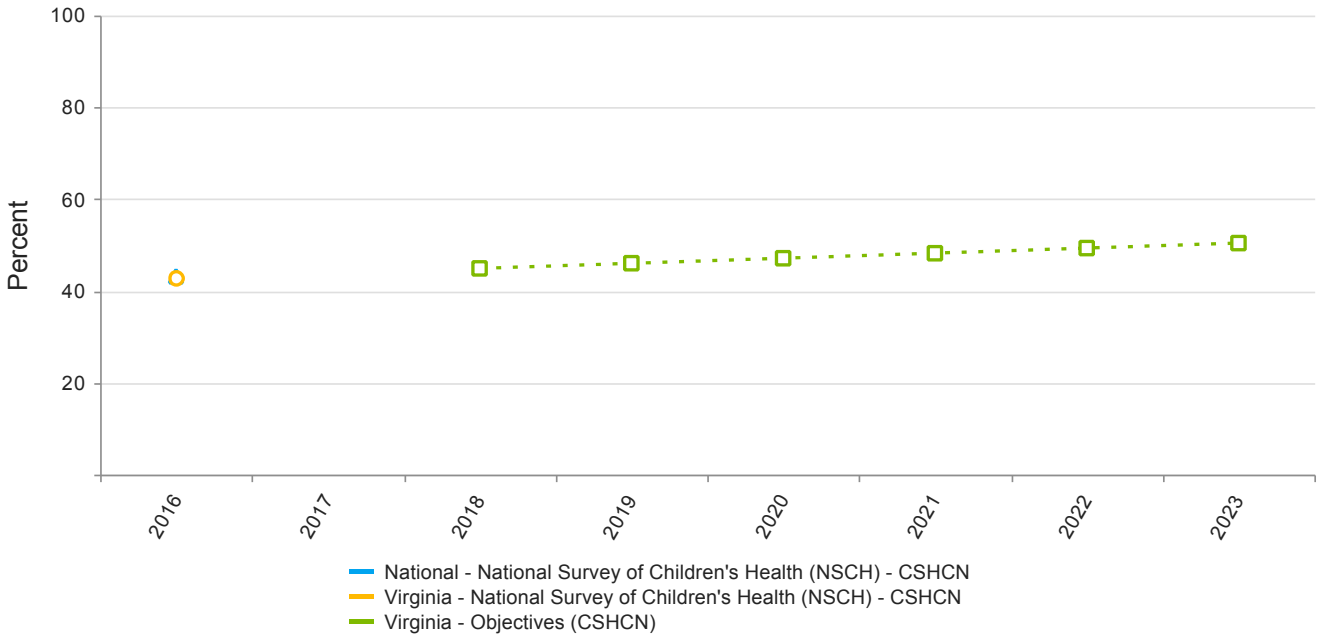
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2016	16.1 %	NPM 11 NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2016	61.7 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	92.9 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year	NSCH-2016	1.6 %	NPM 11

National Performance Measures

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Baseline Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	**2017**
Annual Objective		
Annual Indicator		42.7
Numerator		167,058
Denominator		391,428
Data Source		NSCH-CSHCN
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	44.9	46.0	47.1	48.2	49.3	50.4

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		25
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	Division of Child and Family Health	VDH CYSHCN Program
Data Source Year	2016	2017
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	100.0	250.0	400.0	500.0	525.0	550.0

ESM 11.2 - Percentage of CYSHCN served by the VA CYSHCN Program who report having a medical home

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		90
Annual Indicator	89.2	98.9
Numerator	4,061	4,391
Denominator	4,555	4,439
Data Source	Office of Family Health Services, VDH	VDH CYSHCN Program
Data Source Year	2015	2016
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	91.5	93.0	94.5	96.0	97.5	98.0

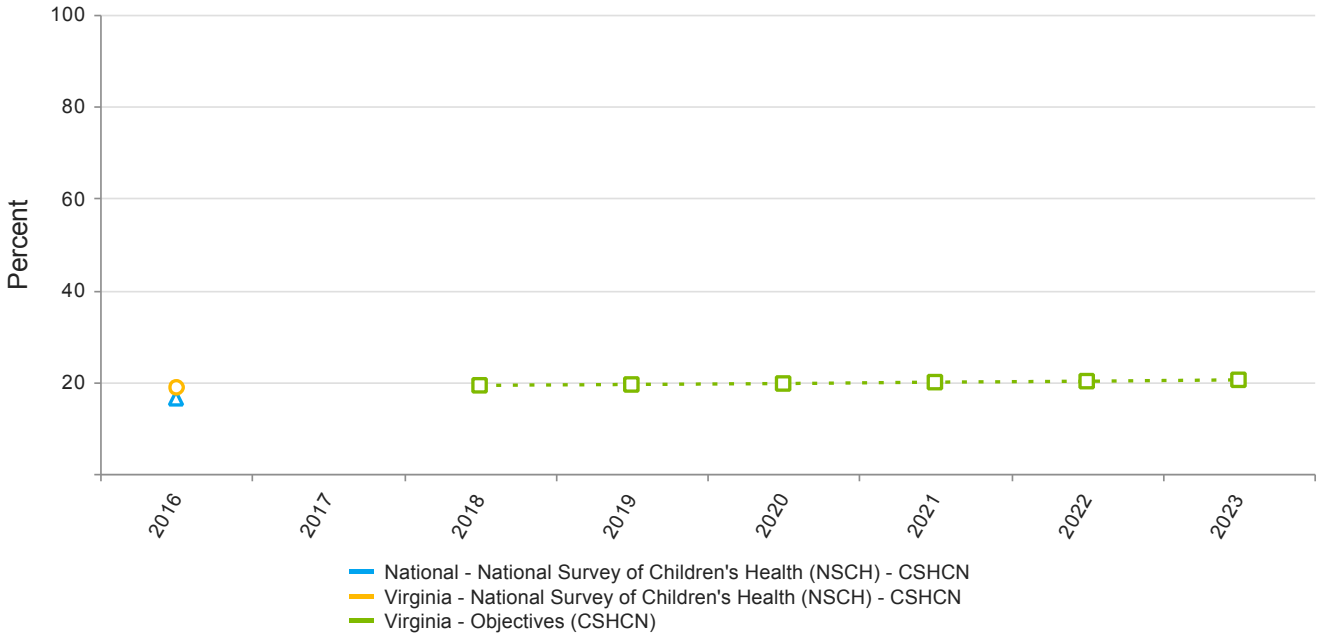
ESM 11.3 - Percentage of children enrolled in public schools who report a primary care provider

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		40
Annual Indicator	30.6	0
Numerator	200,000	
Denominator	653,103	
Data Source	Virginia Department of Education	Virginia Department of Education
Data Source Year	2015-2016	2016
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	42.5	45.0	47.5	50.0	53.0	53.0

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care
Baseline Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	**2017**
Annual Objective		
Annual Indicator		18.8
Numerator		31,194
Denominator		166,277
Data Source		NSCH-CSHCN
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	19.3	19.5	19.7	20.0	20.2	20.5

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		25
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	Division of Child and Family Health	VDH CYSHCN Program
Data Source Year	2016	2017
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	100.0	250.0	400.0	500.0	525.0	550.0

State Action Plan Table

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

Priority Need

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

NPM

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Objectives

By June 30, 2020, increase the percentage of typical and children with special health care needs served by the VDH CYSCHN Program who can identify a primary care provider as a medical home from 89.2% to 91.5%.

Strategies

Partner with VA Chapter of the American Academy of Pediatrics (AAP), community partners, and Virginia's CYSHCN centers (i.e. CCC centers, CDCs, VBDP sites, Sickle Cell Program sites) to develop a training module for health care providers and families 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.

Assure children with special health care needs receive coordinated, ongoing, comprehensive care within a medical home (CYSHCN National Standard: Medical Home).

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

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

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

Priority Need

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

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Objectives

By June 30, 2020, increase the proportion of children with and without special health care needs in Virginia who are engaged in transition services to adult health care from 44.9% (NSCH-CYSHCN 2010) to 47.1%.

Strategies

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

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

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Children with Special Health Care Needs - Annual Report

Strategies within the FY17 Children and Youth with Special Health Care Needs (CYSHCN) workplan were implemented by the Division of Child and Family Health's CYSHCN Program. Activities completed during the reporting period are detailed below.

VDH's CYSHCN programs serve youth from birth to age 21 who 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. In FY17, the CYSHCN program served about 7,600 families. In FY17, the *Care Connection for Children (CCC)* program served 3,043 families, and the CDC program served 3,266 families, resulting in 5,081 diagnoses and 5,941 referrals for additional services.

NPM 11: Medical Home

Strategies and related evidence-based/informed strategy measures proposed in the FY17 workplan included:

- *Strategy 1: 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.*
- *Strategy 2: 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.*
- *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*

The Virginia MCH leadership team has been very busy working to move the Medical Neighborhood Collaborative work forward. As described in the last block grant application, the purpose of this collaborative is to bring partners together in one region of the state to focus on issues that impact children and CYSHCN. During the last couple of years, several meetings have been held and the collaborative agreed to work with the Virginia Department of Health to support the block grant medical home and transition national performancemeasures. Partners who have been part of the work include the Virginia Chapter of the American Academy of Pediatrics, local pediatricians, care coordinators, the state family lead, Medicaid, home visiting representatives, and others. After a series of meetings, the collaborative decided that it wanted to create Virginia specific online medical home and transition training modules to promote each aim and to educate families/practitioners on the importance of both. Specifically, the meetings focused on sharing the goals of Title V, training the collaborative on collective impact, brainstorming regarding specific module content, and a meeting to approve the final outline of the work.

Since the last meeting, VDH has been very busy writing a scope of services for the module content, identifying funding for the project, and procuring a vendor to do the work. This effort took more time than expected due to complex contract negotiations and approval procedures. Despite the many challenges, VDH was finally able to secure a contract with the University of Virginia Continuing Education Office to create the actual module framework and the agency is now moving into project design.

The CCC program works directly with primary care and specialty care providers to provide care coordination services for families and to help link them to primary care providers as needed. The relationship that the CCC care coordinators have with medical providers is unique. When needed, they support families by:

- Working with primary care providers and specialists to get prior authorizations;
- Explaining health insurance/benefits;
- Linking the families to sometimes hard to find durable medical equipment providers and;
- Helping to overcome any barriers that are making it difficult for the child with special needs to get services.

The CDC program received about 82% of its client referrals from medical providers whom they subsequently worked with to assess youth suspected of having developmental or behavioral disorders. In order to complete the assessments, the program worked closely with parents, referring clinical providers, and school systems. Overall, the number of children served by the CDCs who had a primary care provider at the time of their assessment was approximately 97%. If a child is identified as not having a primary care provider, center staff work closely with the family to connect them to one.

At the end of the State FY 17 quarter 4, the VBDP reported 88% of patients under 21 had a primary care provider (PCP). The program monitored applications quarterly in order to identify medical homes to assure that proper coordination was occurring.

The Sickle Cell Program (SCP) centers reported 91% of patients under 21 had a PCP at the end of the State FY 17 Q4. All four of the centers encouraged families to have a medical home other than the sickle cell center. For example, in one center, the primary care provider (PCP) is verified at each visit. Families are educated on the importance of having a PCP for well visits and issues that are not related to sickle cell disease. The symbiotic relationship between the sickle cell center and the PCP ensures that the center is able to obtain referrals and authorizations for needed studies. Another center communicated with the PCP and family about the child's current immunization status and additional recommended immunizations or vaccinations that the child needed. All of the centers assured that certain vaccinations (pneumococcal, meningococcal conjugate, Meningococcal B vaccines) were given to sickle cell patients but relied on the family to have a PCP to give other routine vaccinations.

The VDH School Nurse Consultant, supported by Title V, continued to support efforts to increase the percentage of school health personnel in Virginia schools who provide education on the importance of all children (including CYSHCN) having a medical home to students and their families. VDH continued its long-standing partnership with the Department of Education (DOE) to provide workforce development and school health guidelines for school nurses. VDH has also partnered with DOE to collect survey data on whether students have a medical home and will continue to advocate for ongoing surveillance.

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

Strategies and related evidence-based/informed strategy measures proposed in the FY17 workplan included:

- *Strategy 1: 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.

- *Strategy 2: Partner with child care, medical providers, CYSHCN resources/organizations, schools, and early childhood serving state agencies to educate and provide support to children (and their families). Include the provision of individualized health care plans and training on transitioning children and adolescents to child care, elementary/middle/high school entry, and into adulthood.*
- *ESM 12.1 - Number of providers in Virginia who have completed the transition training module*

Progress on developing Transition training modules is detailed above.

In addition to work on the modules, the CCC program continued to use the unique transition tool that it created. Care coordinators use the tool to help identify client needs and plan for their future. The tool focuses on all aspects of adult life, including education/vocation/employment, health and wellness, mobility/transportation/recreation, and legal/insurance/adult benefits/housing. The Children's Hospital of the King's (CHKD) Daughters CCC program developed the tool and they update it regularly with consultation from the other CCC centers across our state that are contracted with the CYSHCN program. The tool is based on the work of *Got Transition.*

The CDC program provided assessments and diagnoses of very young children suspected of having developmental and behavioral conditions such as ADHD and autism. However, program staff worked with in-house Virginia Department of Education staff to refer older youth to their local school system for transition services when required (all youth served by this program are referred for clinical services as needed).

The sickle cell centers and hemophilia treatment centers do not have transition programs. Virginia Commonwealth University (VCU), located in Richmond, VA, has the only robust adult centers for bleeding disorders and sickle cell. It is challenging for all centers to have traditional transition programs due to the geography of Virginia and transportation barriers for families. Instead, all eight centers (four hemophilia treatment centers and four sickle cell centers) have transition processes and policies that they use to transition patients from pediatric to adult care.

The bleeding disorder centers had 12 patients transition from pediatric to adult care in SFY17. The Program Manager had quarterly calls to discuss the patients that would be transitioning to adult care. Some of the other efforts that the centers took were:

- The nurse coordinator at CNMC (Children's National Medical Center) presented the transition policy and reviewed the checklist at the beginning of the comprehensive visit. The National Hemophilia Program Coordinating Center (NHPCC) identified adolescent transition as a national priority for quality improvement. The nurse from CNMC completed training to coach in wave 2 of the NHPCC (spell out) Transition QI project.
- The social worker at UVA held a lunch lecture during the June comprehensive hemophilia clinic on "Successful Transition to Independence" for current and past patients and their families.

The sickle cell centers had 48 patients transition from pediatric to adult care in SFY17. Due to the lack of adult centers around the state for sickle cell, the centers have worked to locate hematologists in their respective areas that feel comfortable treating sickle cell patients. Only one center out of the four has a dedicated transition coordinator on staff that works with patients 15-21 years of age; the other centers utilize social workers to coordinate transition activities.

Some of the efforts that the centers took to successfully transition patients were:

- CHKD held a transition retreat for patients. Topics included transition process, pain management, and resume writing/job interview skills. All transition-aged patients created an individualized health care transition plan, had discussions regarding the possibility of losing Medicaid at age 19 and other insurance options and provided relevant educational materials to assist in the patient understanding the transition process.

- UVA held two lunch lectures for transition-aged patients during sickle cell clinic. Education and resources pertaining to transition were discussed. The center also worked on developing interactive sickle cell modules on Prezi to be used on iPad tablets during clinic visits.

VCU usually holds two transition retreats, one in the fall and one in the spring, but the fall retreat was cancelled due to the threat of a hurricane. The spring retreat served as an opportunity for education and team building. The center also held an annual Pediatric Hematology/Oncology Graduation ceremony and invited all graduating seniors. The center was fortunate enough to receive local monetary support from ASK and the local sickle cell association for each student who attended graduation.

In FY17, the VDH School Nurse Consultant continued to support efforts to increase the percentage of adolescents with and without special health care needs who receive services necessary to make transitions to adult health care. VDH partnered with DOE to provide workforce development for school nurses based on the Office of Adolescent Health's *Adolescent Health: Think, Act, Grow® Playbook* and designed and launched a state adolescent health website.

Additional System Outcomes for CYSHCN

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

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

Another one of our core programs, the Child Development Centers (CDCs) also actively engage families. The CDCs provide assessments of children suspected of having developmental and/or behavior conditions. Families are an active part of the assessments that are done and they receive documentation regarding diagnoses. In addition, center staff members refer them to clinical and non-clinical resources for assistance and collaborate with other providers serving the family.

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

The SCP centers offered genetic counseling to aide in future reproductive decision making of families served. The regional centers provided events for families, including social gatherings and overnight camps with educational and group activities focusing on transition and self-advocacy. One center partnered with ASK Childhood Cancer

Foundation to provide monthly discussion groups for patients and families, as well as held a program called “First Steps.” The program provided basic information about SCD and a forum for families to discuss the challenges for caring for an infant with SCD. The social worker continued to send out pertinent information for families as topics arose pertaining to medical advances in SCD. Families with newborns diagnosed with SCD were given a copy of *Hope and Destiny: A Patient’s and Parent’s Guide to Sickle Cell Anemia* and patients entering the transition phase were given a copy of *Hope and Destiny Jr*.

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

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

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

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

The CYSHCN program in Virginia partners very closely with major medical centers across the state. Contractual partners include: Children’s Hospital of the King’s Daughters in the Tidewater Region, the University of Virginia Health System in the Blue Ridge region, Carilion Health System in the Roanoke/southwest region, INOVA Health System and Children’s National Medical Center in the northern region, and Virginia Commonwealth University Health System in the central region. This partnership benefits families tremendously because they are able to receive the services they need through one “open door”. For example, children with sickle cell disease often need care from several specialty providers such as nephrologists, neurologists, and radiologists. The health systems partners refer these children to these specialties within their own health system and services are generally offered on the same campus. This same benefit exists for CYSHCN served through our CCC, CDC, and bleeding disorder programs.

Two of the SCP sites implemented satellite clinics in areas with geographic need for services in order to improve family access of care. They also addressed issues of family support, health insurance, and identified transportation barriers for patients getting to appointments and provided assistance in obtaining bus tickets, Medicaid cabs, gas

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

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

In addition to the above, 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.

Notable Partnerships, Collaborations, and Coordination

The CYSHCN program partners very closely with major medical centers and/or universities across the state. Contractual partners include:

- Children's Hospital of the King's Daughters in the Tidewater Region;
- The University of Virginia Health System in the Blue Ridge region;
- Carilion Health System in the Roanoke/southwest region;
- INOVA Health System and Children's National Medical Center in the northern region;
- Virginia Commonwealth University Health System in the central region;
- James Madison University in the Shenandoah Region.

These partnerships benefit families tremendously because they are able to receive the services they need through one "open door." For example, children with sickle cell disease often need care from several specialty providers such as nephrologists, neurologists, and radiologists. The health systems we collaborate with readily refer children to these specialties within their own health system and services are generally offered at the same campus. This similar benefit exists for CYSHCN served through our CCC, CDC, and bleeding disorder programs at health systems.

In addition, the Virginia Administrative code states that the Virginia Department of Education will collaborate with the four CYSHCN programs to provide consultation for families, educators and school administrators. The program staff partners with the school systems and the educational consultants to ensure students receive services consistent with their level of need. As needed, the Educational Consultants make school visits, communicate with teachers, counselors, and school nurses to activate home schooling and assist with 504 plans and IEPs.

Emerging Challenges

As noted above, VCU, located in Richmond, VA has the only robust adult center for bleeding disorders and sickle cell. A team of professionals who deliver comprehensive care best serves people who are affected by sickle cell disease and bleeding disorders. There are hematologists throughout Virginia that will see patients with the mentioned conditions, but it could be debated whether the care is as adequate as receiving it from a comprehensive

center. For patients in the Virginia Bleeding Disorders Program they have to attend at least one comprehensive visit at VCU in order to continue receiving services. Three out of the four comprehensive sickle cell centers have identified at least one hematologist to transition patients to adult care. One center had written into their work plan that they would establish a transition/bridge program with a local hospital's sickle cell disease management program. However, in SFY17 the program between the two did not happen due to the local hospital's program not accepting new patients. One center continues to see adults in the pediatric clinic well into adulthood due to the lack of hematologists that are in close proximity to the area or local providers who do not feel comfortable with managing patients affected with sickle cell disease. The sickle centers will continue to work on finding adult providers willing to receive transitioning sickle cell clients.

Other Programmatic Activities

Dental Health Program

Oral health services and initiatives serving CYSHCN are detailed in the Cross-Cutting domain annual report.

CYSCHN Program

Other key FY17 program activities and achievements include:

- The Care Connection for Children program was accepted to the AMCHP Innovation Station as an emerging program.
- The VDH Newborn Screening Program and the CYSHCN program created a process to refer children to services who have Zika-related birth defects. Children will be referred to the CCC and CDC and families will be offered services.
- The national hemophilia needs assessment revealed that minority patients face a greater challenge to accessing care than non-minorities. The hemophilia treatment center at Children's Hospital of the King's Daughters assisted two Spanish-speaking patients in getting into comprehensive care.
- Title V funds are used to maintain the CCC database (CCC-SUN) and those same funds have been very helpful in upgrading the security of the database.
- Parent coordinators are included in statewide CCC directors meetings where major decisions are made about the program to help assure that we consider the family perspective.
- CYSHCN program staff serve on the Virginia Department of Education Family Engagement Network and participate in quarterly meetings.
- The sickle cell program was rebranded and has received new energy due to the efforts of the state blood disorders coordinator.
- The Maternal and Child Health Division of Services for CYSHCN in the Maternal Child Health Bureau asked the Virginia CYSHCN program director to participate in a voluntary key informant interview. Karen Trierweiler of Total Population Health, LLC interviewed the state CYSHCN director. The interview focused on Virginia's efforts to move to a population health approach for CYSHCN and the struggles that are related to system transformation

Overview of Virginia's CYSCHN Program

VDH's Children and Youth with Special Health Care Needs (CYSHCN) programs serve youth from birth to age 21 who have, or are at an increased risk for, a chronic physical, developmental, behavioral, or emotional condition, and who also require health and related services of a type or amount beyond that required by children generally. Approximately 50% of the state's federal allocation serves this vulnerable population. To maximize federal funding and facilitate linkages to care, most CYSHCN efforts are provided in partnership with major health care systems and universities. In FY17, the CYSHCN program served about 7,600 families.

Care Connection for Children (CCC)

The CCC program is a statewide network of six regional centers of excellence that provide care coordination services to reduce barriers that families face when trying to access care. Such services include, but are not limited to:

- Medical insurance benefit evaluation and referral (including Medicaid);
- Linkage to a primary care provider/medical home;
- Referrals to necessary resources and specialty services;
- Family-to-family support via parent coordinators;
- Support from the Virginia Department of Education's (DOE's) state educational consultants and;
- A pool of funds for uninsured or underinsured families with no other means for obtaining life-preserving medications and/or durable medical equipment.

In FY17, the CCC program served 3,043 families.

Child Development Centers (CDCs)

The CDC program serves families with children who are suspected of having behavioral or developmental disorders (e.g. autism, ADD/ADHD, learning disabilities, anxiety, PTSD, mood disorders). Five regional centers provide multidisciplinary assessments of each child, as well as diagnoses and short-term care coordination to link families to necessary services beyond the capabilities of most primary care providers. The program helps to respond to state and national shortages of developmental and behavioral pediatric service providers. In FY17, the CDC program served 3,266 families, resulting in 5,081 diagnoses and 5,941 referrals for additional services.

Virginia Bleeding Disorders Program (VBDP)

The VBDP recognizes the ongoing medical costs of treating a bleeding disorder may exceed a families' financial capacity, so the program provides a "safety net" for persons with bleeding disorders and their families. The VBDP also recognizes the importance of comprehensive hemophilia care; therefore, the program supports a statewide network of comprehensive care centers to promote coordinated, family-centered, culturally competent, multidisciplinary system of care for clients of all ages with inherited bleeding disorder. A major service of the program is insurance case management that assists families in knowing all of their insurance options, completing the application and enrollment process. In addition, the program has funds to assist 20 patients with premium assistance and to assist uninsured and underinsured persons obtain medication (factor) and/or supplies via a pool

of funds.

Virginia Sickle Cell Awareness Program (VASCAP)

VASCAP provides access for adult sickle cell screening and follow-up education for individuals and families identified with sickle cell disease and other hemoglobinopathies. VASCAP collaborates with the Virginia Newborn Screening Program and the Pediatric Comprehensive Sickle Cell Centers to insure early parent education, encourage confirmatory testing, and early entry into care for newborns and their families identified with sickle cell disease and other hemoglobinopathies. The Pediatric Comprehensive Sickle Cell Centers are located in major medical systems throughout the Commonwealth. The centers provide comprehensive medical and support services for newborns and children living with sickle cell disease.

State Priority: Medical Home
FY19 Performance Measure: NPM 11 - Percent of children with and without special health care needs having a medical home

OBJECTIVE: By June 30, 2020, increase the percentage of typical and children with special health care needs served by the VDH CYSCHN Program who can identify a primary care provider as a medical home from 89.2% to 91.5%.

Strategy 1: Partner with VA Chapter of the American Academy of Pediatrics (AAP), community partners, and Virginia's CYSHCN centers (i.e. CCC centers, CDCs, VBDP sites, Sickle Cell Program sites) to develop a training module for health care providers and families 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.

Medical Neighborhood Module Plan

For the upcoming application year, the CYSHCN program plans to complete and launch the Medical Neighborhood Collaborative medical home and transition training modules (modules will be targeted to all child populations and not just CYSHCN). As described in the annual report summary, there was some difficulty working to secure a contract with a vendor for this work. However, VDH has been successful in finalizing the scope of services and the agency navigated several procurement and contractual hurdles to secure an agreement with the University of Virginia (UVA). The agreement was signed in January of 2018 and UVA has committed to creating modules that are targeted to providers and families. The online modules will be free to Virginia residents and providers (CMEs offered) who practice in our state. This effort will continue the relationship that VDH already has with UVA for online continuing education modules. UVA currently manages breastfeeding and newborn screening/bloodspot modules for the agency and they are working on an Early Hearing Detection and Intervention training module.

VDH staff will use the outline that was approved by the Medical Neighborhood Collaborative to create module content. This content will draw on the evidenced based resources that already exist such a *Got Transition,* the *National Center for Medical Home Implementation,* and the *American Academy of Pediatrics.* Once UVA creates the first draft of the web based platform, CYSHCN staff will partner with them to demo the modules to the Medical Neighborhood collaborative and various other organizations in the state. A specific focus will be placed on getting feedback from parents with support from family organizations. Once sufficient feedback has been received, the modules will go live on the existing training platform that UVA manages and staff will work closely with the University

to promote it.

Strategy 2: Assure children with special health care needs receive coordinated, ongoing, comprehensive care within a medical home (CYSHCN National Standard: Medical Home).

From a program perspective, the CCC Program will continue to work directly with primary care and specialty care providers to provide care coordination services for families and help link them to services as needed. The program will also continue to help obtain prior authorizations; explain health insurance/benefits to families; link families to sometimes hard to find durable medical equipment providers; and help to overcome any barriers that are making it difficult for children with special needs to get services. The CCC program will survey families to gauge their satisfaction with program services. This survey will be used to help the program identify services that are provided well and those areas where program growth is needed.

The CDC program will continue to serve as a resource for providers and families to provide assessments of children suspected of having developmental or behavioral conditions. Upon diagnosis, the centers will continue to share results with families and providers (as approved by parents) and will connect diagnosed CYSHCN to resources within their own community. In addition, central office staff will organize a statewide meeting with the CDCs to formulate a strategy to address suggested program improvements from the 2016 evaluation.

The VBDP and Pediatric Comprehensive Sickle Cell Centers will continue to encourage families to have a PCP. Once the modules are created, the information will be shared with all the centers for them to share with patients and their families.

State Priority: Transition
FY19 Performance Measure: NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

OBJECTIVE: By June 30, 2020, increase the proportion of children with and without special health care needs in Virginia who are engaged in transition services to adult health care from 44.9% (NSCH-CYSHCN 2010) to 47.1%.

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

The CCC program will continue to use its program specific transition tool. This tool will be utilized to help families prepare their child with special needs to transition clinically, socially, educationally, and vocationally. Once developed, all CYSHCN programs will be expected to support VDH in promoting the transition modules online to all of their partners and to families who receive services.

The CDC program will continue to work with in-house Virginia Department of Education staff to refer older youth to their local school system for transition services when required (all youth served by this program are referred for clinical services as needed).

The sickle centers will continue to work on finding adult providers willing to receive transitioning sickle cell clients. The bleeding disorders program will continue to transition patients to VCU for adult care or transition them within their own community if possible.

Other Programmatic Activities

Managed Care Organizations

The CYSHCN program makes up a large portion of Virginia's federal Title V budget. This is not sustainable long-term, so staff have been working to realign work and to look for alternative funding options. To address this, MCH/CYSHCN leadership are working with Medicaid Managed Care Organizations to explore the possibility of entering into contractual agreements to help pay for care coordination services provided by the CCC program, which is the most costly MCH-funded CYSHCN program. Staff are presently working very closely with one particular MCO to execute a business associate agreement and contract. If this effort is successful, the process of collecting reimbursement will be piloted in one region with the hopes of duplicating it statewide with multiple MCOs. In addition, the CYSHCN Director continues to work with medical center partners to fiscally integrate services within the health systems. This would require health system sites to consider carrying more of the financial burden of the services that are provided. The CCC program is prioritized because the CDC, sickle cell, and bleeding disorders programs already provide substantial financial support.

Continuum of Care for Developmental/Behavioral Pediatrics

Also, the CYSHCN program is exploring the possibility of working with our CDCs to create a continuum of care for developmental and behavioral pediatrics. The desire is to promote the CDCs as the developmental and behavioral experts in our state and to formally connect developmental screening, assessments, and diagnosis together via a regional approach. MCH and CYSHCN staff will formally present this option to our CDC partners during the next contract year.

Cross-Cutting/Systems Building

State Performance Measures

SPM 6 - Cross-cutting (Family Engagement): Implement and develop report on survey of families served by the VDH Care Connection for Children (CCC) programs

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	Yes	No	No	No	No

State Action Plan Table

State Action Plan Table (Virginia) - Cross-Cutting/Systems Building - Entry 1

Priority Need

Family Engagement: Foster a culture of family/youth engagement and leadership.

SPM

SPM 6 - Cross-cutting (Family Engagement): Implement and develop report on survey of families served by the VDH Care Connection for Children (CCC) programs

Objectives

Support and document family engagement in 100% of CYSCHN programs (i.e. Care Connection for Children, Child Development Centers, Bleeding Disorders Program, Sickle Cell Program) annually.

Strategies

Assure families of children with special health care needs partner in decision making at all levels and are satisfied with the services they receive (CYSHCN National Standard: Family Professional Partnerships / Cultural Competence).

Cross-Cutting/Systems Builiding - Annual Report

Strategies within the FY17 Life Course / Cross-Cutting workplan were implemented by the Division of Child and Family Health's Maternal and Infant Health (MIH) Unit, in partnership with the Division of Prevention and Health Promotion (DPHP). Complementary efforts were implemented by the Dental Health Program. Activities completed during the reporting period are detailed below.

SPM: Teen Pregnancy

Teen pregnancy prevention is addressed through coordination with our Title X funded Family Planning program which makes services available to adolescents in 33 of the 35 health districts. The remaining two districts provide family planning under independent programs. The Abstinence Education Program collaborated with the Title V MIH Coordinator with the 6 LHD sites that were working in AEP to leverage resources, staff and maximize reach to adolescents. This effort was in tandem with local efforts in these LHD communities and local coalitions (e.g., outreach, health fairs etc.). The Abstinence Education Coordinator provided trainings when requested.

This SPM was initially listed under the Life Course/Cross--Cutting domain within the FY17 application, with a focus on females ages 15-19. The metric was revised for the FY18 application to capture unintended pregnancy among all women of reproductive age (ages 15-44); proposed evidence-based approaches for FY19 are detailed within the Women's/Maternal Health and Adolescent Health domains.

NPM 14: Tobacco

The MIH worked closely with the DPHP Tobacco Cessation Coordinator to promote the Quitline in LHDs to all pregnant and parenting moms. All 35 LHDs are enrolled in the Fax to Quit program, which allows the provider/nurse to enroll the mom/parent/caregiver into the program by faxing over a short questionnaire. The parent then begins receiving phone calls from the Quitline.

LHDs have access to a regional coordinator for on-site staff training. LHDs also work closely with pediatrics and OB/GYN in local communities to ensure these providers have the information and posters to promote the Quitline.

The Quitline continues to provide an enhanced 10-call pregnancy program with the goal of reducing health risks to


Quit Now Virginia
2015/2016 Stakeholder Report

the baby and other children in the household. The program targets cessation during pregnancy and skill development to help women remain smoke-free postpartum. Title V funds supports access to this program for pregnant women.

In May 2017, Quit Now Virginia released its 2015/2016 Stakeholder Report. From August 1, 2015 to July 31, 2016, 4.3% of women served by the Quitline were pregnant (86), planning pregnancy in the next 3 months (34), or breastfeeding (10). During the evaluation period, 4 out of 12 pregnant women who responded to the follow-up survey remained smoke-free for at least 30 days at 7 months post-enrollment with the VAQL.

Other Programmatic Activities

Dental Health Program

Oral health was added as a state priority to the state action plan under the Life Course/Cross-Cutting domain for the FY18 application year.

Though oral health was not included in the state action plan until FY18, MCH funds supported a number of efforts in FY17. Through a partnership with the Children and Youth with Special Healthcare Needs (CYSHCN) Program's Southwest Care Connection for Children in three Southwestern Virginia counties, a VDH remote-supervised dental hygienist provided oral screenings and varnish for 188 individuals with special health care needs (ISHCN), dental referrals for 129 ISHCN, and oral health education for 187 parents/caregivers.

Also in FY17, 160 dental providers participated in VDH-sponsored continuing education courses regarding the oral health care of ISHCN, young children, and/or perinatal/pregnant women. In addition, the ISHCN program coordinator provided various oral health education courses regarding care of ISHCN and young children attended by 219 lay health workers/home visitors/family educators, 49 medical professionals, and 106 Head Start staff members.

An emphasis was placed on supporting the integration of care for the MCH populations. Medical and dental integration efforts included continued collaboration between medical and dental clinics and drafting of initial documents regarding integration processes.

The FY18 workplan included a commitment to develop an action plan for reintegrating oral health into the state Title V program; ESM 13.1 (completion of action plan identifying strategies and partners for addressing the top 3 MCH oral health needs in Virginia) was also developed in FY18 to track progress. The action plan was completed in the fall of 2017, and ESM 13.1 was replaced with 3 new ESMs. A key strategy is collaborating with the Virginia Oral Health Coalition (VaOHC) to grow a network of 6 regional alliances to address the oral health needs of pregnant women and children. Virginia's proposed FY19 activities to increase access to oral health services are now detailed within the Women's/Maternal, Child, and Adolescent Health domains.

State Priority: Family Engagement

FY19 Performance Measure: Family Engagement - Implement and develop report on survey of families served by the VDH Care Connection for Children (CCC) programs (Y/N).

OBJECTIVE: Support and document family engagement in 100% of CYSCHN programs (i.e. Care Connection for Children, Child Development Centers, Bleeding Disorders Program, Sickle Cell Program) annually.

Strategy 1: Assure families of children with special health care needs partner in decision making at all levels and are satisfied with the services they receive (CYSHCN National Standard: Family Professional Partnerships / Cultural Competence).

Children and Youth with Special Healthcare Needs (CYSCHN) Program

The Division of Child and Family Health (DCFH)'s CYSCHN Program is led by Marcus Allen, MPH (CYSCHN Director).

Activities proposed for FY19 include the following:

- Employ paid parent coordinators at each CCC center to provide support and resources to families served. CCC parent staff will continue to be invited to statewide CCC director's meetings to assure their involvement in policy decisions.
- Continue to partner with Family-to-Family on the medical neighborhood project, to include development of training modules for families and providers on medical home and transition.
- Solicit, document, and respond to family feedback on satisfaction with services (e.g. CCC parent survey every 5 years, bleeding disorders family satisfaction survey every other year).
- Assure CYSHCN centers identify and address family barriers, priorities, and concerns (e.g. sickle cell psychosocial assessments) while promoting family engagement in decision-making at all levels of care planning and management (e.g. IEPs, 504 plans, home management of bleeding disorders).
- Empower and equip populations impacted by sickle cell and bleeding disorders to manage complexities of the disease through various community support and education activities/programs (e.g. youth transition camp, faith-based outreach).
- All CYSCHN centers will continue to work with the VA DOE to help families navigate the education system. DOE consultants do not serve as advocates, but they are a very valuable source of knowledge to help families and staff understand how the school system works when it comes to supporting CYSHCN. In addition, DOE staff in the CDC program will help with educational assessments of children.
- CCC centers will continue to help families navigate Medicaid, find resources to pay for DME/medications, and identify resources/providers.
- CDCs will continue to involve parents in assessments and continue to share their reports and results with parents/families. The CDC Program will continue to make referrals to outside providers to help families access needed services to manage children's diagnosed conditions.

III.F. Public Input

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

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

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

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

Phase 1: Stakeholder Meeting

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

Organizations represented included:

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

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

Phase 2: Key Informant Interviews

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

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

Phase 3: Focus Groups

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

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

Ongoing Efforts for FY19 Application

Annually, VDH puts the Title V annual report and application out for public comment on an online Town Hall platform from August to September. In addition, a public input survey for the FY19 application was developed and will be disseminated during this period. Any formal public comments received during the public comment period will be

noted in this section when the FY19 application is reopened for editing, along with results of the public input survey.

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

No formal comments on the FY18 application were logged. However, Title V and MCH staff continue to work closely with and solicit input from with a large body of stakeholders through various coalitions, advisory boards, partnerships, and projects. Informal stakeholder feedback on the state's MCH efforts are regularly requested in the course of daily program operations to ensure state priorities remain relevant to current MCH needs. This input is taken into account during program planning and implementation and is reflected in annual updates to the state action plan.

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

III.G. Technical Assistance

An ongoing technical assistance opportunity for Virginia is to increase capacity to understand best practices in addressing substance use disorder in MCH populations and how to best utilize Title V to accomplish this. In the fall of 2016, the Commissioner of Health, Dr. Marissa Levine declared a Public Health Emergency for Virginia in response to the increase numbers of individuals and families impacted by substance use disorder, particularly opioids. This declaration allowed a priority to be given to opioid use in Virginia and allowed mobilization of agencies to address SUD. VDH has contributed Public Health expertise in surveillance, assurance and policy development to the statewide efforts; however, Title V has only been leveraged by supporting the staff who are working with the VNPC. There may be additional ways in which Title V can make a greater contribution to the larger opioid response.

In addition, Virginia was selected to receive technical assistance (TA) from the National MCH Workforce Development Center in Chapel Hill, North Carolina, as part of the 2015-2016 state cohort. Virginia's project, the *Medical Neighborhood,* continues to grow, and the VDH MCH team continues to reach out to the MCH Workforce Development Center for ongoing assistance and resources as necessary. Progress on the medical neighborhood project is detailed within the CSHCN annual report.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - DMAS Agreement - Signed 04.25.2016.pdf

V. Supporting Documents

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

Supporting Document #01 - mcha-sha timeline 2018-2020.pdf

Supporting Document #02 - FINAL Attachment - State Title V Partnerships vwh.docx.pdf

Supporting Document #03 - Map -- CYSHCN-Updated (2).pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - FY19 Org Chart.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Virginia

	FY19 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 12,128,653	
A. Preventive and Primary Care for Children	$ 3,749,177	(30.9%)
B. Children with Special Health Care Needs	$ 5,293,471	(43.6%)
C. Title V Administrative Costs	$ 1,212,865	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 10,255,513	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 9,097,551	
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)	$ 1,427,400	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 11,649,951	
A. Your State's FY 1989 Maintenance of Effort Amount $ 8,718,003		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 23,778,604	
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)	$ 16,914,458	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 40,693,062	

OTHER FEDERAL FUNDS	FY19 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 1,254,747
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 122,290
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	$ 388,015
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 4,520,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Zika Surveillance Systems Grant Program	$ 0
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Innovation Grants	$ 1,224,654
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Prescription Drug Overdose: Prevention for States Program	$ 1,567,588
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 7,587,164

	FY17 Annual Report Budgeted		FY17 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 12,072,934		$ 12,128,653	
A. Preventive and Primary Care for Children	$ 3,625,934	(30%)	$ 3,749,177	(30.9%)
B. Children with Special Health Care Needs	$ 7,240,000	(60%)	$ 5,293,471	(43.6%)
C. Title V Administrative Costs	$ 1,207,000	(10%)	$ 1,212,865	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 12,072,934		$ 10,255,513	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 9,054,701		$ 9,097,551	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 1,125,000		$ 1,146,726	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 1,295,711	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 10,179,701		$ 11,539,988	
A. Your State's FY 1989 Maintenance of Effort Amount $ 8,718,003				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 22,252,635		$ 23,668,641	
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		$ 161,040,946	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 213,561,850		$ 184,709,587	

OTHER FEDERAL FUNDS	FY17 Annual Report Budgeted	FY17 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 1,305,215	$ 938,811
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	$ 1,020,000	$ 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	$ 280,089
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 148,000	$ 161,208
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Public Health Actions-1305 Chronic Disease	$ 347,000	$ 338,680
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	$ 309,000	$ 249,585
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Tobacco Control Programs	$ 1,347,000	$ 1,394,621
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Youth Risk Behavior Survey (YRBS)	$ 60,000	$ 79,193
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	$ 6,172,516
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	$ 140,000	$ 140,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	$ 1,080,000	$ 1,092,642
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 263,000	$ 283,009

OTHER FEDERAL FUNDS	FY17 Annual Report Budgeted	FY17 Annual Report Expended
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 3,595,000	$ 3,374,670
US Department of Agriculture (USDA) > Food and Nutrition Services > Child and Adult Care Food Program (CACFP)	$ 52,250,000	$ 52,030,937
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 106,000,000	$ 79,762,517
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	$ 2,378,141
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 155,000	$ 212,519
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Children's Oral Healthcare Access Program	$ 246,000	$ 355,799
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Prescription Drug Overdose Program	$ 1,234,000	$ 532,739
US Department of Agriculture (USDA) > Food and Nutrition Services > Summer Feeding Program	$ 12,120,000	$ 10,243,270

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: Program budget allocations were revised to align with updated state action plan for preventive and primary care for children, as detailed in the annual report.	
2.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: Program budget allocations were revised to align with updated state action plan for children with special health care, as detailed in the annual report. This included ongoing efforts to integrate Child Development Centers into continuum of early and continuous screening for all children.	
3.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: This figure includes revenue generated by the Dental Health Program ($249,461.51), Southwest Care Connection for Children ($326.84), and the Child Development Center Program ($1,045,922.47). The SFY17 Child Development Center self-reported revenue is reported as part of annual operations budgets for contracted health systems. For Lenowisco Health District's CDC, revenue is generated by a VDH entity. For the remaining centers, the income does not come the state MCH agency but is held and reinvested in the program by each health system. Reported estimates: VCU CDC $226,000; Carilion CDC $548,012.38; JMU CDC $168,676.52; Lenowisco CDC $103,233.57.	
4.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: Reflects FY17 funds (10/1/2017 - 9/30/2018).	

5.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: FY19 request: $122,290; FY18 award: $122,290.	
6.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: FY19 award: $250,000; FY18 award: $89,125.	
7.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: Currently applying for FY19. FY18 award: $388,015; final year ends 3/31/2019.	
8.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: FY19 requested: $4,520,000; FY18 award: $5,195,000.	
9.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Zika Surveillance Systems Grant Program**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: A $560,000 no-cost extension was awarded in FFY16; $446,779 remaining as of 7/31/17. This grant is in a no-cost extension to spend down remaining funds until 1/31/19. No new awards pending.	

10.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Innovation Grants**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: Iowa award from HRSA. Award from FY17 (12/1/2016 - 11/30/18): $1,224,654, no renewals.	
11.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Prescription Drug Overdose: Prevention for States Program**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: FY19 requested amount. No FY18 funds issued yet. Current award (9/1/17 - 8/31/18): $2,268,588, including carryover (FFY16 and FFY17 funds).	
12.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: Projected based on last award (FY17); FY19 not yet awarded.	
13.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: FY15-17 award: 1,305,215.	
14.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**

	Field Note: FY17 Award: $1,020,000.	
15.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Behavioral Risk Factor Surveillance System (BRFSS)**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: FY17 Award: $280,626.	
16.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: FY17 award: $161,309.	
17.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Public Health Actions-1305 Chronic Disease**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: FY17 Award: $338,686 (School Health).	
18.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: FY17 Award: $340,600.	
19.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Tobacco Control Programs**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**

	Field Note: FY17 Award: $1,395,277 (Quitline and TCP).	
20.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Youth Risk Behavior Survey (YRBS)**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: FY17 Award: $79,915.	
21.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: FY17 Award: $6,244,950.	
22.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: FY17 no-cost extension.	
23.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: FY17 award: $1,207,690.	
24.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**

	Field Note: FY17 Award: $294,432	
25.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: FY17 Award: 3,595,000.	
26.	**Field Name:**	**Other Federal Funds, US Department of Agriculture (USDA) > Food and Nutrition Services > Child and Adult Care Food Program (CACFP)**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: FY17 Award: $52,674,212.	
27.	**Field Name:**	**Other Federal Funds, US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: FY17 Award: $92,664,716.	
28.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: FY17 Award: $2,443,763 (BCC).	
29.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: FY17 Award: $225,482.	

30.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Children's Oral Healthcare Access Program**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: FY17 Award: $376,278.	
31.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Prescription Drug Overdose Program**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: FY17 Award: $1,233,750	
32.	**Field Name:**	**Other Federal Funds, US Department of Agriculture (USDA) > Food and Nutrition Services > Summer Feeding Program**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: FY17 Award: $11,160,815.	

Data Alerts: None

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

State: Virginia

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Pregnant Women	$ 533,413	$ 533,413
2. Infants < 1 year	$ 1,339,727	$ 1,339,727
3. Children 1 through 21 Years	$ 3,749,177	$ 3,749,177
4. CSHCN	$ 5,293,471	$ 5,293,471
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 10,915,788	$ 10,915,788

IB. Non-Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Pregnant Women	$ 316,249	$ 316,249
2. Infants < 1 year	$ 1,881,487	$ 1,881,487
3. Children 1 through 21 Years	$ 1,846,262	$ 1,846,262
4. CSHCN	$ 744,368	$ 744,368
5. All Others	$ 3,327,938	$ 3,327,938
Non-Federal Total of Individuals Served	$ 8,116,304	$ 8,116,304
Federal State MCH Block Grant Partnership Total	$ 19,032,092	$ 19,032,092

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Virginia

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Direct Services	$ 294,464	$ 294,464
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 27,419	$ 27,419
B. Preventive and Primary Care Services for Children	$ 9,936	$ 9,936
C. Services for CSHCN	$ 257,109	$ 257,109
2. Enabling Services	$ 6,367,500	$ 6,367,500
3. Public Health Services and Systems	$ 5,466,689	$ 5,466,689
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		$ 199,066
Physician/Office Services		$ 10,956
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 29,368
Laboratory Services		$ 29,743
Other		
Tobacco Cessation Services		$ 25,331
Direct Services Line 4 Expended Total		$ 294,464
Federal Total	$ 12,128,653	$ 12,128,653

IIB. Non-Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Direct Services	$ 62,227	$ 62,227
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 51,259	$ 51,259
B. Preventive and Primary Care Services for Children	$ 10,694	$ 10,694
C. Services for CSHCN	$ 274	$ 274
2. Enabling Services	$ 5,082,888	$ 5,082,888
3. Public Health Services and Systems	$ 3,952,436	$ 3,952,436
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 18,882
Laboratory Services		$ 14,839
Other		
Tobacco Cessation Services		$ 28,506
Direct Services Line 4 Expended Total		$ 62,227
Non-Federal Total	$ 9,097,551	$ 9,097,551

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: 101,220 **Data Source Year: 2016**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Screen	(B) Aggregate Total Number Presumptive Positive Screens	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	99,914 (98.7%)	1,383	152	152 (100.0%)

Program Name(s)				
3-Hydroxy-3-methyglutaric aciduria	3-Methylcrotonyl-CoA carboxylase deficiency	Argininosuccinic aciduria	Biotinidase deficiency	Carnitine uptake defect/carnitine transport defect
Citrullinemia, type I	Classic galactosemia	Classic phenylketonuria	Congenital adrenal hyperplasia	Critical congenital heart disease
Cystic fibrosis	Glutaric acidemia type I	Hearing loss	Holocarboxylase synthase deficiency	Homocystinuria
Isovaleric acidemia	Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	Maple syrup urine disease	Medium-chain acyl-CoA dehydrogenase deficiency	Methylmalonic acidemia (cobalamin disorders)
Methylmalonic acidemia (methylmalonyl-CoA mutase)	Primary congenital hypothyroidism	Propionic acidemia	S, ßeta-Thalassemia	S,C disease
S,S disease (Sickle cell anemia)	Severe combined immunodeficiences	ß-Ketothiolase deficiency	Trifunctional protein deficiency	Tyrosinemia, type I
Very long-chain acyl-CoA dehydrogenase deficiency				

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 through the Virginia Newborn Screening Program (VNSP); however, the VNSP does have a process in place to refer screen positive infants to Care Connection for Children (CCC) of the VDH Children with Special Health Care Needs Program. The CCC is a statewide network of Centers of Excellence for Children with Special Health Care Needs (CSHCN) that facilitates access to comprehensive medical, support, and case management services for all CSHCN served under VDH programs.

Form Notes for Form 4:

Note for 2017 reporting year: Data reported from most recent available data year 2016; compiled by the Virginia Newborn Screening and Birth Defects Surveillance Programs and Early Hearing Detection Intervention (EHDI); Division of Child and Family Health

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2017**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: Data note for reporting year 2017: Vital Records BIRTH_2016 data table; where BSTATE="VA" (State, U.S. Territory or Canadian Province of Birth (Infant))	

Data Alerts: None

Form 5a
Count of Individuals Served by Title V

State: Virginia

Annual Report Year 2017

		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	13,878	27.1	0.0	3.3	69.3	0.3
2. Infants < 1 Year of Age	77,189	29.5	0.0	66.0	4.3	0.2
3. Children 1 through 21 Years of Age	29,480	30.5	0.0	7.2	59.9	2.4
3a. Children with Special Health Care Needs	7,601	54.7	3.7	27.9	2.8	10.9
4. Others	50,792	16.9	0.0	10.5	71.0	1.6
Total	171,339					

Form Notes for Form 5a:

Note for 2017 reporting year: Data reported from most recent available data year 2016; compiled by the Division of Population Health Data; Population estimates used for all insurance except CSHCN (which had the data available to report); Some individuals may receive multiple services, so there may be some duplication

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2017**
	Field Note: Note for 2017 reporting year: Source of Coverage WebVision – Report #081 from the Data Warehouse; Using the date range Oct 1, 2016 to Sep 30, 2017; 12 of 35 LHDs have maternity clinics; Number reported includes pregnant and postpartum women receiving counseling/education services from LHDs (safe sleep, substance use (including tobacco cessation, alcohol, illicit and prescription drugs), mental health screening, and breastfeeding); obtained from LHD mid-year reports	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2017**
	Field Note: Note for 2017 reporting year: Data reported from most recent available data year 2016; Total Births in safe sleep priority LHDs plus those served by the hearing aid loan bank compiled by the Division of Population Health Data (Hawk10 - Birth file; EHDI hearing aid loan bank)	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2017**
	Field Note: Note for 2017 reporting year: Source of Coverage WebVision – Report #081 from the Data Warehouse; Using the date range Oct 1, 2016 to Sep 30, 2017; number reported includes children obtaining services from LHDs (#081), family planning (LHD mid-year reports for unintended pregnancy priority), dental health (Dental health Program), hearing aid loan bank (EHDI), and safety seats (Injury/Violence).	
4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2017**
	Field Note: Note for 2017 reporting year: Data reported from reporting period (Oct 1, 2016-Sept 30, 2017); number reported includes CYSHCN served by Children with Special Health Care Needs Program (CCC-Sun and program data) and CYSHCN receiving dental services (Dental Health Program)	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2017**
	Field Note: Note for 2017 reporting year: Source of Coverage WebVision – Report #081 from the Data Warehouse; Using the date range Oct 1, 2016 to Sep 30, 2017; number reported includes family planning (LHD mid-year reports), women served in LHDs with Unintended pregnancy priority over age 21 (#081)	

Data Alerts: None

Form 5b
Total Percentage of Populations Served by Title V

State: Virginia

Annual Report Year 2017

Populations Served by Title V	Total % Served
1. Pregnant Women	100
2. Infants < 1 Year of Age	100
3. Children 1 through 21 Years of Age	77
3a. Children with Special Health Care Needs	77
4. Others	25

Form Notes for Form 5b:

None

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2017**
	Field Note: Data note for reporting year 2017: includes funding to local health departments to engage providers, promote and provide screening for depression, smoking or substance use counseling and cessation referrals, safe-sleep practices, access to care, and family planning/unplanned pregnancy initiatives	
2.	**Field Name:**	**Infants Less Than One Year**
	Fiscal Year:	**2017**
	Field Note: Data note for reporting year 2017: includes assurance the newborn screening program	
3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2017**
	Field Note: Data note for reporting year 2017: includes Medical Home and Transition initiatives for school-aged children with and without special health care needs; Partnership to develop training module for health care providers and families to educate on a comprehensive care approach to provide a medical home and a module on best practices regarding the delivery of transition services	
4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2017**
	Field Note: Data note for reporting year 2017: includes Medical Home and Transition initiatives for school-aged children with and without special health care needs; Partnership to develop training module for health care providers and families to educate on a comprehensive care approach to provide a medical home and a module on best practices regarding the delivery of transition services	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2017**
	Field Note: Data note for reporting year 2017: includes funding to local health departments with unplanned pregnancy initiatives/priority	

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

State: Virginia

Annual Report Year 2017

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	106,570	59,151	21,623	14,620	166	8,043	166	0	2,801
Title V Served	14,321	5,898	3,041	4,732	21	537	92	0	0
Eligible for Title XIX	31,061	12,371	10,736	6,143	44	929	47	0	791
2. Total Infants in State	102,243	56,838	20,582	14,211	157	7,754	155	0	2,546
Title V Served	102,243	56,838	20,582	14,211	157	7,754	155	0	2,546
Eligible for Title XIX	31,061	12,371	10,736	6,143	44	929	47	0	791

Form Notes for Form 6:

Note for 2017 Report: Number reported for all deliveries is all deliveries occurring within the state; from 2016 Virginia Health Statistics Birth File

Note for 2017 Report: Number reported for total infants is all live births to VA residents; from 2016 Virginia Health Statistics Birth File

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2017**
	Column Name:	**Total**
	Field Note: Note for 2017 Report: Number reported is all resident live births and fetal demises; from 2016 Virginia Health Statistics BIRTH_2016 file	
2.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2017**
	Column Name:	**Total**
	Field Note: Note for 2017 Report: Number reported is all live births to VA residents; from 2016 Virginia Health Statistics BIRTH_2016 File	

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Virginia

A. State MCH Toll-Free Telephone Lines	2019 Application Year	2017 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 230-6977 x211	(800) 230-6977 x221
2. State MCH Toll-Free "Hotline" Name	Virginia Statewide Human Services I&R System (211)	Virginia Statewide Human Services I&R System (211)
3. Name of Contact Person for State MCH "Hotline"	Carla Hegwood	Carla Hegwood
4. Contact Person's Telephone Number	(804) 864-7674	(804) 864-7674
5. Number of Calls Received on the State MCH "Hotline"		305

B. Other Appropriate Methods	2019 Application Year	2017 Annual Report Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	http://www.vdh.virginia.gov/vdhlivewell/infants-children-and-teens/	http://www.vdh.virginia.gov/vdhlivewell/infants-children-and-teens/
4. Number of Hits to the State Title V Program Website		6,697
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 Ramsey Deagle, PhD, MSPH
Title	Director, Division of Child and Family Health
Address 1	109 Governor Street
Address 2	
City/State/Zip	Richmond / VA / 23219
Telephone	(804) 864-7691
Extension	
Email	cornelia.deagle@vdh.virginia.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Marcus C. Allen, MPH
Title	Director, Children and Youth with Special Health Care Needs Program
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	Dana Yarbrough
Title	Director, Center for Family Involvement at Virginia Commonwealth University
Address 1	700 E. Franklin Street, 1st Floor
Address 2	
City/State/Zip	Richmond / VA / 23219
Telephone	(804) 828-0352
Extension	
Email	dvyarbrough@vcu.edu

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Virginia

Application Year 2019

No.	Priority Need
1.	Safe Sleep: Increase safe sleep practices for infants.
2.	Medical Home: Promote the importance of medical home among providers and families.
3.	Transition: Promote independence and transition of young adults with and without special healthcare needs.
4.	Child/Adolescent Injury: Reduce injuries, violence, and suicide among Title V populations.
5.	Women's/Maternal Health: Support the physical and emotional well-being of women and their children.
6.	Developmental Screening: Support optimal mental health and social-emotional development of all children.
7.	Oral Health: Increase access to oral health services for pregnant women and children.
8.	Family Engagement: Foster a culture of family/youth engagement and leadership.

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
2016	79.9 %	0.1 %	78,094	97,753
2015	79.9 %	0.1 %	72,042	90,155
2014	80.9 %	0.1 %	60,618	74,896
2013	77.5 %	0.2 %	57,327	73,938

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	134.4	4.4	956	71,125
2014	135.3	3.8	1,279	94,522
2013	132.6	3.8	1,235	93,167
2012	133.2	3.8	1,234	92,670
2011	133.9	3.8	1,239	92,553
2010	123.5	3.7	1,146	92,775
2009	128.0	3.7	1,199	93,687
2008	117.8	3.5	1,124	95,443

Legends:

Indicator has a numerator ≤10 and is not reportable

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

NOM 2 - Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

State Provided Data	
	2017
Annual Indicator	15.6
Numerator	
Denominator	
Data Source	CDC, National Vital Statistics System
Data Source Year	2015-

NOM 3 - Notes:

Note for 2017 reporting year: America's Health Rankings analysis of CDC, National Vital Statistics System, United Health Foundation, AmericasHealthRankings.org, Accessed 10 April 2018.

Definition: Number of deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, per 100,000 births

Data Alerts: None

NOM 4 - 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
2016	8.1 %	0.1 %	8,263	102,404
2015	7.9 %	0.1 %	8,111	103,273
2014	7.9 %	0.1 %	8,130	103,255
2013	8.0 %	0.1 %	8,182	102,091
2012	8.1 %	0.1 %	8,375	102,940
2011	8.0 %	0.1 %	8,184	102,590
2010	8.2 %	0.1 %	8,448	102,949
2009	8.4 %	0.1 %	8,779	104,992

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	9.6 %	0.1 %	9,792	102,422
2015	9.3 %	0.1 %	9,549	103,273
2014	9.2 %	0.1 %	9,517	103,268
2013	9.4 %	0.1 %	9,599	102,083
2012	9.5 %	0.1 %	9,774	102,964
2011	9.5 %	0.1 %	9,738	102,598
2010	10.1 %	0.1 %	10,395	102,963
2009	10.2 %	0.1 %	10,702	104,987

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5 - 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
2016	24.6 %	0.1 %	25,192	102,422
2015	24.1 %	0.1 %	24,902	103,273
2014	24.0 %	0.1 %	24,775	103,268
2013	24.3 %	0.1 %	24,807	102,083
2012	24.7 %	0.1 %	25,457	102,964
2011	25.3 %	0.1 %	25,905	102,598
2010	26.6 %	0.1 %	27,356	102,963
2009	27.2 %	0.1 %	28,588	104,987

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016/Q2-2017/Q1	1.0 %			
2015/Q2-2016/Q1	1.0 %			
2015/Q1-2015/Q4	1.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	2.0 %			
2014/Q2-2015/Q1	2.0 %			
2014/Q1-2014/Q4	2.0 %			
2013/Q4-2014/Q3	3.0 %			
2013/Q3-2014/Q2	4.0 %			
2013/Q2-2014/Q1	5.0 %			

Legends:

Indicator results were based on a shorter time period than required for reporting

NOM 7 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	5.5	0.2	566	103,560
2014	5.6	0.2	582	103,562
2013	6.4	0.3	650	102,432
2012	6.6	0.3	686	103,300
2011	6.7	0.3	691	102,938
2010	6.6	0.3	680	103,306
2009	6.4	0.3	676	105,331

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 8 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	5.9	0.2	610	103,303
2014	5.7	0.2	584	103,300
2013	6.2	0.3	631	102,147
2012	6.5	0.3	668	103,013
2011	6.8	0.3	697	102,652
2010	6.8	0.3	703	103,002
2009	7.1	0.3	750	105,059

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	3.9	0.2	399	103,303
2014	3.8	0.2	391	103,300
2013	4.4	0.2	451	102,147
2012	4.7	0.2	480	103,013
2011	4.7	0.2	481	102,652
2010	4.6	0.2	475	103,002
2009	4.7	0.2	493	105,059

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	2.0	0.1	211	103,303
2014	1.9	0.1	193	103,300
2013	1.8	0.1	180	102,147
2012	1.8	0.1	188	103,013
2011	2.1	0.1	216	102,652
2010	2.2	0.2	228	103,002
2009	2.5	0.2	257	105,059

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	210.1	14.3	217	103,303
2014	198.5	13.9	205	103,300
2013	264.3	16.1	270	102,147
2012	249.5	15.6	257	103,013
2011	262.1	16.0	269	102,652
2010	259.2	15.9	267	103,002
2009	290.3	16.7	305	105,059

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	84.2	9.0	87	103,303
2014	101.7	9.9	105	103,300
2013	75.4	8.6	77	102,147
2012	88.3	9.3	91	103,013
2011	94.5	9.6	97	102,652
2010	104.9	10.1	108	103,002
2009	107.6	10.1	113	105,059

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	9.3 %	1.3 %	8,901	95,804

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	5.7	0.3	405	71,397
2014	5.4	0.2	512	94,776
2013	4.7	0.2	437	93,393
2012	3.8	0.2	353	92,827
2011	3.2	0.2	287	90,911
2010	3.0	0.2	272	91,919
2009	2.4	0.2	227	94,034
2008	2.0	0.1	189	95,336

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 year

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	9.9 %	1.4 %	172,390	1,749,952

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable 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
2016	15.6	1.3	145	928,114
2015	17.5	1.4	163	930,662
2014	16.3	1.3	152	931,531
2013	14.6	1.3	136	932,216
2012	17.4	1.4	161	927,706
2011	19.1	1.4	176	922,806
2010	16.1	1.3	148	921,396
2009	15.7	1.3	143	913,341

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 15 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	30.4	1.7	323	1,062,972
2015	29.5	1.7	313	1,059,818
2014	26.2	1.6	277	1,059,336
2013	26.8	1.6	283	1,057,209
2012	28.9	1.7	306	1,058,560
2011	29.7	1.7	314	1,059,168
2010	27.3	1.6	290	1,062,211
2009	26.1	1.6	278	1,063,377

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 16.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2016	10.6	0.8	171	1,616,229
2013_2015	9.8	0.8	158	1,612,618
2012_2014	10.6	0.8	171	1,616,074
2011_2013	11.2	0.8	181	1,623,241
2010_2012	11.8	0.9	193	1,637,028
2009_2011	11.8	0.8	194	1,648,677
2008_2010	14.3	0.9	237	1,657,939
2007_2009	17.2	1.0	285	1,657,396

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 16.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2016	9.8	0.8	159	1,616,229
2013_2015	9.1	0.8	147	1,612,618
2012_2014	9.0	0.8	145	1,616,074
2011_2013	8.3	0.7	134	1,623,241
2010_2012	7.8	0.7	127	1,637,028
2009_2011	7.4	0.7	122	1,648,677
2008_2010	7.7	0.7	128	1,657,939
2007_2009	7.5	0.7	125	1,657,396

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	21.0 %	1.6 %	391,428	1,864,898

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable 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), ages 0 through 17, who receive care in a well-functioning system

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	16.1 %	2.9 %	62,910	391,428

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, 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
2016	3.0 %	0.6 %	46,358	1,548,323

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, 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
2016	9.9 %	1.2 %	152,374	1,538,283

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, 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
2016	61.7 %	5.6 %	132,277	214,368

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, 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
2016	92.9 %	1.0 %	1,731,288	1,863,687

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	20.0 %	0.2 %	11,616	57,983
2012	20.1 %	0.2 %	10,385	51,739
2010	21.5 %	0.2 %	10,527	48,920
2008	20.2 %	0.2 %	8,538	42,364

Legends:

Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable

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

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	13.0 %	0.9 %		
2013	12.0 %	0.6 %		
2011	11.1 %	1.2 %		

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)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	14.1 %	2.4 %	103,901	737,946

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	4.9 %	0.3 %	91,347	1,864,204
2015	4.9 %	0.3 %	91,415	1,869,889
2014	5.9 %	0.3 %	109,627	1,867,159
2013	5.7 %	0.3 %	106,008	1,863,314
2012	5.5 %	0.3 %	102,837	1,855,004
2011	5.8 %	0.3 %	107,695	1,853,192
2010	6.5 %	0.3 %	119,764	1,853,506
2009	6.7 %	0.3 %	124,160	1,846,249

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	65.9 %	4.5 %	98,501	149,577
2015	64.4 %	4.2 %	96,290	149,556
2014	73.7 %	4.5 %	111,178	150,878
2013	69.2 %	5.1 %	104,185	150,476
2012	69.8 %	3.9 %	104,231	149,242
2011	68.3 %	3.6 %	104,315	152,773
2010	55.2 %	3.4 %	86,228	156,154
2009	40.0 %	3.9 %	64,151	160,571

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	60.2 %	2.2 %	1,056,622	1,754,894
2015_2016	62.4 %	2.2 %	1,086,888	1,740,971
2014_2015	65.0 %	2.2 %	1,135,952	1,746,813
2013_2014	61.9 %	2.4 %	1,059,657	1,711,340
2012_2013	61.3 %	2.9 %	1,060,831	1,729,774
2011_2012	50.6 %	2.9 %	882,291	1,743,986
2010_2011	54.9 %	2.3 %	941,040	1,714,099
2009_2010	49.8 %	3.3 %	849,428	1,705,679

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen (Female)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	50.7 %	5.7 %	130,657	257,872
2015	61.2 %	5.7 %	157,210	256,938
2014	59.2 %	5.3 %	151,461	255,680
2013	51.9 %	6.5 %	131,510	253,273
2012	50.9 %	5.6 %	128,594	252,490
2011	46.9 %	4.9 %	119,190	254,247
2010	54.0 %	5.0 %	133,850	247,731
2009	36.8 %	4.4 %	91,914	249,895

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Teen (Male)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	56.4 %	5.1 %	151,282	268,422
2015	40.1 %	5.4 %	107,420	267,833
2014	36.3 %	5.3 %	97,067	267,078
2013	26.4 %	5.4 %	70,046	265,592
2012	12.1 %	2.9 %	31,935	264,659
2011	NR	NR	NR	NR

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	87.1 %	2.6 %	458,489	526,294
2015	82.2 %	3.3 %	431,301	524,771
2014	91.2 %	2.0 %	476,967	522,759
2013	83.6 %	3.3 %	433,804	518,865
2012	88.7 %	2.2 %	458,761	517,148
2011	77.9 %	2.9 %	405,505	520,702
2010	72.0 %	3.2 %	365,111	506,826
2009	56.1 %	3.2 %	286,211	510,091

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	71.5 %	3.6 %	376,523	526,294
2015	66.8 %	3.9 %	350,435	524,771
2014	72.5 %	3.4 %	379,117	522,759
2013	64.2 %	4.3 %	333,122	518,865
2012	62.1 %	3.8 %	321,221	517,148
2011	61.8 %	3.1 %	321,925	520,702
2010	54.5 %	3.5 %	276,139	506,826
2009	48.1 %	3.2 %	245,326	510,091

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	15.5	0.2	4,114	265,098
2015	17.1	0.3	4,508	263,523
2014	18.5	0.3	4,859	263,184
2013	20.1	0.3	5,300	264,395
2012	22.9	0.3	6,076	265,903
2011	24.4	0.3	6,524	267,267
2010	27.4	0.3	7,374	269,197
2009	30.4	0.3	8,228	270,590

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	11.7 %	1.6 %	11,030	94,096

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	1.6 %	0.6 %	30,045	1,857,731

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10a
National Performance Measures (NPMs)

State: Virginia

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

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2017
Annual Objective	81
Annual Indicator	78.0
Numerator	73,007
Denominator	93,567
Data Source	PRAMS
Data Source Year	2015

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	81.6	82.8	84.0	85.2	86.4	87.6

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**

Field Note:
Note for 2020 target: based on % increase needed to meet HP2020 baseline; calculated from 2015 VA PRAMS as baseline

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

FAD for this measure is not available for the State.

State Provided Data	
	2017
Annual Objective	
Annual Indicator	59.9
Numerator	
Denominator	
Data Source	VA PRAMS
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	62.3	62.9	63.5	64.1	64.7

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2017: data reported is most recent available data year for VA PRAMS (2015). Question reads, “How often does your new baby sleep in the same bed with you or anyone else?” Indicator reported is percent of infants who never or rarely sleep in the same bed as mother or someone else.	
2.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**
	Field Note: Note for 2020 target: based on 5% increase; calculated from 2015 VA PRAMS as baseline	

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

FAD for this measure is not available for the State.

State Provided Data	
	2017
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	VA PRAMS
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	45.0	45.0	45.0	45.0	45.0

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2017: data for this indicator regarding "Mothers reporting that their baby does not usually sleep with blankets, toys, cushions, pillows, or crib bumper pads" is not currently available on the most recent available data year for VA PRAMS (2015). This information will be made available for VA PRAMS 2016 data in PRAMS Phase 8.	
2.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**
	Field Note: Note for reporting year 2017: data for this indicator regarding "Mothers reporting that their baby does not usually sleep with blankets, toys, cushions, pillows, or crib bumper pads" is not currently available on the most recent available data year for VA PRAMS (2015). The objectives reported are arbitrary pending the availability of 2016 VA PRAMS data (Phase 8).	

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	**2017**
Annual Objective		
Annual Indicator		26.8
Numerator		67,562
Denominator		252,334
Data Source		NSCH
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	27.1	27.8	28.1	28.5	28.8	29.2

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**
	Field Note:	
	Note for 2020 target: based on 5% increase from 2016 baseline data	

NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Federally Available Data		
Data Source: HCUP - State Inpatient Databases (SID)		
	2016	**2017**
Annual Objective	86.5	85.5
Annual Indicator	87.0	101.5
Numerator	899	785
Denominator	1,033,738	773,528
Data Source	SID-CHILD	SID-CHILD
Data Source Year	2014	2015

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	94.9	92.8	90.7	88.7	86.7	84.8

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**

Field Note:
Note for 2020 target: based on Average Annual Percent Change from 2008-2015 trend data

NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Federally Available Data		
Data Source: HCUP - State Inpatient Databases (SID)		
	2016	**2017**
Annual Objective	180	172
Annual Indicator	172.4	182.6
Numerator	1,826	1,451
Denominator	1,059,470	794,656
Data Source	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2014	2015

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	162.9	156.8	151.0	145.3	139.9	134.7

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**

Field Note:
Note for 2020 target: based on Average Annual Percent Change from 2008-2015 trend data

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	**2017**
Annual Objective		
Annual Indicator		42.7
Numerator		167,058
Denominator		391,428
Data Source		NSCH-CSHCN
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	44.9	46.0	47.1	48.2	49.3	50.4

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**
	Field Note: Note for 2020 target: based on % increase needed to meet HP2020 baseline; calculated on 2016 state baseline data	

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	**2017**
Annual Objective		
Annual Indicator		18.8
Numerator		31,194
Denominator		166,277
Data Source		NSCH-CSHCN
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	19.3	19.5	19.7	20.0	20.2	20.5

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**
	Field Note: Note for 2020 target: based on 5% increase ; calculated on 2016 state baseline data	

NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2017
Annual Objective	45
Annual Indicator	46.5
Numerator	44,225
Denominator	95,088
Data Source	PRAMS
Data Source Year	2015

State Provided Data		
	2016	**2017**
Annual Objective		45
Annual Indicator	43.6	
Numerator		
Denominator		
Data Source	PRAMS	
Data Source Year	2010-2011	
Provisional or Final ?	Provisional	

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	49.7	50.8	51.9	53.0	54.1	55.1

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**

Field Note:
Note for 2020 target: based on % increase needed to meet National PRAMS 2014 rate; calculated on 2015 state baseline data

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Child Health

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	**2017**
Annual Objective		
Annual Indicator		81.4
Numerator		1,407,907
Denominator		1,729,004
Data Source		NSCH
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

State Provided Data		
	2016	**2017**
Annual Objective		
Annual Indicator	77.8	77.8
Numerator		
Denominator		
Data Source	NSCH	NSCH
Data Source Year	2016	2016
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	79.7	80.7	81.7	82.7	83.6	84.6

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2017: the data source is the latest available data year (2016) from the National Survey of Children's Health. Data is reported from age break-out for children age 1-5 years and children age 6-11 years.	
2.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**
	Field Note: Note for 2020 target: based on 5% increase ; calculated on 2016 state baseline data	

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Adolescent Health

State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	90.9	90.9
Numerator		
Denominator		
Data Source	NSCH	NSCH
Data Source Year	2016	2016
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	93.2	94.3	95.5	96.6	97.7	98.9

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2017: the data source is the latest available data year (2016) from the National Survey of Children's Health. Data is reported from age break-out for children age 12-17 years.	
2.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**
	Field Note: Note for 2020 target: based on 5% increase ; calculated on 2016 state baseline data	

Form 10a
State Performance Measures (SPMs)

State: Virginia

SPM 3 - Infant Mortality Disparity: Infant Mortality Disparity Ratio

Measure Status:	Inactive - Inactive - Due to shift in priorities and initiatives, including agency programs outside of Title V funding, this measure has been shifted to an SOM

State Provided Data		
	2016	2017
Annual Objective		1.6
Annual Indicator	2.1	2.3
Numerator	10.3	10.5
Denominator	4.9	4.5
Data Source	VDH - Division of Population Health Data	VDH - Division of Population Health Data
Data Source Year	2015	2016
Provisional or Final ?	Final	Provisional

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: SSDI Minimum-Core Dataset; NVSS-Linked Birth/Infant Death Records	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Note for 2017 reporting year: 2016 data is provisional; Division of Health Statistics, compiled by the Division of Population Health Data, Office of Family Health Services	

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

Measure Status:	Active

State Provided Data	
	2017
Annual Objective	2.6
Annual Indicator	31
Numerator	
Denominator	
Data Source	VA PRAMS
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	33.3	34.1	34.9	35.7	36.4	37.2

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Note for 2017 reporting year: data source change; 2015 VA PRAMS data; Survey Question: What kind of birth control are you or your husband or partner using now to keep from getting pregnant?; Tiered Postpartum Birth Control includes: Tier 1 (Tubes tied, vasectomy, implant, IUD), Tier 2 (BC Pills, Injection, Patch), Tier 3(Condoms, rhythm, withdrawal, abstinence); Division of Population Health Data, Office of Family Health Services	
2.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**
	Field Note: Note for 2020 target: based on 10% increase; calculated from 2015 VA PRAMS as baseline	

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

Measure Status:	Inactive - Due to a shift in VDH Title V priorities and initiatives, including agency programs outside of Title V funding that are taking on this priority.

State Provided Data	
	2017
Annual Objective	
Annual Indicator	7.1
Numerator	447
Denominator	6,338
Data Source	VDH - Maternal/Infant-Health Stats/Pop Health Data
Data Source Year	2016
Provisional or Final ?	Provisional

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Note for 2017 reporting year: 2016 data is provisional; Numerator: Mataernal and Infant Health Program, LHD Reports (Only 2 LHDs reported data for Maternal Mental Health); Denominator: Division of Health Statistics, compiled by the Division of Population Health Data (Live births to residents of LHD area)

SPM 6 - Cross-cutting (Family Engagement): Implement and develop report on survey of families served by the VDH Care Connection for Children (CCC) programs

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	Yes	No	No	No	No

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**

Field Note:
Note for 2017 reporting year: The CYSHCN Program with the MCH Epidemiology Unit expect to implement this survey every five years.

Form 10a
State Outcome Measures (SOMs)

State: Virginia

SOM 2 - Infant Mortality Disparity: Infant Mortality Rate

Measure Status:	Inactive - Due to a shift in VDH Title V priorities and initiatives, including agency programs outside of Title V funding that are taking on this priority.

State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	5.9	5.8
Numerator		
Denominator		
Data Source	NVSS-Linked Birth/Infant Death Records	Health Statistics, Population Health Data
Data Source Year	2015	2016
Provisional or Final ?	Final	Provisional

Field Level Notes for Form 10a SOMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Note for 2017 reporting year: 2016 data is most recent available data year; Division of Health Statistics, compiled by the Division of Population Health Data, Office of Family Health Services

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

Measure Status:	Inactive - Due to a shift in VDH Title V priorities and initiatives, including agency programs outside of Title V funding that are taking on this priority.

State Provided Data		
	2016	2017
Annual Objective		80
Annual Indicator	79.2	70.9
Numerator		
Denominator		
Data Source	PRAMS	PRAMS
Data Source Year	2014	2015
Provisional or Final ?	Final	Final

Field Level Notes for Form 10a SOMs:

None

SOM 4 - Unintended Pregnancy: Percent of unintended pregnancy among all women of child-bearing age

Measure Status:	Inactive - Unintended pregnancy efforts will be linked to only SPM; unable to link both SOM and SPM within state action plan.

State Provided Data	
	2017
Annual Objective	40
Annual Indicator	49.5
Numerator	
Denominator	
Data Source	PRAMS
Data Source Year	2015
Provisional or Final ?	Final

Field Level Notes for Form 10a SOMs:

None

Form 10a
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Virginia

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

Measure Status:	Active

State Provided Data	
	2017
Annual Objective	150
Annual Indicator	1,373
Numerator	
Denominator	
Data Source	VDH-OFHS Communications Specialist
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	200.0	250.0	300.0	350.0	400.0	450.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Note for 2017 Reporting Year: Data reported from unique site visits/hits occurring FY17 (Oct 2016-Sept 2017)

ESM 5.3 - Number of individuals counseled/educated about Safe Sleep environments

Measure Status:	Active

State Provided Data	
	2017
Annual Objective	
Annual Indicator	9,924
Numerator	
Denominator	
Data Source	Maternal/Infant Health Program - LHD Reports
Data Source Year	2017
Provisional or Final ?	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	10,000.0	10,000.0	10,000.0	10,000.0	10,000.0	10,000.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Note for 2017 reporting year: data provided from Local Health District mid-year reports from LHD Grant Year 3 (FY17); 22 LHDs reported

ESM 5.4 - Number of providers (home-visitors, doctors, nurses, health educators, etc.) educated about Safe Sleep environments and resources provided at www.safesleepva.com

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	500.0	500.0	500.0	500.0	500.0

Field Level Notes for Form 10a ESMs:

None

ESM 5.5 - Interdisciplinary Workforce Development - Number of Local Health Departments (LHD) attending VDH technical assistance for safe sleep environment.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	35.0	35.0	35.0	35.0	35.0

Field Level Notes for Form 10a ESMs:

None

ESM 5.6 - Interdisciplinary Workforce Development - Number of home visitors completing Early Impact Virginia training modules that discuss safe sleep environment.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	375.0	400.0	425.0	450.0	475.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active

State Provided Data	
	2017
Annual Objective	7
Annual Indicator	150
Numerator	
Denominator	
Data Source	VDH Division of Child and Family Health
Data Source Year	2016-2017
Provisional or Final ?	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	15.0	20.0	25.0	35.0	50.0	100.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Data note for reporting year 2017: Developmental screening resources, training, and TA were provided to local health district staffs and non-MIECHV home visiting staff. The training included two face-to-face events and one poly com linked to eight sites. In addition, training requests were referred to community ASQ trainers to assure timely response in addressing needs. TA and resources were provided upon request via email, nursing newsletter to the health districts, or phone call.

ESM 6.2 - Number of hits to the VDH web pages by individuals seeking information about the importance of regular developmental screening and Bright Futures

Measure Status:	Active

State Provided Data	
	2017
Annual Objective	100
Annual Indicator	0
Numerator	
Denominator	
Data Source	VDH Division of Child and Family Health
Data Source Year	2016-2017
Provisional or Final ?	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	125.0	200.0	250.0	300.0	350.0	400.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Note for reporting year 2017: Unfortunately, the Office of Information Management does not have the analytics for the Bright Futures site. This site is on the IIS (old) serve and the ability to track analytics on the IIS server was lost when VDH switched to WordPress and Google Analytics. WebTrends was used for this purpose on the IIS server, but it became incredibly expensive t maintain so it was discontinued mid-year. The staff are working with the web master to convert Bright Futures web page to WordPress and Google Analytics.

ESM 6.3 - Completion of actionable 2-year plan (FY19-FY20) for strengthening the comprehensive, complex developmental screening system of care for children 0-8

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 7.1.1 - Proportion of maternity centers with prenatal courses including Virginia's injury prevention curriculum

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		0
Annual Indicator	0	0
Numerator	0	0
Denominator	60	60
Data Source	Office of Family Health Services, VDH	Office of Family Health Services, VDH
Data Source Year	2016	2017
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	10.0	15.0	20.0	25.0	30.0	35.0

Field Level Notes for Form 10a ESMs:

None

ESM 7.1.2 - Number of child safety seats disseminated through the LISSDEP network

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	2,549.0	2,549.0	2,549.0	2,549.0	2,549.0

Field Level Notes for Form 10a ESMs:

None

ESM 7.1.3 - Number of healthcare providers receiving Project ECHO content in reducing the impact of NAS

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	25.0	30.0	35.0	40.0	45.0

Field Level Notes for Form 10a ESMs:

None

ESM 7.2.1 - Number of gatekeepers trained in the prevention of suicide among youth

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	10.0	10.0	10.0	10.0	10.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		25
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	Division of Child and Family Health	VDH CYSHCN Program
Data Source Year	2016	2017
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	100.0	250.0	400.0	500.0	525.0	550.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Note for 2017 reporting year: Modules are not complete at this time due to contract negotiations

ESM 11.2 - Percentage of CYSHCN served by the VA CYSHCN Program who report having a medical home

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		90
Annual Indicator	89.2	98.9
Numerator	4,061	4,391
Denominator	4,555	4,439
Data Source	Office of Family Health Services, VDH	VDH CYSHCN Program
Data Source Year	2015	2016
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	91.5	93.0	94.5	96.0	97.5	98.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Note for 2017 reporting year: This figure represents data taken from 3 of our programs (CDC, VBDP, and SCP).

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		40
Annual Indicator	30.6	0
Numerator	200,000	
Denominator	653,103	
Data Source	Virginia Department of Education	Virginia Department of Education
Data Source Year	2015-2016	2016
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	42.5	45.0	47.5	50.0	53.0	53.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Note for 2017 reporting year: Data not available this reporting year due to question removal from the school nurse survey. The state MCH director, epidemiologist, and Title V coordinator are developing plans with the Department of Education school nurse contact to review processes and maximize opportunity for data collection.

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		25
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	Division of Child and Family Health	VDH CYSHCN Program
Data Source Year	2016	2017
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	100.0	250.0	400.0	500.0	525.0	550.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Note for 2017 reporting year: Modules are not complete at this time due to contract negotiations

ESM 13.1.1 - Completion of action plan identifying strategies and partners for addressing top 3 MCH population oral health needs in Virginia

Measure Status:	Inactive - Completed

State Provided Data	
	2017
Annual Objective	No
Annual Indicator	Yes
Numerator	
Denominator	
Data Source	Dental Staff program data
Data Source Year	2017
Provisional or Final ?	Final

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Completed during FY18	

ESM 13.1.2 - Number of Regional Oral Health Alliances that implemented work plans to increase dental visits among pregnant women

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	6.0	6.0	6.0	6.0	6.0

Field Level Notes for Form 10a ESMs:

None

ESM 13.2.1 - Number of Regional Oral Health Alliances that implemented work plans to increase dental visits among children (ages 0-11 years) and adolescents (ages 12-17 years)

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	6.0	6.0	6.0	6.0	6.0

Field Level Notes for Form 10a ESMs:

None

Form 10b
State Performance Measure (SPM) Detail Sheets

State: Virginia

SPM 3 - Infant Mortality Disparity: Infant Mortality Disparity Ratio
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Inactive - Inactive - Due to shift in priorities and initiatives, including agency programs outside of Title V funding, this measure has been shifted to an SOM
Goal:	Eliminate the racial disparity in Virginia's infant morality rate.
Definition:	**Numerator:** Rate of non-Hispanic Black infant mortality **Denominator:** Rate of non-Hispanic White infant mortality **Unit Type:** Ratio **Unit Number:** 1
Data Sources and Data Issues:	Virginia Vital Records
Significance:	This state priority measure was identified through the Title V needs assessment, Virginia's Well-being Plan, CDC winnable battle, and Virginia Health Opportunity Index.

SPM 4 - Unintended Pregnancy: Proportion of females ages 15-44 using Tier 1 (most effective) contraceptive methods
Population Domain(s) – Women/Maternal Health, Adolescent Health

Measure Status:	Active
Goal:	Virginians plan their pregnancies.
Definition:	**Numerator:** Number of females ages 15-44 using Tier 1 method of contraceptive **Denominator:** Number of females ages 15-44 **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Increase the proportion of pregnancies that are intended (FP-1). Increase the percentage of adult females aged 20 to 44 years who are at risk of unintended pregnancy that adopt or continue use of the most effective or moderately effective methods of contraception (FP-16.1). Increase the percentage of adolescent females aged 15 to 19 years who are at risk of unintended pregnancy that adopt or continue use of the most effective or moderately effective methods of contraception (FP-16.2). Reduce pregnancies among adolescent females aged 15 to 17 years (FP-8.1). Reduce pregnancies among adolescent females aged 18 to 19 years (FP-8.2).
Data Sources and Data Issues:	VA PRAMS
Significance:	This state priority measure was identified through the Title V needs assessment, CDC winnable battle, and Healthy People 2020. The goal aligns with the Virginia Plan for Well-Being (Goal 2.1). Comprehensive family planning and preconception health lead to improved birth outcomes, which are associated with better health and cognition as children mature. Family planning services include providing education and contraception. These services help families have children when they are financially, emotionally, and physically ready. Publicly-supported family planning services prevent an estimated 1.3 million unintended pregnancies a year in the United States. The trend toward having smaller families and waiting at least 24 months between pregnancies has contributed to better health of infants and children. Preconception health services for females and males include health screenings, counseling, and clinical services that enable them to become as healthy as possible before pregnancy.

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

Measure Status:	Inactive - Due to a shift in VDH Title V priorities and initiatives, including agency programs outside of Title V funding that are taking on this priority.
Goal:	To increase the number of women who are screened for substance abuse and depression within 6 weeks after giving birth.
Definition:	**Numerator:** Number of women who attend a postpartum visit with a healthcare provider within 6 weeks after giving birth and are screened using an SBIRT tool **Denominator:** Number of Live Births **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	[Developmental] Increase the proportion of women giving birth who attend a postpartum care visit with a health worker (MICH-19).
Data Sources and Data Issues:	VDH - Maternal and Infant Health Program documents; LHD reports
Significance:	This state priority measure was identified through the Title V needs assessment, Virginia's Plan for Well-Being, Virginia DMAS/Medicaid priority, and Healthy People 2020.

SPM 6 - Cross-cutting (Family Engagement): Implement and develop report on survey of families served by the VDH Care Connection for Children (CCC) programs
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Assure families of children with special health care needs partner in decision making at all levels and are satisfied with the services they receive (CYSHCN National Standard: Family Professional Partnerships / Cultural Competence)
Definition:	**Numerator:** N/A **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Healthy People 2020 Objective:	MICH-31: Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, and coordinated systems
Data Sources and Data Issues:	VDH CYSHCN Program and MCH Epidemiology Unit program documents
Significance:	Building the capacity of women and children, including CSHCN, and their families to partner in decision-making is a critical strategy in helping states to achieve the identified MCH priorities.

Form 10b
State Outcome Measure (SOM) Detail Sheets

State: Virginia

SOM 2 - Infant Mortality Disparity: Infant Mortality Rate
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Inactive - Due to a shift in VDH Title V priorities and initiatives, including agency programs outside of Title V funding that are taking on this priority.
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:	NVSS-Linked Birth/Infant Death Records - Virginia Vital Records
Significance:	Priority measure was identified through the Title V needs assessment, Virginia's Well-being Plan, CDC winnable battle, and Virginia Health Opportunity Index.

SOM 3 - Maternal Mental Health Screening: Proportion of women who are educated and/or screened during pregnancy or after delivery about depression by a health care worker
Population Domain(s) – Women/Maternal Health

Measure Status:	Inactive - Due to a shift in VDH Title V priorities and initiatives, including agency programs outside of Title V funding that are taking on this priority.
Goal:	Increase the number of women who are educated and/or screened during pregnancy or after delivery about depression by a health care worker
Definition:	**Numerator:** Number of women reporting a healthcare worker discussing depression during pregnancy or after delivery **Denominator:** Total number of live births **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	[Developmental] Decrease the proportion of women delivering a live birth who experience postpartum depressive symptoms (MICH-34).
Data Sources and Data Issues:	Virginia PRAMS
Significance:	This state priority measure was identified through the Title V needs assessment, Virginia's Well-being Plan, Virginia DMAS/Medicaid priority, and Healthy People 2020.

SOM 4 - Unintended Pregnancy: Percent of unintended pregnancy among all women of child-bearing age
Population Domain(s) – Women/Maternal Health, Adolescent Health

Measure Status:	Inactive - Unintended pregnancy efforts will be linked to only SPM; unable to link both SOM and SPM within state action plan.
Goal:	Reduce Virginia's unintended pregnancy rate to the lowest in the United States by 2020.
Definition:	**Numerator:** Number of women reporting pregnancy was unintended or mistimed **Denominator:** Female respondents, excluding those reporting fetal demise **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Increase the proportion of pregnancies that are intended (FP-1)
Data Sources and Data Issues:	Virginia PRAMS
Significance:	This state priority measure was identified through the Title V needs assessment, Virginia's Well-being Plan, CDC winnable battle, and Healthy People 2020.

Form 10c
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Virginia

ESM 5.2 - Number of visits to the SafeSleepVA.com website
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	To promote safe sleep practices to parents, providers, and caregivers of infants.
Definition:	**Numerator:** Number of visits to the SafeSleepVA.com website **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1,000,000
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Child and Family Health
Significance:	Reducing sleep-related infant deaths is a state priority.

ESM 5.3 - Number of individuals counseled/educated about Safe Sleep environments
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	To increase consistent messaging regarding safe sleep practices.
Definition:	**Numerator:** Number of individuals counseled/educated about Safe Sleep environments **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100,000
Data Sources and Data Issues:	VDH, Office of Family Health Services, Division of Child and Family Health - Maternal and Infant Health Program documentation; Local Health District reports
Significance:	The number of U.S. sleep-related Sudden Unexpected Infant Death (SUID) cases, including Sudden Infant Death Syndrome (SIDS), is approximately 3,500 deaths per year. Since the Back to Sleep campaign launched in 1994, the overall U.S. SIDS rate declined by more than 60%; the proportion of infants placed on their backs to sleep increased from 27% in 1993 to 74% in 2011. Strategies to increase the percentage of infants usually placed to sleep on their backs include supporting the implementation of safe sleep practices through policies, accreditation, and legislation.

ESM 5.4 - Number of providers (home-visitors, doctors, nurses, health educators, etc.) educated about Safe Sleep environments and resources provided at www.safesleepva.com
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Increase safe sleep educational awareness to providers
Definition:	**Numerator:** Number of providers (home-visitors, doctors, nurses, health educators, etc.) educated about Safe Sleep environments and resources provided at www.safesleepva.com **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100,000
Data Sources and Data Issues:	VDH, Office of Family Health Services, Maternal and Infant Health Program documents; Local Health District Reports
Significance:	The number of U.S. sleep-related Sudden Unexpected Infant Death (SUID) cases, including Sudden Infant Death Syndrome (SIDS), is approximately 3,500 deaths per year. Since the Back to Sleep campaign launched in 1994, the overall U.S. SIDS rate declined by more than 60%; the proportion of infants placed on their backs to sleep increased from 27% in 1993 to 74% in 2011. Strategies to increase the percentage of infants usually placed to sleep on their backs include supporting the implementation of safe sleep practices through policies, accreditation, and legislation.

ESM 5.5 - Interdisciplinary Workforce Development - Number of Local Health Departments (LHD) attending VDH technical assistance for safe sleep environment.
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	To promote safe sleep practices to parents, providers, and caregivers of infants.
Definition:	**Numerator:** Number of LHDs attending VDH/Maternal & Infant Health Program polycom for technical assistance on safe sleep environment. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	Virginia Department of Health, Division of Child and Family Health; Maternal and Infant Health Program documents/attendance sheets.
Significance:	Sleep-related infant deaths, also called Sudden Unexpected Infant Deaths (SUID), are the leading cause of infant death after the first month of life and the third leading cause of infant death overall. Sleep-related SUIDs include Sudden Infant Death Syndrome (SIDS), unknown cause, and accidental suffocation and strangulation in bed. Due to heightened risk of SIDS when infants are placed to sleep in side (lateral) or stomach (prone) sleep positions, the American Academy of Pediatrics (AAP) has long recommended the back (supine) sleep position. Successful methods for improving parent safe sleep knowledge range from hospital staff education to crib distribution programs. Such efforts have been shown to increase parental knowledge, reduce bed-sharing rates, increase supine sleeping rates, and decrease incidences of SIDS. Thus, increasing the number of health care professionals receiving the safe sleep training will increase the number of parents educated about sleep safety.

ESM 5.6 - Interdisciplinary Workforce Development - Number of home visitors completing Early Impact Virginia training modules that discuss safe sleep environment.
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	To promote safe sleep practices to parents, providers, and caregivers of infants.
Definition:	**Numerator:** Number of home visitors completing Early Impact Virginia training modules that discuss safe sleep environment. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100,000
Data Sources and Data Issues:	Virginia Department of Health, Division of Child and Family Health; Home visiting program/Early Impact Virginia documentation
Significance:	Sleep-related infant deaths, also called Sudden Unexpected Infant Deaths (SUID), are the leading cause of infant death after the first month of life and the third leading cause of infant death overall. Sleep-related SUIDs include Sudden Infant Death Syndrome (SIDS), unknown cause, and accidental suffocation and strangulation in bed. Due to heightened risk of SIDS when infants are placed to sleep in side (lateral) or stomach (prone) sleep positions, the American Academy of Pediatrics (AAP) has long recommended the back (supine) sleep position. Successful methods for improving parent safe sleep knowledge range from hospital staff education to crib distribution programs. Such efforts have been shown to increase parental knowledge, reduce bed-sharing rates, increase supine sleeping rates, and decrease incidences of SIDS. Thus, increasing the number of health care professionals receiving the safe sleep training will increase the number of parents educated about sleep safety. Modules through Early Impact Virginia include Secrets of Baby Behavior, Three-Step Counseling, Promoting Safe and Healthy Homes, and a new Safe Sleep module scheduled to launch August 2018.

ESM 6.1 - Number of LHDs, community partners, and providers receiving developmental screening resources, training, or TA
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	To increase developmental screening rates for all children in Virginia.
Definition:	**Numerator:** Number of LHDs, community partners, and providers receiving developmental screening resources, training, or TA **Denominator:** N/A **Unit Type:** Count **Unit Number:** 150
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Child and Family Health
Significance:	Increasing early identification of disease or conditions through developmental screening will improve referral and treatment for children with special needs.

ESM 6.2 - Number of hits to the VDH web pages by individuals seeking information about the importance of regular developmental screening and Bright Futures
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	To improve awareness and understanding among families, providers, and community members about the importance of regular developmental screening for children.
Definition:	**Numerator:** Number of hits to the VDH web pages by individuals seeking information about the importance of regular developmental screening and Bright Futures **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1,000
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Child and Family Health
Significance:	Increasing early identification of disease or conditions through developmental screening will improve referral and treatment for children with special needs.

ESM 6.3 - Completion of actionable 2-year plan (FY19-FY20) for strengthening the comprehensive, complex developmental screening system of care for children 0-8
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Improve the health status of Virginia's children through ongoing optimal screening, monitoring and surveillance of development.
Definition:	**Numerator:** Completion of actionable 2-year plan (FY19-FY20) for strengthening the comprehensive, complex developmental screening system of care for children 0-8 **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	Virginia Department of Health; Division of Child and Family Health program data
Significance:	Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics (AAP) recommends screening tests begin at the nine month visit. The Virginia priority need is the enhancement of processes through which every child may succeed by providing a sustainable and coordinated system of developmental support, access and followup. The support for need is based on 1) Lack coordinated system for referrals and follow-up; 2) Lack of data to drive strategic planning; 3) Evidence-based research that universal developmental screening connects children at risk of developmental delay with early intervention services. The data to support this shows that 1 in 4 children under 5 are at risk for developmental, behavioral or social delays, fewer than 30% of delays are identified before kindergarten; only 29% of Virginia's 0-5 children received any recommended developmental screening compared to the national average of 30% and that access to screening is even more difficult for children of color.

ESM 7.1.1 - Proportion of maternity centers with prenatal courses including Virginia's injury prevention curriculum
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
ESM Subgroup(s):	Children 0 through 9
Goal:	Reduce non-fatal injury related hospitalizations for children ages 0 through 9 and adolescents ages 10 through 19.
Definition:	**Numerator:** Number of maternity centers with prenatal courses including Virginia's injury prevention curriculum **Denominator:** Number of 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; piloting evaluation tool in REDCap to track information from maternity centers
Significance:	This ESM was identified through the Title V needs assessment, Virginia's Well-being Plan, and Healthy People 2020 (IVP 1.2). Research from a variety of external sources indicates that the impact of childhood injuries can be reduced with effective primary prevention strategies.

ESM 7.1.2 - Number of child safety seats disseminated through the LISSDEP network
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
ESM Subgroup(s):	Children 0 through 9
Goal:	Reduce non-fatal injury related hospitalizations for children ages 0 through 9 and adolescents ages 10 through 19.
Definition:	**Numerator:** Number of child safety seats disseminated through the LISSDEP network **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 (DPHP); the DPHP tracks the inventory disseminated
Significance:	This ESM was identified through the Title V needs assessment, Virginia's Well-being Plan, and Healthy People 2020 (IVP 1.2). Research from a variety of external sources indicates that child restraint and restraint systems reduce injury and injury severity in children.

ESM 7.1.3 - Number of healthcare providers receiving Project ECHO content in reducing the impact of NAS
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
ESM Subgroup(s):	Children 0 through 9
Goal:	Reduce non-fatal injury related hospitalizations for children ages 0 through 9 and adolescents ages 10 through 19.
Definition:	**Numerator:** Number of healthcare providers receiving Project ECHO content in reducing the impact of NAS **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 (DPHP); DPHP will track using self-reports from UVA to project ECHO database
Significance:	The Project ECHO (Extension of Community Healthcare Outcomes) Opioid Case Management learning lab is a collaborative exchange of knowledge among providers across the Commonwealth. The goal of this program is to increase the capacity of primary care providers to safely and effectively treat chronic, common, and complex condition through bi-directional learning, knowledge sharing, and networking.

ESM 7.2.1 - Number of gatekeepers trained in the prevention of suicide among youth
NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Measure Status:	Active
ESM Subgroup(s):	Children 10 through 19
Goal:	Reduce non-fatal injury related hospitalizations for children ages 0 through 9 and adolescents ages 10 through 19.
Definition:	**Numerator:** Number of gatekeepers trained in the prevention of suicide among youth **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 (DPHP); DPHP will track the number of participants from quarterly reports of program stakeholders
Significance:	Unintentional injury is the leading cause of child and adolescent mortality, from age 1 through 19. Homicide and suicide, violent or intentional injury, are the second and third leading causes of death for adolescents ages 15 through 19. Gatekeeper training is designed to help professionals interacting with youth and adolescents identify and refer students at risk for suicide.

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, ages 0 through 17, who have a medical home

Measure Status:	Active
ESM Subgroup(s):	CSHCN and non-CSHCN
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 CYSHCN served by the VA CYSHCN Program who report having a medical home
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
ESM Subgroup(s):	CSHCN
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 CYSHCN served by the VA CYSHCN Program who report having a medical home **Denominator:** Total number of CYSHCN served by the VA CYSHCN Program **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, CYSHCN Program; includes the CCC-SUN database and figures reported directly by contractors/program partners for the state fiscal year.
Significance:	The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. Providing comprehensive care to children in a medical home is the standard of pediatric practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. The Maternal and Child Health Bureau uses the AAP definition of medical home.

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, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Increase the number of typical and children with special health care needs who can identify a primary care provider as a medical home
Definition:	**Numerator:** Number of children enrolled in public schools who report a primary care provider **Denominator:** Total number of children enrolled in public schools **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Department of Education
Significance:	This ESM was identified through the Title V needs assessment, Virginia's Well-being Plan, and Healthy People 2020 (MICH-30).

ESM 12.1 - Number of providers in Virginia who have completed the transition training module.
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Active
ESM Subgroup(s):	CSHCN and non-CSHCN
Goal:	Increase the number of children ages 10-24 engaged in transition services to adult health care
Definition:	**Numerator:** Number of providers in Virginia who have completed the transition training module **Denominator:** n/a **Unit Type:** Count **Unit Number:** 100,000
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Child and Family Health
Significance:	This ESM was identified through the Title V needs assessment, Virginia's Well-being Plan, and Healthy People 2020 (DH-5).

ESM 13.1.1 - Completion of action plan identifying strategies and partners for addressing top 3 MCH population oral health needs in Virginia
NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

Measure Status:	Inactive - Completed
Goal:	To collaborate with state oral health partners to identify priority needs and resource gaps and to develop an action plan to address them.
Definition:	**Numerator:** N/A **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Prevention and Health Promotion
Significance:	Due to changes in resources at the community-level, oral health is a reemerging Title V priority for Virginia.

ESM 13.1.2 - Number of Regional Oral Health Alliances that implemented work plans to increase dental visits among pregnant women
NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

Measure Status:	Active
ESM Subgroup(s):	Pregnant Women
Goal:	Assure access to oral health services for pregnant women, all children (including those with special health care needs), and their families.
Definition:	**Numerator:** Number of Regional Oral Health Alliances that implemented work plans to increase dental visits among pregnant women **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1,000
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Prevention and Health Promotion (DPHP); Oral Health Program documentation
Significance:	Oral health is a vital component of overall health and oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children's health, education, and ability to prosper. Preventive dental care in pregnancy is also recommended by the American College of Obstetricians and Gynecologists (ACOG) to improve lifelong oral hygiene habits and dietary behavior for women and their families.

ESM 13.2.1 - Number of Regional Oral Health Alliances that implemented work plans to increase dental visits among children (ages 0-11 years) and adolescents (ages 12-17 years)
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
ESM Subgroup(s):	All Children 0 through 17
Goal:	Assure access to oral health services for pregnant women, all children (including those with special health care needs), and their families.
Definition:	**Numerator:** Number of Regional Oral Health Alliances that implemented work plans to increase dental visits among children ages 0-17 years **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1,000
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Prevention and Health Promotion (DPHP); Oral Health Program documentation
Significance:	Oral health is a vital component of overall health and oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children's health, education, and ability to prosper. To prevent tooth decay and oral infection, the American Academy of Pediatric Dentistry (AAPD) recommends preventive dental care for all children after the eruption of the first tooth or by 12 months of age, usually at intervals of every 6 months.

Form 11
Other State Data

State: Virginia

The Form 11 data are available for review via the link below.

Form 11 Data