Maternal and Child Health Services Title V Block Grant

Virginia

FY 2021 Application/ FY 2019 Annual Report

Created on 9/15/2020 at 11:16 PM

VDH VIRGINIA DEPARTMENT OF HEALTH

VIRGINIA MATERNAL & CHILD HEALTH

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

September 15, 2020

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 very pleased to submit Virginia's 2021 Application and 2019 Annual Report for the Title V Maternal and Child Health Services Block Grant.

Also enclosed are the results of our comprehensive 2020 Five-Year State Needs Assessment.

My team looks forward to your continued partnership during the upcoming five-year grant cycle.

Thank you for your leadership and support in championing the health of Virginia's families.

Sincerely,

Carla Hegwood, MPH
Maternal & Child Health Director
Project Director, Title V Block Grant
Office of Family Health Services
Virginia Department of Health

Enclosures: *MCH Services Title V Block Grant FY21 Application/FY19 Annual Report*
2020 Five-Year State Needs Assessment

cc: M. Norman Oliver, MD, MA, 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

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

Who We Are

There are three federally-defined positions on our state Title V team:

- Carla Hegwood, MPH, is the state's Maternal and Child Health ("MCH") Director and Title V Project Director.
- Marcus Allen, MPH, is the state's Children and Youth with Special Health Care Needs (CYSHCN) Director.
- Dana Yarbrough is the state Title V Family Delegate.

Our leadership team also includes the state MCH epidemiologist, Meagan Robinson, DrPH and the Director of the Division of Child & Family Health, Jennifer MacDonald, BN, RN, MPH.

We're joined by a team of 15 state program managers, approximately 70 state-level staff and contractors, and over 110 local health district staff.

What We Do

The Title V team administers over 75 state programs and contracts serving Virginia families. Our mandate is broad. Populations served include women and men of reproductive age, pregnant and parenting women, and children and adolescents from birth through age 21. Title V also supports work at various levels, from investments in community organizations and population health systems to direct payments for individually-delivered clinical services.

The Title V program supports multiple statewide systems of services that are comprehensive, community-based, and family-centered. The statewide reach of staff and the integration of Title V across the state health agency ensure capacity to coordinate initiatives and work collaboratively to address the needs of the MCH population. Coordinated and integrated systems of care are a particular priority for CYSHCN, a population uniquely served by Title V.

Title V serves as a foundational funding stream for state, regional, and local MCH programs and critical public health infrastructure. In addition to an array of programs for women and children, Title V funding supports delivery of clinical services and health education within each of Virginia's 35 local health districts (LHDs).

The Title V Project Director oversees strategic planning, program development and management, and fiscal operations. Strategic partnerships with other state and federal MCH investments are central to the work; Title V federal and state funds are braided with a number of federal grants from the Centers for Disease Control and Prevention and the Health Resources and Services Administration to accomplish shared goals. The program

sustains partnerships within VDH and with state, local, and federal agencies, non-profits, health systems, and private sector organizations. The scope of the program includes but is not limited to: newborn screening, including early hearing detection/intervention; early childhood, including infant health and home visiting; reproductive health; school health; services for CYSHCN, including care coordination, behavioral/developmental, and insurance case management programs; injury prevention; dental health; and data/evaluation infrastructure.

About Title V Funding

Virginia receives an award of approximately $12M annually from the Maternal and Child Health Bureau. The state contributes $9M of required matching funds. The program generates about $2M of revenue and $1.8M of special enterprise funds per year that are reinvested in sustaining operations.

Title V funds are allocated to each state based on the size and needs of its MCH population. States must provide a match of three dollars of state funding for every four dollars of federal funding received.

Title V of the Social Security Act outlines federal requirements for administering the funds. Thirty percent or more of our federal allocation must support preventive services for children ages 1 to 22, and another thirty percent or more must support services for CYSHCN.

Section 32.1-77 of the Code of Virginia authorizes the Virginia Department of Health (VDH), led by the State Health Commissioner, to prepare and administer the state's Title V plan for MCH.

Virginia's 2021-2025 MCH Priority Needs

- **Upstream / Cross-Sector Strategic Planning:** Eliminate health inequities arising from social, political, economic, and environmental conditions through strategic, nontraditional partnerships.
- **Community, Family, & Youth Leadership**: Provide dedicated space, technical assistance, and financial resources to advance community leadership in state and local maternal and child health initiatives.
- **Mental Health**: Promote mental health across MCH populations, to include reducing suicide and substance use.
- **Finances as a Root Cause**: Increase the financial agency and well-being of MCH populations.
- **Racism as a Root Cause**: Explore and eliminate drivers of structural and institutional racism within programs, policies, and practices to improve maternal and child health, to include providing racial equity training to internal staff and sub recipients.
- **Maternal & Infant Mortality Disparity**: Eliminate the racial disparity in maternal and infant mortality rates by 2025.
- **MCH Data Capacity**: Maintain and expand state MCH data capacity, to include ongoing needs assessment activities, program evaluation, and modernized data visualization and integration.
- **Reproductive Justice & Support**: Promote equitable access to choice-centered, reproduction-related services, including sex education, family planning, fertility/grief support, and parenting support.
- **Strong Systems of Care for All Children**: Strengthen the continuum supporting physical/socio-emotional development (i.e. screening, assessment, referral, follow-up, coordinated community-based care).
- **Oral Health**: Maintain and expand access to oral health services across MCH populations.

How State Priorities Are Determined

At the beginning of each five-year grant cycle, a state MCH needs and assets assessment is conducted to inform

selection of priorities for the state Title V action plan.

During interim years, the Title V leadership team conducts ongoing monitoring and surveillance to identify shifts in needs, resources, and priorities. The action plan is reviewed annually and updated as needed to reflect noted changes in MCH priority needs.

For the 2021-2025 Five-Year Needs Assessment, the Title V team implemented a mixed-methods approach. The MCH Director/Title V Project Director designed the scope of the MCH Needs Assessment and advised the directors of the Divisions of Child & Family Health and Population Health Data and their teams on its design and implementation. The design sought to maximize input from both internal and external partners, with attention to centering the voices and lived experience of families, consumers, and historically marginalized groups. The needs assessment process was designed to align with the Block Grant's life-course framework, the social-ecological model, and a grounded theory approach. Considerations were periodically assessed for inclusion and applying a health equity lens throughout the process. Quantitative and qualitative data were collected to assess MCH health status, needs and assets; state and local capacity; and partnerships and collaboration. The information gathered informed the prioritization and selection of the priorities to guide program planning and performance.

Title V data needs are fulfilled by the State Systems Development Initiative (SSDI) Grant Program, with staff providing MCH data support to inform program planning and resource allocation. Virginia's SSDI maintains representation on the Virginia PRAMS steering committee. The public facing MCH Dashboard is regularly monitored and updated. SSDI leverages partnerships across the state to broadly inform identification of MCH priorities, alignment with Title V national and state performance and outcome measures, and action plan development and implementation.

Selected Title V National Performance Measures (NPMs) by Population

- Breastfeeding (Perinatal/Infant)
- Developmental Screening (Child)
- Injury Hospitalization (Child, Adolescent)
- Medical Home (CSHCN)
- Transition (CSHCN, Adolescent)
- Preventive Dental Visit (Women/Maternal, Child, Adolescent)
- Adequate Insurance (CSHCN)

Additional State Performance Measures (SPMs) and Outcome Measures (SOMs)

- Pregnancy Intention
- Family Leadership
- Youth Leadership
- Early and Continuous Screening
- Outcome Measures: Maternal Mortality Disparity, Infant Mortality Disparity

Performance Measures and Outcomes	
Virginia ranks 18th for the overall health of women and children	
Women's/Maternal Health	• 22nd overall for the health of women • 49.9% of moms had a preventive dental visit during pregnancy • Percentage of women reporting that they wanted to become pregnant later or never was 25.3% • 44.5% of pregnancies were described by women as unintended • Maternal mortality rate was 29.5 per 100,000 live births (White – 27.7; Black – 52.6) • Leading causes of pregnancy-associated deaths were cardiac disorders, accidental overdoses, motor vehicle accidents, homicide, and suicide • Percentage of women who experience postpartum depressive symptoms following a recent live birth was 13.5%
Perinatal/Infant Health	• 23rd overall for the health of infants • 89.4% of moms ever breastfed and 24.6% breastfed for 1-10 weeks – 56.2% were breastfeeding at the time of the VA PRAMS survey (White – 61%; Hispanic – 52%; Black – 39%) • Infant mortality rate was 5.6 per 1,000 live births (White – 4.6; Black – 9.7) • Leading causes of infant mortality were birth defects, disorders related to short gestation and low birth weight, and sudden infant death syndrome
Child Health	• 6th overall for the health of children • Percent of children, ages 9-35 months, who received a developmental screening using a parent-completed screening tool in the past year is 31.4% • Rate of hospitalization for non-fatal injury among children was 98.6 per 100,000 (<1 year – 210.8; 1-4 years – 108.9; 5-9 years – 68.5) • 65.6 % of children age 1-5 years and 89.5% of children age 6-11 years had a preventive dental visit
Adolescent Health	• Rate of hospitalization for non-fatal injury among adolescents was 184.5 per 100,000 (10-14 years – 103.9; 15-19 years – 262.8) • Among students who reported that they seriously considered attempting suicide – 82% felt sad, empty, hopeless, angry, or anxious; 40.8% attempted suicide; 24.9% were physically hurt by someone they were dating or going out with; 36.2% were bullied on school property; 29.2% were bullied electronically • 11.6% of adolescents received services necessary to make transitions to adult health care • 88.2% of adolescents had a preventive dental visit • Teen pregnancy rate is 19.1 per 1,000 females age 15 to 19 years
Children with Special Health Care Needs	• Percent of children with special health care needs (CSHCN) is 20.9% • 48.4% of CSHCN had a medical home • 26.5% of CSHCN age 12-17 years were engaged in transition services to adult health care • 71.3 % of CSHCN continuously and adequately insured (Medicaid – 29.4%; Private – 17.4%; Uninsured – 13.4%)
Cross-Cutting / Systems	• Expand capacity to document and track referrals of infants from the Newborn Screening Program to CSHCN programs • Develop and sustain the VDH Youth Advisor Program • Implement MCH workforce development policies addressing racial equity • Maintain and expand family engagement

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

Title V funds sustain core state MCH infrastructure and over 75 contracts with health systems, health districts, and community partners to support regional and local MCH systems-building, clinical services, and education.

The Title V program:

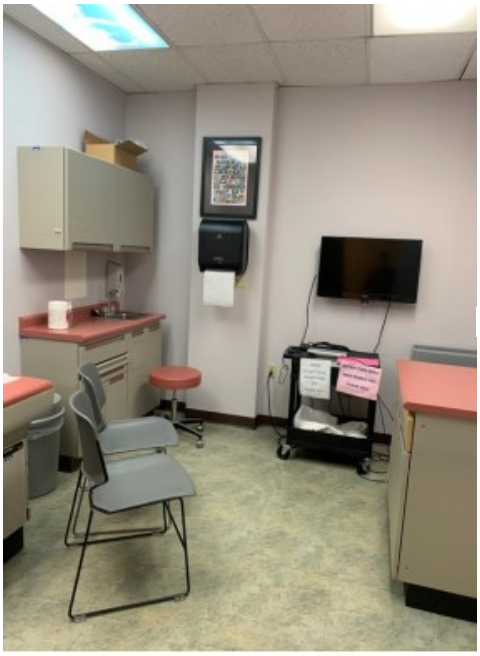
- Sustains the health agency's MCH workforce, to include the Title V Director, 110+ local health district staff, and 60+ staff across the Divisions of Child & Family Health, Prevention & Health Promotion, and Population Health Data.
- Funds an emerging state Black Maternal/Infant Health Program;
- Funds the CSHCN Program, which includes the Child Development Centers, Care Coordination for Children Centers, Sickle Cell Awareness Program, and Bleeding Disorders Program.
- Funds coordinated systems of care for children, including the Developmental Screening Initiative and School Health/Nursing Program;
- Funds state child fatality and maternal mortality review teams;
- Funds family and youth leadership initiatives;
- Supports oral health, suicide prevention, and child safety programs with braided CDC and state funds.
- Supports the Newborn Screening Program (including Early Hearing Detection & Intervention) with braided HRSA, CDC, and state special funds.
- Supports home visiting and child programs with braided MIECHV, Healthy Start, and Mental Health Access Program funds.
- Supports the Reproductive Health Unit's Adolescent Health, LARC, and Resource Mothers Programs with braided Title X, Sexual Risk Avoidance Education, TANF, and state funds.

III.A.3. MCH Success Story

Success Story

Staff at the Southwest Virginia CCC have been working closely with the Department of Developmental Pediatrics at the University of Virginia (UVA) to support CYSHCN during COVID.

This part of the state is very rural with limited internet availability. The center is a location that families can safely visit for telemedicine appointments with a clinical specialist. A private room at the health department is used; the nurse coordinator works closely with UVA to provide on-site technical support and bridge UVA and VDH technology while families communicate with neurodevelopmental specialists. At clinic appointments, he records vitals for the treating physician, helps the families explain specific issues to the doctor, and helps families understand certain medical instructions.



UVA is taking appropriate precautions regarding holding in-person clinics to protect providers and families. This service is not risk-free, but it does provide a controlled environment that helps to assure that families still get the support and service they need without having to rely on their own devices; such requirements can be cost prohibitive for families.

The Title V program is currently exploring opportunities to invest in technology (i.e. personal devices) for both staff and clients across MCH programs, included federal sister programs such as home visiting.

III.B. Overview of the State

Oversight and Authority

The Virginia Department of Health (VDH) is the lead state entity providing core public health functions and essential services.

The VDH Strategic Plan establishes the agency's mission to protect the health and promote the well-being of all people in Virginia, with a vision to become the healthiest state in the nation.

The VDH Plan for Well-Being lays out the foundation for giving everyone a chance to live a healthy life:

1. Factoring health into policy decisions related to education, employment, housing, transportation, land use, economic development, and public safety;
2. Investing in the health, education, and development of Virginia's children;
3. Promoting a culture of health through preventive actions; and
4. Creating a connected system of health care.

The scope of the agency's services includes 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 provides leadership in planning and policy development and supports VDH in implementing a coordinated, prevention-oriented program that promotes and protects the health of all Virginians. The agency is led 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.

Virginia's MCH Program

VDH is responsible for the administration of programs carried out with allotments under Title V. Virginia's MCH program implements strategies that have broad population health impact. The VDH Office of Family Health Services (OFHS) houses the state Title V program and complementary MCH programs under its flagship brand, *VDHLiveWell*. OFHS programs include 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**. MCH block grant funding is allocated by formula to each of Virginia's 35 local health districts to support local MCH implementation, with two of these districts being governed locally.

Virginia's MCH program works with and garners partnerships across state agencies and programs, including the Department of Medical Assistance Services, Department of Social Services, Department of Education, and Department of Behavioral Health and Developmental Services. Virginia's Healthy Start and Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Programs are administered through the VDH Division of Child and Family Health.

MCH Priorities: Virginia's Title V MCH programming aligns with the agencies mission and core values by establishing upstream approaches to MCH priorities:

- **Upstream / Cross-Sector Strategic Planning:** Eliminate health inequities arising from social, political,

economic, and environmental conditions through strategic, nontraditional partnerships.

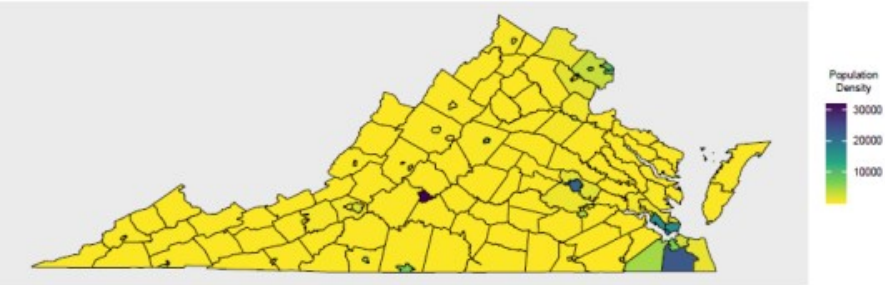
- **Community, Family, & Youth Leadership:** Provide dedicated space, technical assistance, and financial resources to advance community leadership in state and local maternal and child health initiatives.
- **Mental Health:** Promote mental health across MCH populations, to include reducing suicide and substance use.
- **Finances as a Root Cause:** Increase the financial agency and well-being of MCH populations.
- **Racism:** Explore and eliminate drivers of structural and institutional racism within OFHS programs, policies, and practices to improve maternal and child health.
- **MCH Data Capacity:** Maintain and expand state MCH data capacity, to include ongoing needs assessment activities, program evaluation, and modernized data visualization and integration.
- **Reproductive Justice & Support:** Promote equitable access to choice-centered reproduction-related services, including sex education, family planning, fertility/grief support, and parenting support.
- **Strong Systems of Care for All Children:** Strengthen the continuum supporting physical/socio-emotional development (i.e. screening, assessment, referral, follow-up, coordinated community-based care).

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 and 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 199.1 people per square mile. The largest cities are Virginia Beach (450,135), Norfolk (245,592), Chesapeake (237,820), the state's capital Richmond City (223,787) and Newport News City (180,145). 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 2018 population estimates. There are just under 160,000 people living within the city, for a population density of 10,434 residents/square mile. In contrast, Highland County has the lowest density at 5.335 residents/square mile.



The most populous county and largest jurisdiction in the Commonwealth is Fairfax County in Northern Virginia, with a climbing population of 1.15 million. Fairfax County has a major urban business and shopping center in Tysons Corner, Virginia's largest office market. Neighboring Prince William County (468,011) 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 (450,189) to become the second-most-populous jurisdiction in Virginia. Three out of four of the state's largest counties, now in Northern Virginia, account for 23.8% of the state's population growth. Loudoun County with 406,850 residents surpasses Chesterfield County with 348,556 residents. The four counties with the largest portions of population 35 and younger were Fairfax, Prince William, Virginia Beach, and Loudon Country respectfully according to the 5-year (2018) census estimates. The four Virginia jurisdictions that have the smallest ratios of people 65 and older are Radford City, Harrisonburg City, Manassas Park City and Loudoun County.

Virginia is a place where state averages hide the contrasting stories of its subpopulations. There are approximately 1.0 million residents living within rural areas of the state, compared to over 7.5 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 include 3 of the 50 richest places in America according to Bloomberg, 2020. 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 8.6 million people (World Population Review). There were 49.2% of the population reporting male and 50.8% female (2018: ACS 5-Year Estimates Data Profiles, Demographic and Housing Estimates).

Race/Ethnicity

Among people reporting one race alone, 68.0% identified as White, 19.2% identified as Black, 0.3% American Indian and Alaska Native, 6.3% Asian, and 0.1% Native Hawaiian and Pacific Islander (2018: ACS 5-Year Estimates Data Profiles, Demographic and Housing Estimates). There were 9.2% of individuals that identified as Hispanic or Latino. According to the Census Bureau, Virginia ranks 9th in having the largest African American population (HHS Office of Minority Health Resource Center).

There were over 1.69 million women of childbearing age (15-44 years) in 2018, with race and ethnicity composition consisting of 58.1% non-Hispanic white, 21.5% non-Hispanic black, 8.9% non-Hispanic Asian, 0.3% non-Hispanic Native American or Alaska Native, and 11.2% Hispanic (any race) (2018 Virginia resident population estimates). The Virginia population, like that of the nation, is becoming more racially and ethnically diverse where 12.3% of the population are foreign-born (2018: ACS 5-Year Estimates Data Profiles, Selected Social Characteristics).

Age and Sex

The median age of Virginians is 38 years. Persons age 65 years and older represent 15.9% of the population (U.S. Census Bureau, QuickFacts, Virginia). There were 190,459 grandparents, and among those, 35.1% were responsible for their grandchildren (2018: ACS 5-Year Estimates Data Profiles, Selected Social Characteristics). There were 21.8% of persons under 18 years, 5.9% under 5 years, and 50.8% were female.

Economic Well-Being

Educational Attainment

Educational attainment is a predictor of personal wealth and well-being and is directly related to social disparities. In Virginia, 10.7% have a 9th to 12th grade education with no diploma, 24.1% are high school graduates or equivalent, 21.7% have a bachelor's degree, and 16.5% have a graduate or professional degree. Thirty-six percent (38.2%) of Virginians have a bachelor's degree or higher compared with 31.5% 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 3.8 million civilian workers, and one-sixth of the jobs are in the service sector. The unemployment rate in Virginia was 3.0% as per ACS 2018, below the national rate of 4.0%. The median household income in Virginia is $72,577 compared to $63,179 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 (10.7% vs. 11.8% for the U.S.) and also a lower percentage of children under age 18 lived in households with incomes below the federal poverty level (13.8% vs. 17.8% for the U.S.). However, wealth varies significantly across the state. The percentage of children living in poverty was 13.8% in 2018 (U.S. Census Bureau, Small Area Income and Poverty Estimates 2018). For the years 2017-2018, 19.1% of children with special health care needs lived in families with incomes less than 100% of the federal poverty level. This is in comparison to children without special health care needs, of which 14.7% are in families with incomes less than 100% of the federal poverty level.

Housing

The factors that relate to housing have the potential to affect health in major ways. These factors include physical conditions within homes, conditions in the neighborhoods surrounding homes, and housing affordability. Among occupied housing units in Virginia, 33.8% are rented. In renter-occupied units, nearly half (48.7%) pay 30 percent or more of their household income to rent (2018: ACS 5-Year Estimates Data Profiles, Selected Housing Characteristics). In 2018, 65% of Virginia children lived in low-income households with high housing cost burden (KIDSCOUNT Data Center). The median rent in Virginia is $1,202. The median home value for owner-occupied units in Virginia is $264,900 (2018) compared to $243,500 in 2014, representing an 8.8% increase in median home value in five years. Communities without safe and affordable housing affect the overall ability of families to make healthy choices and access to quality homes.

Food Security

Food insecurity is a social and economic condition where access to food is limited or uncertain. In Virginia, 842,870 people are struggling with hunger, and 1 in 8 children struggle with hunger (Hunger in Virginia). According to America's Health Rankings in 2019, 10.1% of Virginia households were unable to provide adequate food for one or more household members due to lack of resources. Charity and government assistance programs are necessary to help bridge the meal gap. Among households receiving Supplemental Nutrition Assistance Program (SNAP) benefits, 44.9% had children.

Primary Care Access and Health Insurance Coverage

Based on the 2013-2018 ACS data, 87.3% of Virginians have health insurance of some kind and 95.1 percent of those under age 19 have health insurance. Among the uninsured population, 14.1% are young adults age 26 to 34. Others that are uninsured include 8.0% of the White population compared to 10.1% of non-Hispanic African Americans, and 21.4% of those with less than a high school education.

In 2019, the Bureau of Labor Statistics reported 4,230 family and general practitioners in Virginia, and 570 obstetricians/ gynecologists. There were 490 pediatricians, 3,430 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 106 counties/cities in Virginia designated as Primary Care Health Professional Shortage Areas (HPSAs), 98 in Dental Care, and 74 in Mental Health (HRSA Data Warehouse). Virginia expanded the Medicaid program on January 1, 2019, a significant change in health care policy that was realized without the expenditure of state dollars. More than 380,000 Virginia adults are enrolled and receiving services under the new eligibility rules.

Community and Social Well-Being

Social and emotional support

Research has supported that social and emotional support from others can be protective for health. Overall, 31.6% of Virginia children were living in single parent households. There were 4% of children in the care of grandparents. The majority of Virginia parents (78.8%) report that they have someone to turn to for day-to-day emotional support with parenting or raising children. Hispanic parents (60.8%) and Black parents (76.6%) were less likely to report having emotional support with parenting compared to White parents (87.8%) (NCHS 2017-2018). There were 70.3% of high school students that have an adult to go to for help with a serious problem (71.4% male, 69.2% female) (Virginia YRBS).

Racism and Discrimination

Racism and discrimination are among other social determinants of health that negatively influence health. During their pregnancy, mothers expressed experiencing discrimination or harassment due to their race, ethnicity or culture (3.63%); insurance or Medicaid status (2.68%); weight (5.33%); and marital status (1.12%). Among those reporting discrimination or harassment due to their race, ethnicity or culture, 8% were Black and 9.21% were Hispanic. Among high school students, 16.8% have been a victim of teasing or name-calling because of their actual or perceived race or ethnic background, and 11.8% because of their actual or perceived sexual orientation in the past year.

Performance Measures and Outcomes

DOMAIN: Women's/Maternal Health

According to America's Health Rankings (2019), Virginia ranks 22nd overall for the health of women, and 18th for the overall health of women and children.

NPM 13.1: Preventive Dental Visit During Pregnancy – Data from the Pregnancy Risk Assessment Monitoring System (PRAMS) showed that 49.9% of moms had a preventive dental visit during pregnancy (2017). 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: Pregnancy Intention: Mistimed or Unwanted Pregnancy – The percentage of women reporting that they wanted to become pregnant later or never was 25.3% (2018 VA PRAMS). The concept of unintended pregnancy helps in understanding the fertility of populations and the unmet need for contraception and family planning (CDC 2019). In Virginia 44.5% of pregnancies were described by women as unintended.

SOM 2: Maternal Mortality Disparity – Maternal mortality is a sentinel indicator of health and health care quality worldwide. In 2019 Virginia's governor announced a goal to eliminate the racial disparity in the maternal mortality rate in Virginia by 2025. The maternal mortality rate was 29.5 per 100,000 live births, with a rate of 27.7 per 100,000 among White women and 52.6 per 100,000 among Black women (2019).

Mental Health - The percentage of women who experience postpartum depressive symptoms following a recent live birth was 13.5% (PRAMS 2018).

DOMAIN: Perinatal/Infant Health

According to America's Health Rankings (2019), Virginia ranks 23rd overall for the health of infants.

NPM 4: Breastfeeding – Research shows that breastfeeding provides many health benefits for moms and babies,

including lower risk of type 2 diabetes and certain cancers for moms, and protection from illness for babies. VA PRAMS (2018) showed 89.4% of respondents ever breastfed, 24.6% breastfed for 1-10 weeks, and 56.2% were breastfeeding at the time of the survey. There were some differences observed in continuation by race, where by the time of the survey 61% of White moms were breastfeeding, 52% of Hispanic moms, and 39% of Black moms.

SOM 1: Infant Mortality Disparity – Infant mortality is a sentinel measure of population health that reflects the underlying well-being of mothers and families, as well as the broader community and social environment that cultivate health and access to health-promoting resources. A significant disparity exists in infant deaths between racial groups in Virginia, where Black women had an infant mortality rate in 2018 at 9.7, twice that for White women (4.9 per 1,000 live births). Goal 2.3 of the VDH Plan for Well-Being is to eliminate the racial disparity in Virginia's infant mortality rates.

Newborn Screening – The Virginia Newborn Screening program consists of dried blood spot (DBS) newborn screening, the Early Hearing Detection and Intervention (EHDI) and CCHD follow-up teams. The DBS and EHDI teams track and follow-up on all out-of-range results, facilitates access to specialty services for further testing and confirmation of diagnosis, and infants that are diagnosed with a newborn screening disorder are referred to Care Connection for Children Centers (CCC) for care coordination services. EHDI also refers diagnosed infants to Early Intervention (EI).

DOMAIN: Child Health

According to America's Health Rankings (2019), Virginia ranks 6th overall for the health of children. The child mortality rate was 23.6 per 100,000 children ages 1-19.

NPM 6: Developmental Screening – The percent of children, ages 9-35 months, who received a developmental screening using a parent-completed screening tool in the past year is 31.4% (2017-2018) in Virginia, compared to the U.S. at 33.5%. Early identification of developmental disorders is critical to child well-being and is an integral function of primary care.

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 98.6 per 100,000 in 2017. Among age groups, the annual indicator was 210.8 for children less than one year of age, 108.9 among children ages 1-4, and 68.5 among children ages 5-9. 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 13.2: Preventive Dental Visit (ages 1-11 years) – The NSCH showed that 65.6 % of children age 1-5 years and 89.5% of children age 6-11 years had a preventive dental visit (2017-2018). Insufficient access to oral health care and effective preventive services affects children's health, education, and ability to prosper.

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 184.5 per 100,000 in 2017. The annual indicator was 103.9 among age 10-14 years and 262.8 among age 15-19 years. Among students who reported that they seriously considered attempting suicide, 82.0% reported having felt sad, empty, hopeless, angry, or anxious; 40.8% attempted suicide; 24.9% were physically hurt by someone they were dating or going out with; 36.2% were bullied on school property; 29.2% were bullied electronically; and only 54.2% had at an adult they can talk to (Virginia Youth Survey, 2017).

NPM 12: Transition (ages 12-17 years) – The NSCH (2017-2018) showed only 11.6% of adolescents received services necessary to make transitions to adult health care. Health care transition focuses on building independent health care skills – including self-advocacy, preparing for the adult model of care, and transferring to new providers.

NPM 13.2: Preventive Dental Visit (ages 12-17 years) – The NSCH (2017-2018) showed that 88.2% of adolescents had a preventive dental visit.

SPM 4: Pregnancy Intention – The teen pregnancy rate in Virginia is 19.1 per 1,000 females age 15 to 19 years (2018). Differences exist among race/ethnicity and regions within the state. Hispanic and non-Hispanic Black teens had the highest teen pregnancy rates in 2018 at 34.6 and 28.9 respectfully. The Eastern (24.0), Southwest (23.7), and Central (21.9) regions had rates higher than the state rate. The public savings in 2015 due to declines in the teen birth rate totaled $72 million (Power to Decide, 2020).

DOMAIN: Children with Special Health Care Needs

The percent of children with special health care needs (CSHCN), ages 0 through 17, in Virginia is 20.9% (NSCH 2017-2018).

NPM 11: Medical Home (CSHCN ages 0-17 years) – The NSCH (2017-2018) showed that 48.4% of CSHCN had a medical home. Children with a stable and continuous source of health care are more likely to receive appropriate preventive care.

NPM 12: Transition (CSHCN ages 12-17 years) – The NSCH (2017-2018) showed that 26.5% of CSHCN age 12-17 years were engaged in transition services to adult health care.

NPM 15: Continuous and Adequate Insurance (CSHCN ages 12-17 years) – The NSCH (2017-2018) showed that 71.3 % of CSHCN continuously and adequately insured. There were 29.4% of CSHCN that had Medicaid, 17.4% private insurance, and 13.4% uninsured.

DOMAIN: Cross-Cutting/Systems

SPM 1: Cross-Cutting (Early and Continuous Screening) – Early identification of developmental disorders is critical. The newborn screening and birth defects surveillance program seek to maintain the VaCARES Registry and expand capacity to document and track referrals of infants from the Newborn Screening Program to CSHCN programs.

SPM 2: Cross-Cutting (Youth Leadership) – Through the development of a Youth Advisor Program, the Adolescent Health Program seeks to increase equity in VDH's public health initiatives by incorporating youth voice into the development, planning and management of public health initiatives that impact young people.

SPM 3: MCH Workforce Development (Racial Equity) – The VDH MCH Program will develop and implement MCH workforce development policies addressing racial equity for all Title V program staff and subrecipient staff.

SPM 5: Cross-Cutting (Family Leadership) – The VDH MCH Program seeks to maintain and expand family engagement to assure families of children with special health care needs partner in decision making at all levels and are satisfied with the services they receive.

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.

Given improvements in care, most children with sickle cell disease (SCD) survive into adulthood. Virginia has a strong pediatric comprehensive sickle cell network that has been in existence since the 1990s, but until recently did not focus on the adult population. In 2020, the General Assembly passed legislation for the Board of Health to adopt regulations to implement an adult comprehensive sickle cell network, as well as funding to support the adult clinics' infrastructure. The regulations are in the process of being drafted and approved for the Virginia Administrative Code. The regulations will outline the scope and services the adult comprehensive sickle cell network will provide. After the regulations are approved, VDH will move forward with issuing requests for proposals and contracts to aid the clinics' in building the needed infrastructure to improve the quality of care for adults living with SCD.

Virginia House Bill 1467 requires the Board of Health to adopt regulations to include NAS on the list of diseases that shall be reported by physicians and directors of medical care facilities. Virginia medical facilities began reporting clinical diagnoses of NAS in an electronic case reporting system on November 27, 2017. Information captured includes severity of NAS signs, supportive elements for diagnosis, and source of exposure.

Virginia House Bill 1157 provides that the Department of Health shall serve as the lead agency with responsibility for the development, coordination, and implementation of a plan for services for substance-exposed infants in the Commonwealth. It details that plans shall (i) support a trauma-informed approach to identification and treatment of substance-exposed infants and their caregivers and (ii) include (a) options for improving screening and identification of substance-using pregnant women, (b) use of multidisciplinary approaches to intervention and service delivery during the prenatal period and following the birth of the substance-exposed child, and (c) referral among providers serving substance-exposed infants and their families and caregivers.

Virginia House Bill 2546 establishes the Maternal Mortality Review Team (MMRT) to develop and implement procedures to ensure that maternal deaths occurring in the Commonwealth are analyzed in a systematic way. The bill requires the MMRT to (i) develop and revise as necessary operating procedures for maternal death reviews, including identification of cases to be reviewed and procedures for coordinating among the agencies and professionals involved; (ii) improve the identification of, and data collection and record keeping related to, causes of maternal deaths; (iii) recommend components of programs to increase awareness and prevention of, and education about, maternal deaths; and (iv) recommend training to improve the review of maternal deaths.

Children's Cabinet: In June 2018 Virginia Governor Ralph Northam issued Executive Order No. 11 reestablishing the Children's Cabinet (Press Release). The First Lady is leading the effort to improve quality of and access to early childhood education programs across Virginia, support the early childhood education workforce, and ensure that Virginia makes the most of early childhood education resources. The Children's Cabinet prioritizes issues including early childhood development and school readiness, nutrition and food security, and systems of care and safety for school-aged youth.

Maternal & Child Population Overview

In 2018, infants were 1.2% (99,261) of the total population[1]. There were 99,629 infants born to Virginia residents in 2018[2]. Women of reproductive age (15-44 years) accounted for 19.8% (1,688,184) of the total population of Virginia[1]. There were 2,339,032 children and adolescents aged 1-21 years, representing 27.8% of the population[3]. According to the 2017- 2018 National Survey of Children's Health[4], 20.9% of Virginia children aged 0 to 17 (Pop. Est. 389,683 children) were identified as having special health care needs.

Key Virginia Characteristics

The following represent a snapshot of key Virginia Characteristics and health indicators

Number of Births: 99,091

- % Preterm Birth: 9.4
- % Low Weight Births: 8.2
- Infant Mortality Rate (per 1000 births)
  - State: 5.6
  - White: 4.9
  - Black: 9.7
  - Other: 3.1
- Number (%) of Children 0 – 19 years old: 2,096,027 (25%)
- % Children with special health care needs: 20.9
- % Births covered by Medicaid: 30%
- % children <18 years old without health insurance: 5%

SOURCES:

1. 2018 Virginia resident population estimates
2. VDH Division of Health Statistics, Statistical Reports and Tables
3. NCHS Vintage population https://dataviz.vdh.virginia.gov/authoringNewWorkbook/NCHS_Vintage_Population#1
4. National children health survey, 2017-2018
5. Annie E. Casey Foundation KIDS COUNT Data Center

KIDS COUNT Key Indicators

Compared to other states, Virginia's overall child well-being rank for the 2020 Kids Count Profile is 14

Indicators	Virginia	United States	Rank
Economic Well-Being			***11***
Percent of children in poverty (2018)	14	18	
Percent of children whose parents lack secure (2018)	24	27	
Percent of children living in households with high housing cost burden (2018)	29	31	
Percent of teens not in school and not working (2018)	4	7	
Education			***6***
Percent of young children (ages 3-4) not in school (2016-18)	51	52	
Percent of fourth-graders not proficient in reading (2019)	62	66	
Percent of eighth-graders not proficient in math (2019)	62	67	
Percent of high school students not graduating on time (2017-18)	13	15	
Health			***24***
Percent of low birth weight babies (2018)	8.2	8.30%	
Percent of children without health insurance (2018)	5	5	
Child and teen deaths per 100,000 (2018)	24	25	
Percent of children and teens (ages 10-17) who are oveweight or obese (2017-18)	30	31	
Family and Community			***18***
Percent of children in single-parent families (2018)	32	35	
Percent of children in families where the household head lacks a high school diploma (2018)	9	13	
Percent of children living in high-poverty areas (2014-2018)	5	10	
Teen births per 1,000 (2018)	14	17	

Source: The Annie E. Casey Foundation, 2020 Kids Count Profile: Virginia
https://www.aecf.org/resources/2020-kids-count-data-book/

Healthy People 2020 Maternal, Infant, and Child Health Indicators - Virginia

Indicators	2010	2011	2012	2013	2014	2015	2016	2017	2018	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	5.8	5.3	5.6	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	23.2	22.6	18.9	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	9.6	12.4	10.1	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	13.8	10.5	16.3	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	46.4	46.5	47.4	54.3
Reduce low birth weight (LBW)[1]	8.2	8.0	8.1	8.0	7.9	7.9	8.1	8.4	8.2	7.8
Reduce total preterm births[1]	10.1	9.5	9.5	9.4	9.2	9.2	9.5	9.5		9.4
Reduce the rate of maternal mortality[3] (deaths per 100,000 live births (5-year average))		--				29.5			--	11.5
Pregnancy Health and Behaviors										
Increase the proportion of pregnant women who receive prenatal care beginning in the first trimester[1]	--	--	--	56.1	58.7	69.7	76.2	74.0	78.4	77.9
Increase abstinence from cigarette smoking among pregnant women[1]	--	--	--	68.1	65.6	82.3	92.7	93.3	94.5	98.6
Increase initiation, duration and exclusivity of breastfeeding.										
Percent of mothers who exclusively breastfed their infants through 6 months of age[4]	16.6	22.9	23.6	22.0	21.7	26.6	26.4	--	--	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.

III.C. Five-Year Needs Assessment Summary
(as submitted with the FY 2021 Application/FY 2019 Annual Report)

III.C.2.a. Process Description

Background

Every five years, Virginia's Title V Maternal and Child Health (MCH) Program conducts a statewide needs assessment of the health and well-being of women, children, youth, and families living in Virginia. The Virginia Department of Health (VDH) Office of Family Health Services (OFHS) houses the state Title V program and complementary MCH programs. The Title V MCH Block Grant requires states to prepare and submit a statewide Needs Assessment every five years that identifies population needs. Conducting this assessment is a best practice in public health. Virginia seeks to inform the selection of the state's highest priority needs for Women, Pregnant Women, Infants, Children, Adolescents, Children and Youth with Special Health Care Needs (CYSHCN), and Men. The goals of Virginia's 2021-2025 needs assessment were to:

1. Complete a state-level assessment of key maternal and child health populations: woman, pregnant women and infants, men, children, adolescents, and children and youth with special health care needs.
2. Complete an environmental scan of maternal and child health programs, services, policies, systems, and environmental changes identified as assets and needs.
3. Develop informed and vetted priorities and recommendations for population health improvement in key maternal and child health populations.

Process Description and Oversight

Virginia's MCH staff invested significant staff time, expertise and funding in order to design and implement a data-driven needs assessment process for the 2021-2025 Block Grant funding cycle. The team employed rigorous research methodology, skilled and knowledgeable staff, a leadership committee, and stakeholder engagement to identify priorities to drive the development of the five-year action plan. OFHS convened a cross-program steering committee (MCH Assessment Lead Team) that met monthly to conduct assessment of processes, data sources and indicators, and gap analysis. A summary of the needs assessment process and findings are presented and supporting documentation and tools are in the attachments. The following teams and people were integral to the design and implementation of the needs assessment process:

- Needs Assessment Project Team: OFHS staff within the Divisions of Population Health Data and Child and Family Health who organize, inform, and implement the process. This team included contractors hired to coordinate and implement the assessment.
- MCH Needs Assessment (MCHNA) Lead Team: MCH leadership who inform and make final decisions on process and priorities, including the OFHS Director, directors of the Divisions of Population Health Data and Child and Family Health, Title V Grant Coordinator, Lead MCH Epidemiologist, the VDH Population Health Trainer, and the VDH Population Health Surveys Supervisor.
- Advisory Team: MCH program managers, subject matter experts (SME), stakeholders and cross-agency partners who inform the process and priority selection, including collaboration with MIECHV needs assessment leadership and the VDH Office of Health Equity.
- Partners and people: Professional partners and community members who inform processes, implementation, and priorities; including local health districts and community-based organizations (CBO).

Planning for the needs assessment began in February 2018. Beginning in May 2018, the MCHNA Lead Team was convened under the guidance of the directors of the
Division of Population Health Data and Division of Child and Family Health. The MCHNA Lead Team was tasked to:

- Convene a project team of staff to implement the assessment.
- Identify lead-team structure.
- Develop work plans and timelines.
- Develop the overall approach to the assessment using the Block Grant guidance.
- Adopt guiding principles for the assessment.
- Adopt frameworks, principles, and tools from the MCH Needs Assessment Toolkit to guide data collection and needs assessment efforts.
- Perform key quantitative data collection methods and develop LiveStories boards for data products.
- Identify new and existing data sets and reports related to the MCH population to leverage assessment purposes.
- Work with the Early Childhood and MIECHV programs and partners to ensure alignment with needs assessments.
- Developed qualitative data collection methods and tools.

Guiding Frameworks

The needs assessment process was designed to align with the Block Grant's life-course framework, the social-ecological model, and a grounded theory approach. Considerations were periodically assessed for inclusion and applying a health equity lens throughout the process. The life course approach assured alignment with the Title V population domains. The social-ecological model provided a lens to drive upstream thoughts, where the team considers potential priority issues and strategies through the complex interplay between individual, relationship, community, and societal factors. This further leads to the promotion of health equity, by reviewing data, considering priorities, and developing strategies with the social determinants of health at the forefront of thought and discussion. Grounded theory provides the systematic guidelines for gathering, synthesizing, analyzing, and conceptualizing qualitative data.

Methodology

A mixed-methods approach for the needs assessment was implemented, with a priority to maximize the input of internal and external partners, and engagement of families and consumers in a meaningful way. Quantitative and qualitative data were collected to assess MCH health status, state and local capacity, partnerships and collaboration. The data collected informed the prioritization process leading to the selection of MCH priorities to guide implementation of strategies to address the most pressing issues among Virginia's MCH population.

Stakeholder Engagement, Existing Efforts and Resources

In November 2018, the MCHNA Lead Team developed a partner survey to obtain stakeholder input in selecting priorities and areas of focus for qualitative assessment. The survey was distributed to over 382 statewide partners and received 287 responses.

The VDH Population Health Trainer is responsible for leading the coordination and planning of community health assessments and community health improvement plans (CHA/CHIP) with the 35 local health districts (LHD). As a member of the MCHNA Lead Team, the Population Health Trainer was able to help assure the systematic review of available reports to discern what was already known about the needs and strengths of the MCH population within Virginia. This also presented opportunity to use networks and existing alliances at the local level. The MCHNA Team gathered data and knowledge from entities with established relationships, partners were able to aid in facilitation and recruitment for qualitative methods, and the team was able to reach new partnerships.

The MCHNA Team had the unique opportunity to leverage and align key needs assessment activities with MIECHV.

Virginia's MIECHV program is housed within VDH OFHS, presenting prime opportunity to ensure combined efforts to gather the information and data required for both needs assessments. This opportunity ensured that programs avoided duplication of efforts, leveraged staff and fiscal resources, and aligned the data collected by each program. The Title V Grant Coordinator and the MCH Epidemiology Lead met periodically with Early Impact Virginia (EIV), a key Virginia MIECHV partner and facilitator of the state's MIECHV Needs Assessment. Data, tools, and information were shares seamlessly and utilized by both programs, and plans were discussed to ensure gap-filling efforts.

Data Collection

Quantitative Data

Quantitative Data collection started in June of 2018 with data compiled at the state and local levels (where applicable) by population domains. Quantitative Data were obtained from a range of sources, including population-based surveys (PRAMS, BRFSS, YRBS, NSCH, NIS), vital statistics (birth, death, fetal death, induced terminations of pregnancy), American Community Survey and Census data, programmatic-level data, and data from cross-agency partners (DMAS, DOE, DSS) and CBOs (EIV), just to name a few. MCH-focused LiveStories dashboards were then created on a variety of health issues affecting the MCH population. These dashboards are organized by population domain, and are currently published for use. Updates for these dashboards are ongoing as these are meant to be living documents for broader use as part of ongoing assessment used by MCH stakeholders. The Virginia MCH LiveStories serve as a significant resource to inform stakeholders about the health status of the Virginia MCH population.

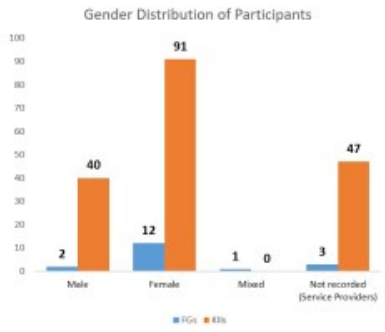
Qualitative Data

In February 2019, the team began qualitative assessment planning. The assessment was population-based and action-focused using a grounded theory approach. VDH hired three contract staff to support the management, coordination, and completion of the assessment recruitment, transcription, document formatting, and analysis. Three qualitative methods were used to collect data: key informant interviews (KIIs), focus groups (FGs), and open-ended questions in an online survey. Using the quantitative data to influence development, structured interview questions and protocols, focus group questions and guidelines, and open-ended survey questions were created for the population group between February and May 2019. Questions, protocols and guidelines were also validated with non-affiliated VDH staff for clarity in understanding and cultural appropriateness. Locations of assessments were selected utilizing the Virginia Health Opportunity Index. The health district with the lowest health opportunity per VDH region was selected, with the southwest split into two, due to its size. Through various partner providers and collaborators, we conducted interviews and focus groups at LHDs, health fairs, prayer breakfasts, a Virginia Premier Baby Shower, faith and community engagement day, and AfroFest. All qualitative data collection concluded in September 2019. There were 178 KIIs and 18 FGs conducted across five population domains. Gender distribution of KIIs was 91 females, 40 males, and 47 not recorded, and for FGs was 12 female, 2 male, 2 coed, and 2 not recorded. The distribution of KIIs and FGs by population had strong representation across the six population domains.

MCH Population Domain	Number of FGs	Number of KIIs	Total
Women of reproductive age	7	37	44
Men	2	40	42
Pregnant women (or new mothers) & Mothers of young children	4	42	46
Parents of CYSHCN	2	12	14
MCH Providers/Stakeholder Meeting	3	47	50
Total	18	178	196

We sought inclusion and diversity within the population domains with certain lived experiences. KIIs and FGs with

residents who speak Spanish (10), are within the refugee/immigrant community (8), have been incarcerated (3) or were in foster care (2), are women of color (2), identify as LGBTQ+ (1), and women who have experienced infertility (1).



Special Population Group	FGs	KIIs	Total
Spanish-speaking people	2	8	10
Refugee/immigrant community	0	8	8
Incarcerated women	1	2	3
Foster care youth	0	2	2
Women of color	2	0	2
LGBTQ+ community	0	1	1
Women who experienced infertility	0	1	1
Total	**5**	**22**	**27**

The adolescent online survey launched, using the SurveyGizmo platform, in August 2019 and yielded 403 respondents (N=213 survey completions). Thorough reports regarding the needs assessment can be found in the appendices.

Prioritization Process

The MCHNA Team designed the prioritization process through researching best practice methods and commonly used criteria. The prioritization process was done in phases, each including quantitative and qualitative data, capacity/partnership information, and inclusion of the importance and feasibility of potential priority issues.

First, the team implemented the MCH Partner Survey to obtain partner input in selecting priorities, and an internal prioritization process among the VDH MCH programs to assess importance, feasibility and impact regarding resources and current efforts. Major re-occurring topics were assessed from each of these processes and used to guide qualitative methods to fill in gaps and further explore population needs. Here, context around potential priorities was gathered and information was organized by population groups.

The next phase of prioritization involved many discussions and the review and synthesis of large amounts of quantitative and qualitative data. Quantitative data were reviewed for notable disparities and differences among populations via the Virginia MCH LiveStories. This information was then compared with notable themes from quantitative data by population domain. This phase allowed the MCHNA Team to narrow focus on a list of priorities to present in a final prioritization template. During this phase, the MCHNA Team also considered the way in which priorities were defined. Historically, Virginia has defined priorities based on the key measures they address. The process of this needs assessment showed that there were key themes that resonated across populations, therefore potential priorities were inclusive of needs by domain and subpopulation through a cross-cutting approach.

In the final phase of prioritization, state program staff and key partners attended a multi-day virtual retreat. Initially, it was planned to have a series of in-person meetings by population group with key partners and stakeholders complete the prioritization template, but this was not feasible due to the COVID-19 pandemic. A prioritization template for each of the potential priority topics was created. The prioritization templates included key information such as Community & Political Will, Equity Lens, and Impact & Severity (template attached). MCH programs were also asked to work through potential program initiatives with the Government Alliance on Race and Equity (GARE) Racial Equity Toolkit. From this virtual retreat and final discussions among the team, ten priorities for the 2021-2025 Block Grant cycle were ultimately identified.

Capacity and Partnerships/Collaboration

MCH efforts in Virginia demonstrate a multidisciplinary partnership approach to health care by including traditional and nontraditional 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, CBOs, 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).

The MCHNA Team took advantage of existing efforts and resources to assess state and local program capacity and state partnerships/collaboration. This needs assessment process allowed Virginia's MCH programs to broaden its reach and gain new partners by promoting MCH needs assessment activities at state conferences such as the Virginia Neonatal Perinatal Collaborative (VNPC) Maternal Mortality Conference, and taking opportunities to hold listening sessions with key groups, such as the State Health Commissioner's Advisory Council on Health Disparity and Health Equity.

III.C.2.b. Findings

III.C.2.b.i. MCH Population Health Status

Population Needs

According to America's Health Rankings, Virginia is an overall healthy state when compared to the rest of the country, ranking 15th according to the 2019 report. According to the 2020 State Data Profiles on Kids Well-Being, Virginia ranks 14th overall. However, health inequities across MCH populations are prevalent and persistent within the state, particularly across geography and among the state's lower-income and minority populations. During the needs assessment process, a few cross-cutting issues emerged that deserved the attention of Virginia's MCH programs, including:

- Mental health
- Health disparities and inequities
- Health care infrastructure and networking
- Community and family voice and supports

The information in the sections below provide a comprehensive overview of general findings and themes regarding the health status of Virginia's MCH population. A majority of the data collected and synthesized throughout the needs assessment process can be viewed in the Virginia MCH LiveStories and the attached Qualitative Assessment of Maternal and Child Health in Virginia Report located in the appendices.

General Findings and Themes from Quantitative Data Collection

Major re-occurring topics observed from the synthesis of quantitative data included social determinates of health (SDOH), behavioral and mental health, and health access. These topics are reflected among MCH population domains within the Virginia MCH LiveStories.Once on the Virginia MCH LiveStories landing page, viewers can choose a population domain and a topic to explore.

Population	Key Themes within Quantitative Data - LiveStories
Women of Reproductive Age	• SDOH (Insurance, Educational attainment, Employment) • Supporting reproductive health (Unplanned pregnancy, family planning, fertility support; Coordination of annual/physical) • Physical activity and obesity • Mental Health • Reproductive justice • HIV & chlamydia incidence; STIs (racial disparity) • Injury/suicide
Pregnant Women and Infants	• Reproductive health • Access to dental care (racial/ethnic, age and education disparity) • Breastfeeding continuation (racial disparity) • Mental Health – Emotional Well-Being • Maternal Morbidity/Mortality (racial disparity) • Infant Mortality (racial disparity; persists in urban and rural settings) • Safe sleep (racial disparity) • Unintended pregnancy (racial disparity) • Prenatal Care (ethnic disparity inadequacy and insurance)
Children	• Homelessness/poverty (racial/ethnic disparity) • Household smoking (racial, educational attainment, health insurance, poverty, household structure disparities) • Family engagement – outreach/support to caregivers • Mental health/ACEs/SDOH • Education (racial, ethnic, and economic disparities in SOLs, PALS-K, and bullying at school entry) • Dental health • Developmental screening (below national average) • Physical activity • Asthma prevalence (racial, males) • Injury (accidents)
Adolescents	• Teen Pregnancy (regional, racial disparities) • SDOH (housing and poverty) • Education – on-time graduation (regional) • Bullying • Mental health/Suicide (gender disparity) • Asthma prevalence (racial/ethnic disparity) • Overweight/obesity (racial/ethnic disparity)
Children & Youth with Special Health Care Needs (CYSHCN)	• Medical home and transition services • Adequate insurance • Mental/Behavioral health • Availability of disaggregate data
Men	• Reproductive Health – STIs (Syphilis, HIV incidence) • Mental health • Injury – Suicide

General Findings and Themes from Qualitative Data Collection

Key themes were developed using a grounded theory approach to a population-based needs assessment of maternal and child health in Virginia. Collecting codes of similar content into concepts and categories led to a theoretical understanding of the needs and gaps to be addressed by population domain. These findings are induced through an active role of the Virginians who shared their lives and stories so we can fully understand and know socially-shared meaning that forms maternal and child health-related risk and protective factors and actions for implementation.

Women of Reproductive Age

Reproductive health needs for Virginia's women include pregnancy prevention and family planning, preventive screenings, disease testing, and barriers related to infertility, abortions, and sterilization. Women report the need for more awareness and promotion in situations of intimate partner violence or domestic violence. Women see that resolving food deserts and improving healthy eating is essential to manage chronic disease. Mental health is a primary need, and common complaints relate to finding a mental health provider, long wait times to schedule an appointment, large gaps between appointments, and long-distance travel to see providers or access services. Lack of transportation, living in a rural area, being a woman of color, economic and insurance discrimination, and language and cultural barriers are health disparities experienced by women of reproductive age. Women of reproductive age believe that by having adequate resources and educational opportunities in their communities, they can live healthier lives.

Pregnant Women and Mothers of Young Children

Childcare is unachievable for some families because it is too expensive or hard to find. Parenting needs include affirmation and reassurance that they are doing the right thing. Support system and service needs include financial stress and issues, access to and navigation within housing and transportation, lack of community, essential supplies for infants like diapers, breastfeeding, and mental health counseling. Pregnant women want their entire medical and mental health needs met. Infant and child health is very important to expectant and new mothers. Health Insurance for children is necessary to have.

Adolescents

Health issues that impact youth include mental health and substance abuse, nutrition and food security, vaping and smoking, physical fitness and recreation, chronic diseases like obesity and cancer, community and social issues, and discrimination of the LGBTQ+ population. Services and investments to improve adolescent health should focus on mental health services in schools, healthy eating and recreation opportunities, teen-centered medical and dental care, and equitable investments in Internet access and social cohesion. Methods for addressing physical and mental trauma in youth should center on finding the right care, having someone to talk to and outlets for relaxation, and acknowledging a sense of persistent desperation. Barriers to appropriate mental health care relate to lack of responsive and cooperative mental health services, stigma and parental denial, lack of understanding within the school and community, and feeling trapped in their situations. Reproductive and sexual health care education provided by public schools is inadequate and fails to include LGBTQ education, among other limited topics, so information is gained from Planned Parenthood, family, the Internet, peers, and social media. Recommendations for improving adolescent health comprises expanding the mental health system and services, offering comprehensive sexual health education, addressing substance use, and including youth in planning.

Parents of CYSHCN

Health insurance for health care services is an asset and a frustration. Care coordination involves knowledge of the services, where they exist, and how to access them. Community-based resources promote inclusive recreation and acceptance in social settings. Dental care is a long-standing issue for children with special health care needs.

Therapies and support services are challenging to access but effective when secured. Afterschool, summer, and respite (temporary relief) care are inconsistent across localities and expected level of support is lacking.

Men

Men's health is described by diseases and conditions that range from chronic diseases to social health influences that perpetuate poor health behaviors. Mental health issues are common among men, including those that lead to diagnosis and substance abuse based on reasons associated with social factors and cultural issues. Services relate to general health care, resolving issues with health care, and needed specialty care access.

MCH Providers and Systems

Many gaps and unmet needs exist among the current maternal and child health (MCH) providers and systems in which they function, from the individual to policy levels. Focusing MCH interventions on the individual patient is a common approach but too narrow to be effective. Relationships within families are known sources of influences to improved health but providers and systems do not readily provide support at this level. MCH providers describe system gaps related to capacity, coordination and availability of services, including specialists, itinerant care, medical homes, mental health, dental health, and hemophilia care. Community-level health influence is based on the relationships between organizations and the connection with social determinants and factors such as transportation, housing, food security, childcare, and employment. National, state, local laws and regulations governs health care access, including Medicaid expansion. MCH providers demonstrate implicit bias in their practice and systems of healthcare have chronically oppressed and disenfranchised people of color, immigrants and non-native English speakers, persons of low socioeconomic status, incarcerated persons, people with disabilities, and those who identify as LGBTQ+. Many MCH providers in Virginia offer education, advocacy, health promotion, chronic disease management, preventive screenings, case management and care coordination, developmental evaluations, leadership and systems development, and general health care. Resolving the gaps may include more transparency on health care costs, culturally-responsive services, supporting the family unit in care settings, integration of medical-mental-dental care, employ telemedicine and satellite clinics, and move MCHBG funds to greatest needs in locality.

Summary of Key Population Health Findings

On the surface, Virginia seems to be an overall healthy state, with high rankings compared to other states in the country, and consistent metrics that rank positively when compared to the U.S. However, intentional disaggregation and focus on special population groups throughout the needs assessment process revealed disparities. While there are strengths in the MCH population groups, there are also needs. Virginians experience disparities in overall mental and physical health, and struggle with navigating essential medical, reproductive, mental, and dental health services. Health disparities caused by racism, health insurance bias and discrimination, language and culture responsiveness, and regional funding inequities further expand the health gap. Access to key social and community supports such as childcare, employment opportunities, transportation, and general financial well-being arose as an issue across population domains. There is wide opportunity to address these issues by creating a culture of health, normalizing health-seeking behaviors, and full engagement of key stakeholders in all population domains for policy and program influence.

III.C.2.b.ii. Title V Program Capacity

III.C.2.b.ii.a. Organizational Structure

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 Governor's Administration is supportive of women's health, children and youth and has initiated several efforts to expand state capacity to improve the health and well-being within these groups.

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 grant is administered within the Office of Family Health Services.

The Title V Director manages the state programs, provides strategic direction and ensures coordination with other state and federal MCH programs. She reports to the Director of the Division of Child & Family Health is responsible for strategic and fiscal guidance and day-to-day operations (e.g. overseeing grant activities, liaising with program managers, monitoring grant expenditures) and prepares and submits the Title V grant.

The Director of Children and Youth with Special Healthcare Needs program also reports to the Director of the Division of Child & Family Health and provides oversight and management of the Child Development Centers, Care Coordination for Children Centers and Bleeding disorders programs in Virginia.

A Shared Business Services team submits fiscal reports.

Funded teams are described in the State Title V Program Purpose and Design section o this submission. See attached organizational chart for details on how funded programs are organized within the Department of Health.

III.C.2.b.ii.b. 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 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 VDH infrastructure includes 35 health districts. Each district received an allotment of the federal Title V funds to address the needs of MCH populations in the local communities.

The Title V team is composed of 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.

III.C.2.b.ii.c. MCH Workforce Capacity

There are three federally-defined positions on our state Title V team:

- Carla Hegwood, MPH, is the state's Maternal and Child Health ("MCH") Director and Title V Project Director.
- Marcus Allen, MPH, is the state's Children and Youth with Special Health Care Needs (CYSHCN) Director.
- Dana Yarbrough is the state Title V Family Delegate.

Our leadership team also includes the state MCH epidemiologist, Meagan Robinson, DrPH and the Director of the Division of Child & Family Health, Jennifer Macdonald, BN, RN, MPH. We're joined by a team of 15 state program managers, approximately 70 state-level staff and contractors, and over 110 local health district staff.

Since the VDH is within the Executive branch of Virginia's Government, the issues affecting MCH populations have a direct linkage to the Governor and subsequently Secretary of Health and Human services for Virginia, which 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.

The 2021-2025 MCH Needs Assessment included a robust qualitative analysis of the MCH workforce, to include key informant interviews with MCH providers. A detailed summary is provided in the attached contractor's report.

III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

Title V Partnerships

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 Appendices.

III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

Priority Need Selection

Virginia used specific and complex criteria (see 'Prioritization Process') to organize, analyze, and prioritize MCH issues. Phase I prioritization with VDH MCH programs assessed the importance, feasibility and impact regarding resources and efforts (template in appendices). Phase II-IV assessed Community & Political Will, Equity Lens, and Impact & Severity. Due to the cross-cutting nature of the needs assessment findings, the MCHNA was able to cover more broadly the recurring priorities.

No.	Priority Need	Type
1	Upstream / Cross-Sector Strategic Planning: Eliminate health inequities arising from social, political, economic, and environmental conditions through strategic, nontraditional partnerships.	New
2	Community, Family, & Youth Leadership: Provide dedicated space, technical assistance, and financial resources to advance community leadership in state and local maternal and child health initiatives. *Formerly: Family Engagement*	Revised
3	Mental Health: Promote mental health across MCH populations, to include reducing suicide and substance use.	New
4	Finances as a Root Cause: Increase the financial agency and well-being of MCH populations.	New
5	Racism: Explore and eliminate drivers of structural and institutional racism within OFHS programs, policies, and practices to improve maternal and child health.	New
6	MCH Data Capacity: Maintain and expand state MCH data capacity, to include ongoing needs assessment activities, program evaluation, and modernized data visualization and integration.	New
7	Reproductive Justice & Support: Promote equitable access to choice-centered reproduction-related services, including sex education, family planning, fertility/grief support, and parenting support. *Formerly: Women's/Maternal Health*	Revised
8	Strong Systems of Care for All Children: Strengthen the continuum supporting physical/socio-emotional development (i.e. screening, assessment, referral, follow-up, coordinated community-based care). *Formerly: Medical Home; Transition; and Early and Continuous Screening*	Revised
9	Maternal and Infant Mortality Disparity: Eliminate the racial disparity in maternal and infant mortality rates by 2025.	New
10	Oral Health: Maintain and expand access to oral health services across MCH populations.	Continued

Priority Needs and Performance Measures

Goals for each priority statement were identified and specific objectives and strategies to address each goal were stated in the action plan. The Virginia Title V is carrying forward priority needs from the previous cycle, either in its entirety or through revisions in language to capture reach. The following table depicts the linkage of Virginia's MCH priorities, performance measures, and population domains.

Priority Need	National Performance Measure	State Performance / Outcome Measure	Population Domain
Upstream / Cross-Sector Strategic Planning: Eliminate health inequities arising from social, political, economic, and environmental conditions through strategic, nontraditional partnerships.	Rate of hospitalization for non-fatal injury per 100,000 children ages 0-9		Child Health
Community, Family, & Youth Leadership: Provide dedicated space, technical assistance, and financial resources to advance community leadership in state and local maternal and child health initiatives.	Percent of infants who are ever breastfed; Percent of infants breastfed exclusively through 6 months	Cross-cutting (Youth Engagement): Develop and sustain the Virginia Department of Health Youth Advisor Program	Perinatal / Infant Health Cross-Cutting / Systems Building
Mental Health: Promote mental health across MCH populations, to include reducing suicide and substance use.	Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9 Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19		Child Health Adolescent Health
Finances as a Root Cause: Increase the financial agency and well-being of MCH populations.	Rate of hospitalization for non-fatal injury per 100,000 children ages 0-9 Percent of children, ages 0 through 17, who are continuously and adequately insured	Infant Mortality Disparity: Infant Mortality Disparity Ratio	Child Health Children with Special Health Care Needs Perinatal / Infant Health
Racism: Explore and eliminate drivers of structural and institutional racism within OFHS programs, policies, and practices to improve maternal and child health.		MCH Workforce Development: Racial Equity	Cross-Cutting / Systems Building
MCH Data Capacity: Maintain and expand state MCH data capacity, to include ongoing needs assessment activities, program evaluation, and modernized data visualization and integration.	Percent of infants who are ever breastfed; Percent of infants breastfed exclusively through 6 months	Infant Mortality Disparity: Infant Mortality Disparity Ratio	Perinatal / Infant Health
Reproductive Justice & Support: Promote equitable access to choice-centered reproduction-related services, including sex education, family planning, fertility/grief support, and parenting support.		Unintended Pregnancy: Mistimed pregnancy- wanted to become pregnant later/never	Women / Maternal Health Adolescent Health

Priority Need	National Performance Measure	State Performance / Outcome Measure	Population Domain
Strong Systems of Care for All Children: Strengthen the continuum supporting physical/socio-emotional development (i.e. screening, assessment, referral, follow-up, coordinated community-based care).	Percent of children, ages 9-35 months, who received a developmental screening using a parent-completed screening tool in the past year Percent of children with and without special health care needs having a medical home Percent of adolescents, ages 12 through 17, who received services necessary to make transitions to adult health care	Cross-Cutting (Early and Continual Screening): Percent of infants who are diagnosed with a newborn screening disorder that are referred to care coordination services in the CYSHCN program	Child Health Children with Special Health Care Needs Adolescent Health Cross-Cutting / Systems Building
Maternal and Infant Mortality Disparity: Eliminate the racial disparity in maternal and infant mortality rates by 2025.		Infant Mortality Disparity: Infant Mortality Disparity Ratio Maternal Mortality Disparity: Maternal Mortality Disparity Ratio	Perinatal / Infant Health Women / Maternal Health
Oral Health: Maintain and expand access to oral health services across MCH populations.	Percent of women who had a preventive dental visit during pregnancy Percent of children, ages 1 through 17, who had a preventive dental visit in the past year		Women / Maternal Health Child Health Adolescent Health

Emerging Issues and Other Needs

Primary emerging needs are related to the COVID-19 pandemic and Health Equity. See technical assistance section for details.

III.D. Financial Narrative

	2017		2018	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$12,072,934	$12,128,653	$12,092,401	$12,287,553
State Funds	$9,054,701	$9,097,551	$9,069,301	$9,215,665
Local Funds	$0	$0	$0	$0
Other Funds	$1,125,000	$1,146,726	$1,125,000	$1,618,704
Program Funds	$0	$1,295,711	$200,000	$2,086,819
SubTotal	$22,252,635	$23,668,641	$22,486,702	$25,208,741
Other Federal Funds	$191,309,215	$161,040,946	$12,847,299	$14,898,453
Total	$213,561,850	$184,709,587	$35,334,001	$40,107,194

	2019		2020	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$12,128,653	$12,287,553	$12,287,553	
State Funds	$9,097,551	$9,215,665	$9,215,665	
Local Funds	$0	$0	$0	
Other Funds	$1,125,000	$1,618,704	$1,618,704	
Program Funds	$1,427,400	$1,852,807	$2,086,819	
SubTotal	$23,778,604	$24,974,729	$25,208,741	
Other Federal Funds	$16,914,458	$0	$16,989,838	
Total	$40,693,062	$24,974,729	$42,198,579	

	2021	
	Budgeted	Expended
Federal Allocation	$12,287,553	
State Funds	$9,215,665	
Local Funds	$0	
Other Funds	$1,618,704	
Program Funds	$2,086,819	
SubTotal	$25,208,741	
Other Federal Funds	$0	
Total	$25,208,741	

III.D.1. Expenditures

Form 2

In FY19, Virginia received a total federal allocation of $12,287,553.

During the same period:

- The program expended $12,921,188 of federal funds and $9,215,665 of State MCH Funds.
- A total of $1,618,704 in Other Funds was generated and expended (to perform newborn screening services, as required by the Virginia General Assembly; state special funds generated as detailed in Cross-Cutting/Systems Domain application).
- A total of $2,086,819 in program income was generated and reinvested in delivery of Title V services.

FY19 expenditures for the state-federal Title V partnership totaled $25,208,741.

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 FY17 award) and strategic efforts to broaden the impact of Title V initiatives.

Form 3

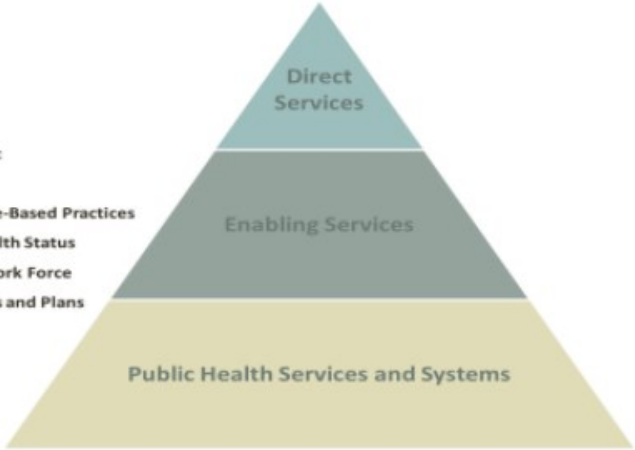
On Form 3a, expenditure data was captured and grouped into categories of people served (Pregnant Women, Infants < 1 year old, etc.). On Form 3b, the expenditure data was captured and grouped by types of expenditures. The types of expenditures were grouped into the categories required on Form 5 (Direct 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 with the MCH pyramid by reducing direct patient care expenditures and increasing enabling services and public health systems investments. All expenditures support one or more of the 10 Essential Public Health Services.

Public Health Services for MCH Populations: The Title V MCH Services Block Grant

MCH Essential Services

1. Provide Access to Care
2. Investigate Health Problems
3. Inform and Educate the Public
4. Engage Community Partners
5. Promote/Implement Evidence-Based Practices
6. Assess and Monitor MCH Health Status
7. Maintain the Public Health Work Force
8. Develop Public Health Policies and Plans
9. Enforce Public Health Laws
10. Ensure Quality Improvement



III.D.2. Budget

The Title V MCH Block Grant budget for the FY21 Application allocates funds for MCH services, primary care for children and adolescents, and preventive and maintenance services for CYSHCN.

Preventive and primary care services include policy and procedural oversight, LHD agreements, pharmacy and laboratory testing, newborn screening (dried blood spot, non-Title V funds; see Other Funds below), and varied family, maternal, and child health initiatives that bolster protective factors and mitigate 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. MCH communications campaigns employ evidence-based, appropriate, and culturally-relevant approaches to connect with communities with greatest need and "meet people where they are" (e.g. web-based community outreach and education through social media, online training modules for families, sexual education textline).

A sum of $1,618,704 in Other Funds is included for newborn screening services, as required by the Virginia General Assembly. These special revenue funds are generated through hospital fees assessed by the Division of Consolidated Laboratory Services. These funds not only sustain the program but ensure early screening, testing, and referral for all infants.

Services for CSHCN include an array of care coordination, insurance case management, and clinical services 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. Program-generated income is reinvested in program operations.

The Title V Program budgets 30 percent or more of our federal allocation for preventive and primary care services for infants, children, and women. An additional 30 percent or more of federal funding is budgeted for services for CSHCN. A maximum of 10 percent of the federal allocation is budgeted for administration of Title V funds. Administration costs include accounting and budgeting services and associated administrative support.

The program budget includes the mandated state match on a 4-to-3 ratio of federal to state funds and meets the maintenance of effort ("MOE") threshold. Sec. 505 (a)(4) of the Social Security Act requires that states maintain the level of funds provided solely by the state for MCH health programs (i.e. "state match") at a level at least equal to the level provided by the state in fiscal year 1989. The FY21 budget complies with both the state match and MOE mandates, as below:

FY21 Anticipated Federal Allocation: $12,287,553
FY21 Budgeted State Match: $9,215,665
(Virginia's 1989 MOE Threshold: $8,718,003)

The Virginia Department of Health's Office of Family Health Services has reviewed all federal investments relevant to the MCH state and national priorities, as reported in the state's MCH budget (as reported on line 11 of Form 2).

The program maximizes opportunities to leverage complementary state and federal MCH funding streams to meet Title V priority needs. Such opportunities are described through this submission.

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

Advancing Core Commitments

Virginia's Title V program strives to be family-centered, data-driven, and evidence-informed. The team seeks to balance investments in upstream work with critical, gap-filling, individually-delivered services to meet urgent needs.

By (1) sustaining attention to data and (2) inviting family and youth leadership, the team seeks to understand the lived experiences of those we seek to serve, understand the rich landscape of their health priorities and challenges, and ground our decisions and resource allocations in evidence.

Data-Informed Program Planning

The Title V team annually reviews and updates the state action plan. All strategies are informed by review of federally-provided details about the significance and context for each NPM and NPM, as well as review of state-specific data, ongoing analysis of service gaps and community needs, and stakeholder input.

Relevant federally-provided details on NPMs and NOMs have been included throughout this submission. These excerpts are from the *Title V Maternal and Child Health Services Block Grant Guidance Appendix* and are presented in italics; full text of this guidance document is available here.

Core Commitments to Family/Community Partnerships and Racial Equity

As noted within the Overview of the State, Virginia is a place where state averages hide the contrasting stories of its subpopulations. While Virginia is often at or above the national average for key measures of maternal and child health, disparities persist. Health outcomes tend to be poorer among pregnant women (and their children) who are younger, are unmarried, have lower educational attainment, have lower access to financial resources, or who live in urban or rural (rather than suburban) areas. However, even after controlling for each of these factors, outcomes among non- Hispanic Black women (and their children) are worse than those of other groups across most MCH indicators.

The Title V Director set forward a vision of:

1. Sustaining and deepening partnerships with youth, families, communities, and consumers, to include centering their voices in program planning and delivery, and
2. Adopting a racial equity focus, to include maintaining a racial/ethnic disparity lens in program planning and implementation as well as attention to multi-sector partnerships to address upstream and community-level factors that drive and perpetuate disparities.

These commitments were integrated into the design of the 2020 state MCH needs assessment, with plans to partner with families and communities, including those communities that experience disparate rates of poor health outcomes, highlighted throughout the 2021-2025 action plan.

These commitments are well-timed, as in June 2019, Governor Ralph Northam announced a goal to eliminate the racial disparity in the maternal mortality rate in Virginia by 2025.

Efforts to fulfill these commitments have included data-driven discussions about factors driving disparities during domain team strategic planning meetings. During FY21 action planning, templates provided to program managers challenged program mangers to explore opportunities to deepen youth/family/community engagement and to consider ways to patients/clients to provide feedback on satisfaction with services. Each program manager was also tasked with completing the Government Alliance for Racial Equity (GARE) Racial Equity Toolkit for one or more programs.

Resulting strategies are reflected throughout the 2021-2025 action plan.

PRESS RELEASE: JUNE 5, 2019

"A critical component of improving maternal health outcomes is the elimination of the racial disparity we are seeing in Virginia and across the nation. This is a worthy goal that is perfectly within reach, and I am directing leaders in my administration and in the healthcare and human services community to develop strategies to get us there by 2025."

Governor Ralph Northam

"I am proud we are making a bold commitment to improving maternal health in the Commonwealth of Virginia. I look forward to collaboration across a variety of sectors to ensure that women in Virginia have access to high quality care and services before, during, and after pregnancy."

Secretary of Health and Human Resources
Daniel Carey, M.D.

https://www.governor.virginia.gov/newsroom/all-releases/2019/june/headline-840941-en.html

Maternal and Child Health Leadership

VDH is the state Title V agency. On June 1, 2018, Dr. M. Norman Oliver was appointed State Health Commissioner.

The Office of Family Health Services houses a Shared Business Services (SBS) team, Communication Team, and the Divisions of Child & Family Health (DCFH), Prevention and Health Promotion (DPHP), Population Health Data (DPHD), and Community Nutrition (DCN).

Title V Leadership Transition

In FY16, the Title V Coordinator role was established to manage day-to-day grant operations, including management of the budget, preparation of the annual report / application, coordination of MCH special projects, and broad strategic planning for MCH. The coordinator reported to the DCFH Director, who also served as the Title V Director.

In FY19, the DCFH Director position was vacated, and the Director of the Office of Family Health Services initiated a minor reorganization by dividing the DCFH Director position into two distinct but closely linked roles: a DCFH Director and a Title V Director. The DCFH Director continues to provide administrative and overarching leadership for programs within the division, to include non-Title V grants, while the Title V Director now provides administrative and overarching leadership for Title V-funded programs, to include non-DCFH programs. The Title V Director continues to report to the DCFH Director.

In FY20, the Title V Coordinator was permanently appointed Title V Director, and the Public Health Nurse Manager for Newborn Screening and Birth Defects Surveillance was promoted to the role of DCFH Director (Jennifer MacDonald, MPH, BSN, RN).

State Title V Leadership Structure

The Title V Director (Carla Hegwood, MPH) provides strategic and fiscal leadership and oversight to a team of 10-15 funded program managers within Central Office and teams of nurse and business managers at 35 local health districts. She authored the workplan and guiding research questions for the 2020 state MCH needs assessment; partnered with DPHD to draft data collection tools, protocols, outreach strategies, and LiveStories; and provided guidance to the Title V team on translating quantitative and qualitative findings into action. She assures all Title V investments are aligned with national evidence and with broader VDH and interagency strategic goals, and she sits on a number of state advisory committees and interagency workgroups.

Title V-supported teams and core staff noted within the 2021 Application include:

Division of Child & Family Health

- New Staff:
  - Youth Advisors
  - Black Maternal/Infant Health Program Coordinator
  - Child Health Coordinator
- Newborn Screening:
  - CMV Follow-Up Coordinator: Deepali Sanghani, MPH
  - Birth Defects Surveillance Coordinator: Katherine Crawford, MPH
  - Early Hearing Detection & Intervention Supervisor: Daphne Miller
  - Dried Blood Spot & Critical Congenital Heart Disease Nurse Supervisor: Chrisen Crews, MSN, RN

- Maternal and Infant Health:
  - Maternal & Infant Health Coordinator: Vacant
- Early Child Health:
  - Early Child Health Consultant: Bethany Geldmaker, PhD, PNP
  - Early Child Health Supervisor / MIECHV Director: Andelicia Neville, MS
- School Health:
  - School Health Nurse Consultant: Joanna Pitts, BSN, RN, NCSN, CNOR
- CYSHCN:
  - Blood Disorders Program Coordinator: Shamaree Cromartie, MPH,
  - CYSHCN Director: Marcus Allen, MPH
- Reproductive Health:
  - Resource Mothers Program Coordinator: Consuelo Staton, MEd.
  - Adolescent Health Coordinator: Maddie Kapur, MPH, MSW
  - Family Planning QA Nurse Supervisor: Janelle Anthony, MSN, RN, PHNA-BC
  - Reproductive Health Supervisor / Title X Director: Emily Yeatts, MPH, MSW
- Director: Jennifer MacDonald, MPH, BSN, RN, Division of Child & Family Health

DPHP

- Oral Health:
  - Maternal, Infant, & Adolescent Oral Health Consultant: JoAnn Wells, BSHS, RDH
  - Special Needs Oral Health Coordinator: Kami Piscitelli, BSDH, RDH
  - Dental Health Program Manager: Tonya Adiches, BSDH, RDH
- Injury & Violence Prevention:
  - Injury & Violence Prevention Health Systems Coordinator: Jean Hoyt, CMA
  - Statewide Safety Seat Program Manager: Marcia Franchok-Hill
  - Injury Epidemiologist: Lauren Yerkes, MPH
  - Injury & Violence Prevention Supervisor: Lisa Wooten, MPH, BSN, RN
- Director, Division of Prevention & Health Promotion: Heather Board, MPH

DPHD

- MCH Data:
  - Perinatal Epidemiologist
  - NBS / CSHCN Epidemiologist
  - Child/Adolescent Health Epidemiologist
  - MCH Epidemiology Unit Supervisor: Meagan Robinson, MPH
- Director, Division of Population Health Data: Vacant

OFHS

- Policy Analyst: Robin Buskey
- Tim Kliewer, MCH Communications/Branding Consultant
- Taylor Peterson, Web and Social Media Specialist
- SBS Grants & Accounting Manager: Sandy Peterson Director, Office of Family Health Services: Vacant (Acting: Heather Board)

OCME

- New Positions:

    - Maternal Mortality Research Associate
    - Child Fatality Research Associate
- Maternal Mortality Projects Manager: Melanie Rouse, PhD
- Family Violence Programs Manager: Dane De Silva, PhD
- Director, Division of Death Prevention: Ryan Dyduk-Smith, PhD, MPH, CHES

Monthly All-Team and Quarterly Domain Team Meetings

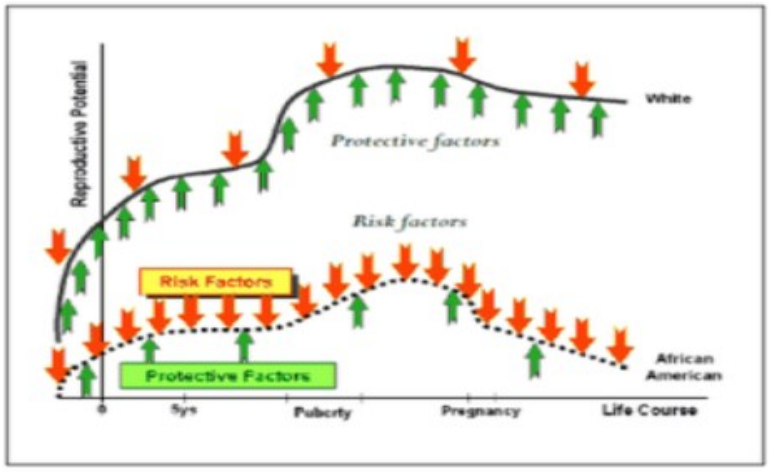
To facilitate cross-division collaboration and strategic planning, the Title V Director implemented monthly MCH all-team meetings and established MCH Domain Teams in FY18. Monthly all-team meetings include discussion of key federal and internal updates, workplans, budgets, performance measures, needs assessment activities, and new MCH-related grants.

Domain Teams meet every quarterly and provide dedicated space outside of monthly all-team meetings to share information, break down siloes, and encourage a culture of team-based leadership and innovation.

Domain Teams also provide opportunities to network and grow MCH leadership competencies, particularly for staff who are currently in non-supervisory roles. Each team has a designed Domain Team Lead who coordinates team meetings, maintains an online log of monthly progress updates, and assists with visioning and peer coaching. Each team is comprised of program staff from three or more Title V-funded programs and an epidemiologist designated by the MCH Epidemiology Supervisor.

Framework and Strategic Approach

The two models that make up Virginia's MCH framework are the life course model and socio-ecological model.



The life course model displays the cumulative impacts of protective and risk factors on an individual's health status as they progress through various life stages (i.e. over their "life course"). This model is illustrates the interconnectedness of state Title V programs.

The ecological model poses that 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). Maximizing program impact requires identifying factors at each level that may impact health outcomes.

Together, the two models help to guide strategic planning. The life course model considers that there are critical life stages (e.g. fetal brain development during pregnancy) that can impact the rest of an individual's life; during these stages, it is especially important to mitigate risk factors (such as maternal substance use) while strengthening and promoting protective factors (such as early prenatal care). State Title V programs must be coordinated to intervene at these critical junctures (e.g. newborn screening referrals to EI services and CYSHCN programs). The life course model also considers that protective factors can build up over time to make it easier for a person to be healthy, while risk factors can build up over time to make it more difficult for a person to be healthy. Thus, the life course model helps to prioritize when to intervene and to begin to identify protective factors to enhance and risk factors to mitigate through interventions at each life stage.

The ecological model then considers that an individual doesn't live in a vacuum – people live within and are impacted by society. The environment they grow up and live in matters. This means an individual's health isn't solely determined by their own decisions, knowledge, attitudes, and skills. It also means individually-delivered health education and clinical and wraparound services may be necessary but are insufficient to improve population health outcomes. In selecting interventions, staff must consider that it may not be possible to identify a single root cause – multiple factors are often concurrently driving health outcomes and require a multi-level approach. Considerations include:

- Formal and informal systems and power structures (i.e. who has access to what, and who gets to decide),
- How individuals navigate the communities they live in (e.g. where people live, eat, work, go to school, and get healthcare; when do they go; how they get there; access to, quality of, and satisfaction with their housing, healthy food options, employment, education, and healthcare), and
- Family, community and social supports (e.g. what are relationships like within households or with family, friends, peers, and teachers/employers; are there trusted people or organizations within the community that can provide supports to help people to be healthier).

MCH Practice

The team aims to be doggedly but strategically collaborative in MCH practice – internally and externally, across teams and across sectors, from family engagement to policymaker engagement. The team is also committed to maximizing family and youth engagement (and increasingly endeavors to foster a culture of family and youth leadership). In order to best serve Virginia's families, the team seeks to identify high-impact, efficient interventions with potential to move the needle at the population level without losing sight of community voice and consumer/patient experience.

The emerging Black Maternal/Infant Health Program will solicit community voice through recruitment of stipended Community Advisors and a stipended parent advisor.

Similarly, the Adolescent Health Domain Team has designed new roles for youth to advise various MCH programs on strategic planning, program adaption/development, and communications strategies. The Adolescent Health Coordinator plans to hire two Youth Advisors to be based at Central Office.

The team is also exploring ways to include families in assessment/evaluation efforts – 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. The Acting Title V Director is currently working to onboard a paid parent representative to the 2021-2025 state MCH needs assessment team.

Virginia's Title V program achieves success through collaborations and partnerships. Title V leadership and program managers sometimes serve as conveners (e.g. Developmental Screening Initiative) and at other times are engaged supporters and participants in interagency or regional efforts (e.g., DMAS Child Health Insurance Program Advisory Board). Each program manager works to include individuals, families, community-based organizations that serve the MCH populations, and larger community partners (e.g. Medicaid) in the planning and implementation of all programs and services funded by Title V.

The Title V Director and the CYSHCN Director have aligned the CYSHCN workplan with the *National Consensus Standards for Systems of Care for Children and Youth with Special Healthcare Needs* and Got Transition's *Six Core Elements of Health Care Transition* guidelines. This includes implementing family leadership across the CSHCN program and using this as a model for other Title V programs.

SSDI and Title V funds provide partial salary support for the MCH epidemiology team, which provides programmatic evaluation, survey, and surveillance support to for all MCH programs. In addition, data dashboards continually updates and made available on the VDH Data Portal for use by state agencies, healthcare providers, local partners, and community members. Both Title V program staff and the MCH epidemiology team are engaged in providing relevant research findings, data, and evidence-based recommendations to inform Virginia's General Assembly each year.

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

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

Title V invests in sustaining a skilled MCH workforce by providing training and technical assistance to staff within the state health department (e.g. program coordinators, epidemiology and evaluation staff, administrative staff) and within local health districts (LHDs; e.g. public health nurses, home visitors). Funds are also allocated to training activities for external partners (e.g. physicians, school nurses, oral health staff, care coordinators at CSHCN centers).

Notably, the first goal of the Virginia Department of Health's Strategic Plan is to maintain a competent and valued workforce. This includes recruiting, training, and retaining the best employees. The VDH Plan for Well-Being 2016-2020 also identifies and prioritizes workforce retention and development as core to the improvement of the health and well-being of Virginians.

In addition to state health agency commitments, the Title V 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, advocacy work by the Virginia Poverty Law Center, and state-level bodies such as the Children's Cabinet.

While providing a full compendium of Title V-funded workforce development investments would not be feasible within the space allotment, one particularly impactful investment is highlighted below. Additional workforce development activities are described throughout this submission.

Title V Training Modules: 'Promoting Healthy Communities'

The Title V and CYSHCN Directors worked with the University of Virginia Office of Continuing Medical Education to create a domain name for a suite of Title V-funded educational modules (some modules were already in existence), along with logos intended to brand the work. The domain name is *Promoting Healthy Communities* and the web address or URL to the site is https://promotinghealthycommunities.org/.

The site includes the newly created medical home and transition training for providers and families, along with Newborn Screening, Breastfeeding, and Early Hearing Detection and Intervention education (described below).

VDH has been in discussions with UVA to possibly expand the content, and we are considering adding a module on trauma and how it impacts children and their health.

Specific to medical home and transition education, VDH has spent more than 2 years working with UVA to create training modules for providers and families to promote the importance of a patient centered medical home and transition from pediatric to adult healthcare. The modules were launched on October 24, 2019.

Title V covers the cost of the modules so they are complimentary for anyone who wishes to take them (Continuing Medical Education Credits are offered), even if they don't live in the state. Content for the medical home and transition modules was finalized in partnership with UVA in summer/early fall of 2019. A team of VDH staff reviewed

several versions and worked very closely with UVA to edit the proposed live content. UVA published the final version on October 24, 2019 after consulting VDH on the domain name and logos used to brand the module. The domain name is *Promoting Healthy Communities* and the web address or URL to the site is https://promotinghealthycommunities.org/. Content for the medical home module aligns with recommendations from the American Academy of Pediatrics and the National Committee for Quality Assurance's Patient Centered Medical Home Recognition Program. Program staff have already begun sharing the modules with national partners such as the AAP, Got Transition, and our CYSHCN centers of excellence. Staff worked with UVA to add pre- and post-test components to each module and receive results for evaluation.

Title V also partners with UVA to maintain and promote breastfeeding and newborn screening provider training modules. The modules are hosted on branded online portals (Breastfeeding Friendly Consortium and Newborn Screening Education) as well as under the 'Promoting Health Communities' portal.

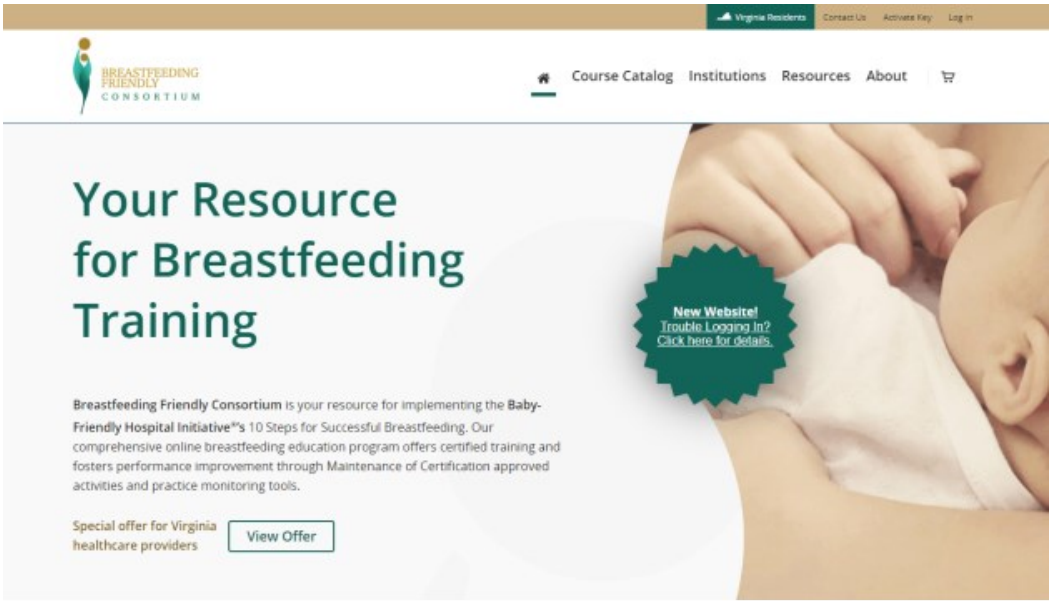
Breastfeeding Modules

Title V funds maintain the Breastfeeding Friendly Consortium**,** an online breastfeeding training portal provided in partnership with the University of Virginia Office of Continuing Medical Education and the Virginia Chapter of the American Academy of Pediatrics. The Breastfeeding Friendly Consortium is an online resource for implementing the Baby-Friendly Hospital Initiative® 10 Steps for Successful Breastfeeding.

This comprehensive online breastfeeding education program offers certified training and fosters performance improvement through Maintenance of Certification approved activities and practice monitoring tools.

The content offers valuable continuing education credit for physicians, nurses, dietitians, IBCLCS, and midwives, including up to 20 hours of continuing education credit as well as MOC Part 2 and Part 4 opportunities. Topics include current trends in infant feeding; labor, delivery, and the immediate postpartum period; preterm and late-preterm infants; the Baby Friendly Hospital Initiative; and more. Content includes case-based scenarios and is available in a mobile-friendly, on-demand format.

Title V funds provide access to continuing education credits (CEUs) for Virginia providers at no cost. Providers from other states may also take courses for a fee.



Title V funds also fund the ongoing maintenance of ‘Newborn Screening Education,’ an online continuing education portal for newborn screening modules.


Newborn Screening Education, an Online Continuing Education Destination for Healthcare Professionals Nationwide
NEWBORN DRIED BLOOD-SPOT SCREENING
GET STARTED!
CRITICAL CONGENITAL HEART DISEASE
GET STARTED!
CCHD MOC PART 2
GET STARTED!
Now available: discounts for training your entire newborn and pediatric staff on the latest screening protocols and best practices to meet your state's regulations.
Our Mission
Provide leading newborn screening education to ensure every well newborn around the globe is accurately screened prior to discharge.

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

Family engagement has often been seen as a set of activities. OFHS, in its adoption of AMCHP's definition of family engagement and partnership, moves to do more by inducting and integrating families into the complex world of health care and investing in families as leaders -- not only of their own family but also in systems change efforts. The AMCHP definition reads as follows:

> *"Family engagement and partnership is defined as patients, families, their representatives, community programs/organizations, and health professionals working in active partnership at various levels across Maternal and Child Health/Title V – direct care, organizational design and governance, and p9olicy making – to improve health and health care. This engagement and partnership is accomplished through the intentional practice of working with families for the ultimate goal of positive outcomes in all areas through the life course."*

OFHS provides a number of opportunities for engaging and partnering for family input into MCH and CYSHCN programs, including but not limited to:

- Parent feedback survey that assesses services provided by Care Connection for Children Centers;
- Contractual relationships with the Center for Family Involvement (CFI) at Virginia Commonwealth University (VCU) who provides outreach, mentoring and training to parents;
- Focus groups to gather input for various MCH programs;
- Parents hired as family specialists/care coordinators at Care Connection for Children centers; and
- Family representatives on the Virginia Early Hearing Detection & Intervention Advisory Committee, regional EHDI Learning Communities, and the Virginia Genetics Advisory Committee.

Since 2005, OFHS has worked collaboratively with the MCHB Family to Family Health Information Center (F2FHIC) housed within the CFI at VCU under the Partnership for People with Disabilities. The Partnership is Virginia's university center for excellence in developmental disabilities and is also home to the Va-LEND program. Some examples of Title V – family engagement collaboration include:

- <u>Funding from Title V to the CFI to initiate supports to culturally and linguistically diverse families of CYSHCN.</u> The resulting Cultural Broker program (with 5 cultural brokers representing African American, Arabic, Korean, Latinx and refugee/immigrant communities) was recently published in a book and an international journal as a best practice for supporting culturally and linguistically diverse families of CYSHCN. The access for Title V to the cultural brokers affords opportunities to reach and learn from diverse communities.
- <u>Representation from Title V on a statewide Family Engagement Network (FEN).</u> Having Title V serve on a state education parent priority project – the FEN facilitated by the CFI – affords opportunities to work with representatives from Virginia schools, military installations, family organizations, and institutes of higher education on best practices in engaging and partnering with families. FEN members are reminded through Title V involvement of the importance of health care in successful outcomes for students and families; particularly as the FEN works with VDOE to develop COVID-19/family engagement related materials and trainings.
- <u>Funding from the EHDI program to the CFI.</u> Since 2007, funding from the EHDI program to the CFI has supported family to family support to families of infants and toddlers diagnosed with hearing loss, and more recently an initiative to engage families in 1-3-6 protocols. Three family members are trained and supported to visit hospital newborn screening teams, audiology clinics and early intervention programs to learn more about the processes they use to communicate information to families and the types of referrals they make to families. And, these families co-facilitate the EHDI Learning Communities in their region that meet quarterly to discuss and share resources on local gaps and concerns in supports and services to families of children who are deaf/hard of hearing.

- Dana Yarbrough, CFI director, serves as Virginia's Family Delegate. In this role, Ms. Yarbrough attends and actively participates in OFHS planning meetings and in Medical Neighborhood and transition to adult health care initiatives. She also participates in Title V meetings related to developmental screening, Care Connection for Children, and oral health to name a few. In addition, Ms. Yarbrough serves on AMCHP committees (past chair of the Family & Youth Leadership Committee, current member of the Governance Committee and Innovation Station Committee) bringing back information to Virginia. She is the 2019 recipient of the Merle McPherson Leadership Award for exemplary contributions to further family professional collaboration within the state Title V Programs and AMCHP.
- Title V representation on CFI team. A member of the OFHS team participates in bi-monthly four hour CFI team meetings that bring together 20 CFI staff and funders. These team meetings offer an opportunity for CFI team members to hear about current health department activities and for OFHS to learn about what is happening that is affecting access to and receipt of services and supports for over 5,000 CYSHCN and their families supported by the CFI each year.

OFHS has created an organizational culture that priorities family engagement and partnership that is vital to improving its programs. OFHS serves for the health department as a touchstone for family participation.

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

The goals of the Virginia States Systems Development Initiative (SSDI) program are to:

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 Virginia; and
3. Provide data support to Virginia quality improvement activities, such as Alliance for Innovation on Maternal Health (AIM) projects and other Virginia Neonatal Perinatal Collaborative (VNPC) initiatives.

The Virginia SSDI program recognizes the importance of availability and accuracy of data to support all Virginia MCH programs, and is heavily involved in ensuring consistent annual access to widely used MCH data sources (including vital statistics, PRAMS, Medicaid, WIC, newborn screening, and hospital discharge). Direct and indirect access to these data sources allows for descriptive and inferential analyses that provide a wealth of information to inform Title V programming, assessment, and monitoring.

Centralized epidemiology unit. The Virginia SSDI and MCH Epidemiology team is housed within the Division of Population Health Data (DPHD) in the VDH Office of Family Health Services (OFHS). The role of DPHD is to provide evaluation support and statistical information for needs assessment, performance management, and decision support throughout OFHS using data analytics, survey work, and evaluation studies. The MCH Epidemiology Unit consists of an MCH Epidemiology Supervisor, a Perinatal Epidemiologist, a Newborn Screening Epidemiologist, two Oral Health Epidemiologists, and two program evaluators. The MCH Epidemiology Supervisor serves as the Lead Epidemiologist for Title V and the SSDI Project Director, and directly oversees data and information efforts related to OFHS's maternal and child health programs. 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 Intervention Program and Newborn Genetic Screening Program. The Oral Health Epidemiologists support the Dental Health Program within the Division of Health Promotion and Prevention. Program evaluators within the unit support MCH programs regarding home-visiting, child and adolescent health, reproductive health, and support needs assessment activities.

Access to MCH data, leveraging data systems and other resources. Through the VDH Office of Information Management (OIM), MCH epidemiology staff have direct, annual access to timely, electronic, and standardized Health Statistics data and Virginia Health Information (VHI) hospital discharge data via an Oracle-based server. OIM coordinates data loading and cleaning functions of these data sources. Direct data access also includes the OIM developed Virginia Infant Screening and Infant Tracking System (VISITS II), a Web-based integrated data tracking and management system that directly supports the Virginia Congenital Anomalies Reporting and Education System (VaCARES) and the Virginia Early Hearing Detection and Intervention Program (VEHDI).

Virginia House Bill 1467 required the Board of Health to adopt regulations to include Neonatal Abstinence Syndrome (NAS) on the list of reportable diseases. Medical facilities report NAS into the VDH online Confidential Morbidity Report portal (Epi-1). The MCH Epidemiology Supervisor has direct access to this data and, along with the Perinatal Epidemiologist, is responsible for reporting of NAS hospital discharges (Opioid Addiction Dashboard) and medical facility reported cases (Physician Reported NAS Cases).

The peer group style of the DPHD allows the MCH Epidemiology Unit to cross-collaborate with data systems and epidemiology units within the division, including Injury/Violence Epidemiology and the Population Health Surveys Team. The Virginia Pregnancy Risk Assessment Monitoring Systems (VA PRAMS), which is a critical source of data for Title V performance measure reporting, is housed within the DPHD, along with the Behavioral Risk Factor Surveillance System (BRFSS) and the Virginia Youth Survey (Youth Risk Behavior Survey). The MCH Epidemiology Supervisor and the Perinatal Epidemiologist support and regularly collaborate with the VA PRAMS Coordinator/Epidemiologist for sampling, reports, data requests, and projects.

Additional Epidemiological and Data Enhancement Activities. The Virginia SSDI continues to maintain and update a public-facing dashboard of locality level data through Tableau. The Maternal and Child Health Dashboard includes MCH indicators such as total births, preterm birth, low weight birth, late or no prenatal care, maternal smoking during pregnancy, infant deaths, and teen pregnancy. The dashboards on the public-facing VDH Data

Portal are used by health districts in the community health assessment (CHA) process and by the public and academia for general direction.

DPHD epidemiologists regularly participate in learning and skills-building opportunities, including attendance and presenting at AMCHP and the American College of Epidemiology during FY 2019. In addition, DPHD provides practicum project opportunities and mentorship for students from local schools of public health. The MCH Epidemiology Unit is actively participates in OFHS needs assessment activities, including those for the Title V MCH Block Grant, Reproductive Health, and MIECHV.

Title V – Medicaid Relationship

A copy of the current interagency agreement between VDH and the Virginia Medicaid agency (Virginia Department of Medical Assistance Services, DMAS) is attached to this application. The Title V Director is working with agency leadership to assure this is updated to reflect new and emerging Title V priorities.

The Title V Director has prioritized developing relationships with counterparts at DMAS to advance shared goals and identify opportunities for closer collaboration.

Examples of successes include:

- In FY19-FY20, the Title V Director served on Virginia's National Academy of State Health Policy (NASHP) MCH Policy Innovations Program state team on a project aiming to advance universal SBIRT for pregnant and parenting women; the project included outreach to two major health systems (Ballad Health and VCU) and provided the opportunity to greatly deepen DMAS-MCH relationships.
- The Title V Director is working to establish population domain-based VDH-DMAS workgroups to discuss ongoing work. In 2020, a monthly meeting of Title V CSHCN leadership and DMAS CSHCN staff was established. DMAS staff also participate in monthly sister agency meetings related to maternal/infant health; administration of these meetings was previously handled by the Title V Maternal/Infant Health Coordinator and recently shifted to the VNPC. In addition to these sister agency meetings, the DMAS MCH Program Manager recently reached out to invite the Title V Director to standing 1:1 meetings (e.g.monthly), and the DMAS Deputy of Programs and Operations recently invited the Title V Director to attend DMAS' monthly maternity care meetings.
- The Title V Director serves on the state Children's Health Insurance Program (CHIP) Advisory Committee and was recently invited to sit on the Executive Committee to advance new ideas about applying data and equity lenses to future strategic planning.

Each of these successes provides opportunities to discuss and partner on:

- Program outreach and enrollment;
- Health care financing,
- Waivers or state plan amendments that influence health care delivery for the MCH population, and
- Joint policy level decision making on issues related to MCH services delivery and coverage, particularly for CSHCN.

The CYSHCN Director continues to actively work with DMAS to identify partnership opportunities for care coordination services. The CYSHCN Director has been working to advance alignment between the CCC and CDC Programs and DMAS MCOs providing care coordination services. The CYSHCN Director also works directly with DMAS regarding waivers and billing for CYSHCN, particularly as changes have occurred at the state and federal levels affecting the coverage for the MCH populations.

In addition, DMAS MCH staff have worked with VDH local health district leadership (namely the Director of Public Health Nursing) on local BabyCare efforts (a Virginia Medicaid Reimbursement schedule for prenatal care). BabyCare enrolls women as early as possible in their pregnancy and follows the woman and infant through the baby's second birthday. In FY20, the Title V Director will convene monthly meetings with the Director of Public Health Nursing, Community Health Services Medical Director, Office of Family Health Services Director, and a team of MCH staff (e.g. MIECHV/Healthy Start, Title X/Reproductive Health, Developmental Screening) to discuss shifts in locally-available services (e.g. access to prenatal care and child health services) and opportunities to align Title V allocations to local health districts to meet emerging needs.

There are currently two related doula initiatives administered through the General Assembly. The first is the VDH is tasked with exploring a state doula registry and certification model (led by a workgroup convened by Consuelo Staton, the state Resource Mothers Coordinator). The second is that DMAS is tasked with completing a doula

reimbursement rate study (for which a state workgroup on Medicaid reimbursement has been formed). Title V is at the table for both efforts. Model states include Oregon and Minnesota would be useful.

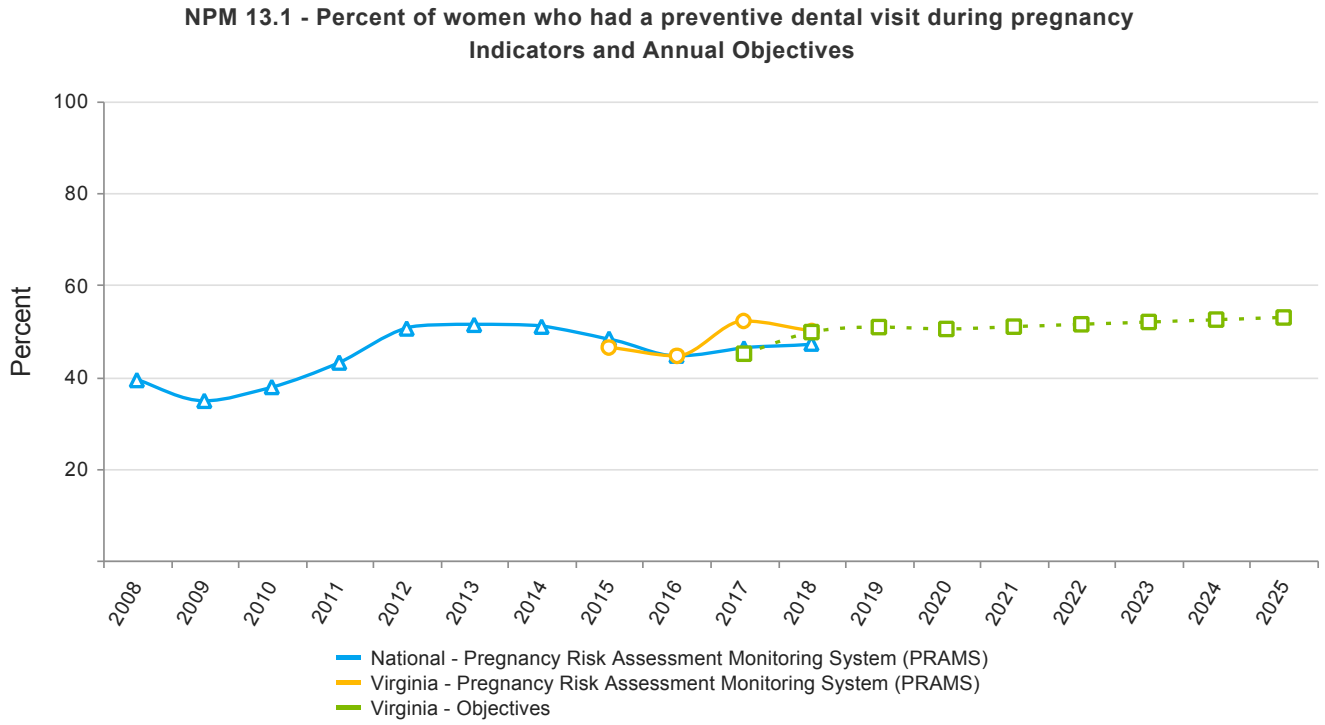
III.E.2.c State Action Plan Narrative by Domain

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-2017_2018	10.4 %	NPM 13.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	91.1 %	NPM 13.1

National Performance Measures



Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2017	**2018**	**2019**
Annual Objective	45	49.7	50.8
Annual Indicator	46.5	44.7	49.9
Numerator	44,225	42,882	46,558
Denominator	95,088	95,839	93,304
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2016	2018

State Provided Data				
	2016	2017	2018	2019
Annual Objective		45	49.7	50.8
Annual Indicator	43.6			
Numerator				
Denominator				
Data Source	PRAMS			
Data Source Year	2010-2011			
Provisional or Final ?	Provisional			

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	50.4	50.9	51.4	51.9	52.4	52.9

Evidence-Based or –Informed Strategy Measures

ESM 13.1.1 - Number of Regional Oral Health Collaborative Projects that implemented work plans to increase dental visits among pregnant women

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			6
Annual Indicator		3	4
Numerator			
Denominator			
Data Source		VDH Oral Health Program documentation	VDH Oral Health Program documentation
Data Source Year		2018	2019
Provisional or Final ?		Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	6.0	6.0	6.0	6.0	7.0	7.0

State Performance Measures

SPM 4 - Pregnancy Intention: Mistimed or Unwanted pregnancy (wanted to become pregnant later or never)

Measure Status:	Active
State Provided Data	
	2019
Annual Objective	
Annual Indicator	25.3
Numerator	
Denominator	
Data Source	VA PRAMS
Data Source Year	2018
Provisional or Final ?	Final

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	23.8	23.3	22.8	22.3	21.8

State Outcome Measures

SOM 2 - Maternal Mortality Disparity: Maternal Mortality Disparity Ratio

Measure Status:	Active

State Provided Data		
	2018	2019
Annual Objective		
Annual Indicator	3.3	1.9
Numerator	36.6	52.6
Denominator	11	27.7
Data Source	CDC WONDER Online Database	CDC WONDER Online Database
Data Source Year	2011-2015	2013-2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	2.8	2.4	2.1	1.7	1.4	1.0

State Action Plan Table

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

Priority Need

Oral Health: Maintain and expand access to oral health services across MCH populations.

NPM

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

Objectives

By June 30, 2025, increase the percent of women who had a dental visit during pregnancy from 50.8% (PRAMS 2018) to 52.9%.

Strategies

Maintain and expand existing MCH-focused dental education programs to improve oral health for individuals across the lifespan, to include advising on oral health integration in primary care settings, education for home visitors, school-aged oral health education, and emerging needs of adolescents.

Sustain network of 5 regional Oral Health Alliances and distribute mini-grants for implementation of systems change and data-sharing initiatives to improve the oral health of all Virginians.

Convene statewide groups focused on targeted oral health issues (e.g. Water Equity Taskforce, Early Dental Home workgroup, Future of Oral Health workgroup), facilitate collaboration and workplan development, and provide leadership and oversight to guide initiatives.

ESMs	Status
ESM 13.1.1 - Number of Regional Oral Health Collaborative Projects 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

Reproductive Justice & Support: Promote equitable access to choice-centered reproduction-related services, including sex education, family planning, fertility/grief support, and parenting support.

SPM

SPM 4 - Pregnancy Intention: Mistimed or Unwanted pregnancy (wanted to become pregnant later or never)

Objectives

Reduce the rate of mistimed pregnancies from 25.3% (PRAMS 2018) to 21.8% by 2025.

Strategies

Work with stakeholders to remove policy, financial, and training barriers to contraceptive access.

Explore opportunities for providing support to families seeking fertility services and families experiencing miscarriage.

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

Priority Need

Maternal and Infant Mortality Disparity: Eliminate the racial disparity in maternal and infant mortality rates by 2025.

SOM

SOM 2 - Maternal Mortality Disparity: Maternal Mortality Disparity Ratio

Objectives

Eliminate the racial disparity in maternal and infant mortality rates by 2025.

Strategies

Explore opportunities to develop and pilot racial equity curricula at Virginia colleges and universities providing medical, nursing, dental, and other clinical health professional training.

Develop and mobilize strong interagency, multisector, and community partnerships to address disparities in maternal and infant mortality rates.

Sustain state maternal mortality and child fatality review programs.

Work with stakeholders to increase access to doula services among women of color.

Maintain Title V representation on the Virginia Neonatal Perinatal Collaborative's Steering and Executive Committees, and develop a shared visioning and planning document specific to the VDH-VNPC relationship.

Launch CDC Project LOCATe by June 2022.

Launch health disparities dashboard by June 2022.

Launch VNPC stillbirths dashboard by June 2022.

State Action Plan Table (Virginia) - Women/Maternal Health - Entry 4

Priority Need

MCH Data Capacity: Maintain and expand state MCH data capacity, to include ongoing needs assessment activities, program evaluation, and modernized data visualization and integration.

SOM

SOM 2 - Maternal Mortality Disparity: Maternal Mortality Disparity Ratio

Objectives

Eliminate the racial disparity in maternal and infant mortality rates by 2025.

Strategies

Sustain and expand data capacity within the Office of the Chief Medical Examiner's related to maternal, infant, and child health.

State Action Plan Table (Virginia) - Women/Maternal Health - Entry 5

Priority Need

Upstream / Cross-Sector Strategic Planning: Eliminate health inequities arising from social, political, economic, and environmental conditions through strategic, nontraditional partnerships.

SOM

SOM 2 - Maternal Mortality Disparity: Maternal Mortality Disparity Ratio

Objectives

Eliminate the racial disparity in maternal and infant mortality rates by 2025.

Strategies

Continue to engage cross-sector partners and address social determinants of health in development of MMRT and CFRT recommendations.

State Action Plan Table (Virginia) - Women/Maternal Health - Entry 6

Priority Need

Community, Family, & Youth Leadership: Provide dedicated space, technical assistance, and financial resources to advance community leadership in state and local maternal and child health initiatives.

Objectives

Eliminate the racial disparity in maternal and infant mortality rates by 2025.

Strategies

Explore expanding community engagement in state maternal mortality and child fatality review.

2016-2020: National Performance Measures

2016-2020: State Performance Measures

2016-2020: SPM 4 - Unintended Pregnancy: Proportion of females ages 15-44 using Tier 1 (most effective) contraceptive methods

Measure Status:			**Active**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective	2.6	33.3	34.1
Annual Indicator	35.5	31	65.1
Numerator			
Denominator			
Data Source	VA PRAMS	VA PRAMS	VA PRAMS
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Women's/Maternal Health Domain
FY19 Annual Report

The Office of Family Health Services administers a number of programs and initiatives serving women, children, and their families. Under strategic direction of the Title V Director, Title V funds are braided with a variety of state and federal funding streams and allocated across teams.

The FY19 workplan for the Women's/Maternal Health Domain included the following performance measures:

1. Unintended Pregnancy
2. Oral Health

Strategies within the FY19 Women's/Maternal Health workplan were implemented by the Reproductive Health Unit and Dental Health Program. Summaries of activities completed during the reporting period are presented by performance measure below.

Complementary efforts were completed by Title V-funded local health districts, the Office of the Chief Medical Examiner, and the Virginia Neonatal Perinatal Collaborative (VNPC). These entities and their efforts are detailed in the 'Other Programmatic Activities' section below.

Oral Health

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

FY19 Performance Measure: NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy

---

Objective

For the FY19 application, the objective was:

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

NPM 13 - Percent of women who had a preventive dental visit during pregnancy was 49.9%, fairly near the target set for reporting year 2019 which was 50.8%.

Progress Updates

The Dental Health Program (DHP) provides:

- Educational activities and resources to a wide variety of partner groups to promote proper oral hygiene and support prevention services and access to dental care;
- Direct clinical preventive services and assistance with establishing a dental home;
- Quality assurance reviews to assure a competent public health oral health workforce; and
- Surveillance and evaluation activities to monitor and track dental disease rates and trends and for Program assessment of effectiveness and planning.

DHP programs include the:

- Special Health Care Needs Oral Health Program,
- Bright Smiles for Babies Fluoride Varnish Program,
- Dental Preventive Services Program, and
- Perinatal and Infant Oral Health Program.

These programs are detailed in the FY21 Application.

The DHP has many internal partners including other VDH MCH programs and the statewide oral health coalition now known as Virginia Health Catalyst (VHC). VHC is a non-profit organization that serves as the only statewide oral health coalition in the Commonwealth. It is a diverse group working to spark change so all Virginians have equitable access to comprehensive health care that includes oral health and to bring excellent oral health to all Virginians through policy change, public awareness and innovative programs. The VHC works closely with VDH to implement grant objectives and has in-depth knowledge of the Virginia Oral Health Plan and the Virginia Oral Health Report Card, foundations that prioritizes oral health activities statewide. VHC has access to a diverse network of key, statewide stakeholders, and the unique ability to share oral health information with both key partners and the public. VHC staffs understand the need to continually promote oral health at the local level, support local initiatives to affect meaningful change, and to evaluate efforts to ensure ongoing, comprehensive support for structural sustainability.

Top FY19 accomplishments included:

- "*Improving Oral Health Outcomes for Pregnant Women and Infants by Educating Home Visitors*" was submitted to AMCHPs Innovation Station and was accepted as an Emerging Practice: http://www.amchp.org/programsandtopics/BestPractices/InnovationStation/ISDocs/Oral%20Health%20Home
- *"Impacting Oral Health in the Community by Engaging Home Visitors and Family Educators to Improve Oral Health Outcomes for Pregnant Women and Infants: One State's Experience"* was submitted to the American Association of State and Territorial Dental Directors (ASTDD) Best Practice Approach and was accepted. ASTDD Best Practice Approach Reports serve as a mechanism for imparting information on specific subject matter as it relates to improving oral health. Descriptive Reports selected for inclusion in Best Practice Approach Reports are reviewed and evaluated by the ASTDD Best Practices Committee. The Committee evaluates the content of each submission using five criteria: impact/effectiveness; efficiency; demonstrated sustainability; collaboration/integration; and objectives/rationale. The selection of your best practice or promising practice indicates that ASTDD has determined it will serve as a valuable resource for other organizations looking to implement a new program or to enhance an existing program.
- The Greater Richmond/Petersburg Oral Health Alliance conducted advocacy visits with elected officials to share community-level stories that reinforce the legislature's support of a dental benefit for pregnant women. They also educated legislators about the need for women of child-bearing age to have access to oral health services as well. Catalyst helped facilitate legislative visits in October 2018 for six community members from the Greater Richmond/Petersburg Oral Health Alliance grassroots engagement subcommittee.

Program Logos, Branding, & Communications:

The Dental Health Program (DHP) does not currently have a logo but uses the Office of Family Health Services LiveWell logo. The DHP is in the process of developing a Dental Health Program Communication Plan with help from ASTDD and the internal communications department. To date primary message topics for each DHP Program have been identified as well as target audiences for each message. An "Observances Calendar" has also been created with state and national observances that specific oral health messages could be tied to. (Ex. February is

national Children's Dental Health Month so messages might focus on sealants, health snacks, and HPV prevention during this month). DHP staff have also worked with the communications team to completely update the look and content of the DHP Website: http://www.vdh.virginia.gov/oral-health/

Strategy 1: Provide preventive dental services for pregnant women.

The HRSA Perinatal and Infant Oral Health Quality Improvement Expansion (PIOHQIE) Grant ended in July 2019 but, with Title V MCH funding, a new program, the Maternal, Infant and Adolescent Oral Health Program was developed to continue important activities related to this priority population.

MCH- and non-MCH funds continued to provide population-level dental health education, services, and workforce development impacting pregnant women continued.

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.

The Virginia Health Catalyst "Catalyst" fostered and supported Regional Oral Health Alliances. Activities completed this grant year that relate to this strategy include:

- The regional Oral Health Alliances and micrograntees held a total of 21 meetings during this time; six meetings in South Hampton Roads, six in Richmond, eight in Northern Virginia, and one in Roanoke.
- Catalyst hired one part-time contractor in both the Northern Virginia and South Hampton Roads areas to help facilitate regular alliance meetings, advance workgroup goals, and serve as a liaison between local, regional, and statewide partners. They have greatly improved the reach, impact, and momentum of the alliances.
- Catalyst staff disseminated newsletters during this time to almost 2,000 recipients that contained updates and information about the VA Maternal and Child Health Needs Assessment Survey, Medicaid expansion dental benefits, VDH oral health programs, and health equity.
- The Greater Richmond/Petersburg alliance conducted advocacy visits with elected officials to share community-level stories that reinforce the legislature's support of a dental benefit for pregnant women. They also educated legislators about the need for women of child-bearing age to have access to oral health services as well. Catalyst helped facilitate legislative visits in October 2018 for six community members from the Great Richmond/Petersburg alliance grassroots engagement subcommittee.
- The Northern Virginia alliance began designing a Brush, Book, Bed Campaign to engage pediatricians in making early dental referrals, including bilingual book, bookmarks and posters.
- The Northern Virginia alliance's Children's Workgroup reviewed data and identified 25 pediatricians in the region with a high volume of Medicaid-enrolled children/adolescents and began to reach out to them to understand their current oral health screening, assessment, and referral practices. They also shared information and resources to improve integrated care and referrals to dental homes.
- Catalyst staff presented for Virginia's Community Health Worker advisory group about the importance of oral health care for children, pregnancy women, and individuals with chronic disease; the Medicaid dental benefit; and Medicaid expansion information.
- Catalyst held the 2018 Virginia Oral Health Summit on Nov. 8, 2018 with 217 attendees from across Virginia, and included information about regional alliances, programs and data regarding oral health during pregnancy, motivational interviewing techniques, health equity information, and a Medicaid update.
- Catalyst issued two microgrants of $5,000 (one in Northern Virginia and one in South Hampton Roads) to implement the Brush, Book, Bed program, an American Academy of Pediatrics-developed initiative to

educate families and children about the importance of oral health at an early age. The alliances will work with home visitors, pediatricians, and Head Starts in their communities to implement this project.
- Catalyst issued a third microgrant to support an inclusion and de-sensitivity initiative to help aid in dental care aces for children with special health care needs in Virginia.

Evidence-Based Strategy Measures

The strategies proposed in the FY19 workplan aligned with the following ESM(s):
- 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)

In FY19, the Catalyst worked with 4 Regional Oral Health Alliances to develop work plans and complete activities with the goal of increasing dental visits among adolescents. This is an ongoing project that will continue in FY20. A total of 6 Regional Alliances will be working to address adolescent oral health by the projects end.

The ESMs proposed in the FY21 workplan are the same as in FY20 - Number of Regional Oral Health Alliances that implemented work plans to increase dental visits among Children.

Reproductive Health

State Priority: Women's/Maternal Health: Support the physical and emotional wellbeing of women and their children.

FY19 Performance Measure: SPM 4: Unintended Pregnancy: Proportion of females ages 15-44 using Tier 1 (most effective) contraceptive methods

---

Objective

For the FY19 application, the objective was:
- 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%.

SPM 4 - Unintended Pregnancy: Proportion of females ages 15-44 using Tier 1 (most effective) contraceptive methods was 65.1%, exceeding the target set for reporting year 2019 which was 34.1%.

Related National Outcome Measures

The national outcome measure (NOM) most relevant to this SPM is:

- NOM 23: Teen birth rate, ages 15 through 19, per 1,000

Significance of NOM 23: Teen pregnancy and childbearing have substantial social and economic costs for both teens and their children. Teen mothers are less likely to complete high school and further education which may reduce earning potential and contribute to intergenerational poverty. Although teen pregnancy and birth rates have declined substantially over the past two decades, rates are still higher than in many other industrialized countries and large racial/ethnic disparities persist. Birth rates for non-Hispanic Black and

Hispanic teens are more than double that of non-Hispanic White teens.
https://www.cdc.gov/teenpregnancy/about/index.htm

Related Healthy People 2020 Objectives:

- *Family Planning (FP) 8.1: Reduce pregnancies among adolescent females aged 15 to 17 years (Baseline 40.2 per 1,000 in 2005; Target 36.2 per 1,000)*
- *FP 8.2: Reduce pregnancies among adolescent females aged 17 to 19 years (Baseline 116.2 per 1,000 in 2005; Target 105.9 per 1,000)*

Progress Updates

The Division of Child and Family Health's Reproductive Health Unit leads this effort. Title V funds provide salary support for administration of the LARC Initiative.

The unit is led by Emily Yeatts, MSW, MPH (Reproductive Health Unit Supervisor) and 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 Program (Sexual Risk Avoidance 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.

VDH's Reproductive Health Unit include several programs dedicated to this population domain, including the Long Acting Reversible Contraceptives (LARC) Stakeholder Workgroup, the Virginia LARC Initiative, the Title X Family Planning Program, and Resource Mothers. The LARC Stakeholder Workgroup is a network of agencies working to reduce unintended pregnancies among women of childbearing age and increase access to comprehensive, quality family planning services. This workgroup was originally developed to address infant mortality, recognizing the role of contraceptive access on maternal and infant health. The workgroup is facilitated by VDH, meets quarterly, and includes over 70 members from a variety of community-based health centers, governmental organizations, hospital systems, payers, and community members. The LARC Stakeholder Workgroup collaborated to successfully advocate for the Virginia LARC Initiative, a two-year pilot program designed to increase access to hormonal LARCs among uninsured, low-income women. Funded through federal TANF funds allocated by the Virginia General Assembly, the LARC Initiative allows VDH to contract with eighteen health providers to offer LARC insertions and removals to eligible patients. VDH's family planning efforts extend beyond the Virginia LARC Initiative as well. VDH's Title X Family Planning program provides comprehensive family planning services at approximately 140 clinical sites across the Commonwealth, including 34 local health districts and 3 federally qualified health centers. As the nation's only federally funded family planning program, Title X provides structure, funding, and technical support to clinics providing family planning services according to CDC's Quality Family Planning Services guidelines. VDH is Virginia's sole Title X grantee. The Title X Family Planning program is not directly supported by Title V funds, but Title X compliments Title V by supporting comprehensive family planning services beyond those provided by the Virginia LARC Initiative. In addition to its pregnancy prevention programs, VDH's Reproductive Health Unit also provides support to young parents. Resource Mothers is an adolescent health program for pregnant and parenting teens. As part of this program, community health workers offer home visiting services to teens until their child reaches the age of one. During these visits, community health workers provide educational and emotional support to the client and her

family. Resource Mothers uses two evidence based programs: Growing Great Kids and AIM4TM (AIM for Teen Moms). Largely funded through federal TANF funds allocated by the Virginia General Assembly, Resource Mothers is offered at six local implementation sites, including five local health districts and one hospital system. 3 The Division of Child and Family Health's Maternal and Infant Health (MIH) Coordinator serves as a subject matter expert housed at VDH's Central Office who partners closely with an array of state and local partners, including the Virginia Neonatal Perinatal Collaborative (VNPC), the Maternal Mortality Review team, and the recently-formed maternal mental health workgroup and Pathway to Coordinated Care for Infants and Families (PCC) workgroup. This unit works closely with the 35 LHDs to provide over $3.5 million in annual funds to support their local maternal and infant health programs and initiatives, providing quarterly recorded meetings via webinar platform for technical assistance and allow LHDs to share lessons learned across LHDs and programs.

Top FY19 accomplishments included:

- During FFY19, the Virginia LARC Initiative provided approximately 1,600 no-cost visits to eligible women.
- During FFY19, 27 community health workers in the Resource Mothers program were trained in AIM4TM, an evidence-based teen pregnancy prevention program that uses a positive youth development framework.

Program Logos, Branding, & Communications:

In order to promote the Virginia LARC Initiative, VDH made a concerted effort to share information about this program with potential patients. First, VDH partnered with its Communications Team to create a promotional video (https://www.youtube.com/watch?v=unYmawE1OTs&feature=youtu.be). This video was shared on social media across the Commonwealth following the launch of the program. VDH also created a public webpage to share information about with patients about participating providers and Title X family planning clinics (http://www.vdh.virginia.gov/family-planning/larc-initiative/)

Recognizing the need for public education about contraception, the LARC Stakeholder Workgroup partnered with VDH's Title X Program to offer a public education campaign. During FFY18, the LARC Stakeholder Workgroup reviewed available data and concluded that, although VDH's Title X family planning program offers a broad range of contraceptive methods to patients, LARCs are still largely inaccessible to many Virginia women. These findings led the workgroup to initiate a partnership with the Power to Decide to the "Whoops Proof Birth Control" campaign. This campaign, launched during FFY19, was designed to increase public awareness and positive regard of LARCs. The group agreed to target cities that had both a large number of women in their early twenties and multiple family planning providers. Below is a photograph of one of these ads at a bus shelter.

CLIENT

Media Partners

(VDH)

CAMPAIGN FLIGHT

CAMPUSES

agency

MSSmedia

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

PRESS RELEASE: OCTOBER 3, 2018

"The Virginia LARC Initiative aims to reduce unintended pregnancy and improve birth spacing, supporting 'Virginia's Plan for Well-Being' goal to establish a strong start for children. This is an important step toward realizing that goal."

State Health Commissioner M. Norman Oliver, MD, MA

"The Virginia LARC Initiative will help ensure that the cost of long-acting contraceptives is not a barrier to low-income women who want to use this form of contraception to plan when or if they become pregnant."

Governor Ralph Northam

"Improvements in maternal and birth outcomes are a top priority for Virginia's health and human resources agencies. LARCs are the most effective form of contraception, and we have seen promising results from similar programs in other states. We are proud that the providers that have been selected for Virginia's program include a diverse array of academic medical leaders, Federally Qualified Health Centers, free-clinics, and private and non-profit providers."

Secretary of Health and Human Resources Daniel Carey, MD

http://www.vdh.virginia.gov/news/2018-news-releases/virginia-launches-6-million-contraceptive-initiative/

During FFY19, the LARC Stakeholder Workgroup met quarterly and worked to better understand the need for family planning services across the Commonwealth. According to the All Payers Claims Database, LARC utilization across the state was well below the national average. Furthermore, the workgroup surveyed 120 private family planning practice providers throughout state, and found that only half offered LARCs. The main reasons given for not offering LARCs included time, training, and cost of devices. This data stood in sharp contrast to 2015 PRAMS data, which stated that 16% of women were using LARCs at 2-6 months postpartum, and VDH Title X family planning patient data, which stated that 19.3% of patients used LARCs in CY2017. This data suggested that although VDH's Title X family planning program was providing the broad range of contraceptive methods to patients, LARCs were largely inaccessible to many Virginia women. These findings led the workgroup to initiate a partnership with the Power to Decide to the "Whoops Proof Birth Control" campaign. This campaign was designed to increase public awareness and positive regard of LARCs, and was launched in FFY19.

Based on conversations among LARC workgroup members, the group determined that community stakeholders and policy makers could also benefit from learning more about the public health benefit of LARCs. Group members worked together to create a one-page document designed for policy makers, decision makers, and other leaders interested in supporting public health programs. Group members used this document to help make the case for the Virginia LARC Initiative, a $6 million pilot program designed to increase access to LARCs among low-income women launched in FFY19. During FFY19, the Virginia LARC Initiative provided approximately 1,600 no-cost visits to eligible women.

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

VDH worked to increase education about contraception among pregnant and parenting teens. During FFY19, all Resource Mothers staff were trained in AIM4TM, an evidence-based teen pregnancy prevention program that uses a positive youth development framework. By participating in AIM4TM, teen clients will have the opportunity to learn skills for advancing their education and professional careers, and also receive education about contraceptive methods. At the conclusion of the program, teens participate in a graduation ceremony, and at one of these ceremonies, a local community member who was a teen mother served as the keynote speaker. AIM4TM officially launched in January 2019, and 27 community health workers were trained during this reporting period.

State Performance Measure Update

According to 2016-18 PRAMS data, unplanned pregnancy rates and unintended pregnancy rates have remained

relatively steady in Virginia. Contraception is still not readily available to all Virginians who want or need it, and while VDH has made a concerted effort to expand family planning services, the true impact of these efforts may not be apparent for a couple years. VDH intends to continue promoting access to family planning services and education through the LARC Workgroup, Title X Family Planning Program, Resource Mothers Program, and Virginia LARC Initiative for the upcoming year, and expects to see the rates drop next year.

	2016	2017	2018
Unplanned pregnancy	46%	42%	44%
Unintended pregnancy	40%	36%	41%

Other Programmatic Activities

Local Health Districts

Title V funds are allocated to 35 local health districts (LHDs) to address locally-identified priorities; each LHD must maintain a workplan and report annually on successes, challenges, and emerging needs. Title V-funded Central Office staff provide technical assistance to LHDs through site visits and bimonthly webinars.

LHD priorities for the previous grant cycle were strongly linked with maternal and infant health topics. This was in part due to alignment with state-level work led by the Maternal and Infant Health Coordinator.

Funded LHD priorities included: (1) access to maternal/prenatal care, (2) substance use, including tobacco and opioid use among pregnant women, and (3) safe sleep. To build capacity of LHDs to enhance community partnerships and community/family voice in program planning and delivery, a fourth funded priority was been included for the FY20 grant year: (4) increased coordination with community-based organizations. Each LHD was required to select at least one of these four priorities.

Office of the Chief Medical Examiner

OCME continued to lead maternal mortality and state fatality review with Title V funds. These activities are described in detail in the FY21 Application.

Virginia Neonatal Perinatal Collaborative

As detailed in the FY19 application, 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's Steering Committee includes:
- 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: Lauren Winston, MPH
- March of Dimes representative: Marie Pokraka MSN, RN, IBCLC
- Virginia Department of Health representative: Jennifer MacDonald, BSN, RN, 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 sought to 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 also worked to identify and reduce barriers related to administering 17P. These five projects were not included in the FY19 or FY20 Title V state action plan, as no Title V funds are directly allocated to these efforts.

However, as VDH administers the contract for non-match General Funds that supports the VNPC, planned strategic collaborations are detailed in the FY21 Application. The Title V Director will also assume a role on the VNPC Executive Committee in FY21.

Women's/Maternal Health Domain
FY21 Application

The FY21 workplan for the Women's/Maternal Health Domain includes the following performance measures:

1. Maternal Mortality Disparity Ratio
2. Pregnancy Intention
3. Oral Health

Under strategic and fiscal guidance from the Title V Director, funded programmatic activities for women's/maternal health will be implemented by the following entities:

- Black Maternal/Infant Health Program
- Office of the Chief Medical Examiner's Division of Death Prevention
- Reproductive Health Unit
- Dental Health Program
- Virginia Neonatal-Perinatal Collaborative

These entities and their proposed activities for the upcoming grant period are detailed below.

I. Black Maternal & Infant Health Program

A new Black Maternal & Infant Health Program will be led by the Title V Director (Carla Hegwood, MPH). A full-time Program Coordinator position will be established to support this program.

During the quantitative portion of the 2020 MCH Needs Assessment, intentional disaggregation of by race/ethnicity for each NPM revealed glaring and consistent racial disparities. These disparities are particularly pronounced among Black women, infants, and children.

Disparities are noted for the following metrics:

- Breastfeeding (ever breastfed, exclusive)
- Infants placed on back to sleep
- Maternal Morbidity
- Maternal Mortality
- Infant Mortality
- Neonatal Mortality
- Unintended Pregnancy
- Maternal dental visit (12 months before pregnancy, during pregnancy)

In light of the Governor's mandate for all state agencies to work jointly to eliminate racial disparities in maternal mortality by 2025 – and recognizing that the historical, structural, and community context in which these disparities exist are complex and require dedicated space, time, scholarship, and community engagement strategies, above and beyond existing staff tasked with serving all women at the population level – the Title V Director will onboard a new full-time Program Coordinator. This position will support a variety of initiatives, including development of a Shared MCH Agenda for Maternal/Infant Mortality Disparity, culturally-appropriate programming, and community- and policy-level interventions.

While all Title V-funded programs will be expected to apply a racial equity lens to program planning across domains, this program will focus on better understanding, centering, and adaptively responding to the experiences and needs of Black women and mothers. Innovative data visualization and cross-sector/nontraditional partnerships will be explored.

FY21 Application Overview: Maternal Mortality Disparity

State Priority: Maternal Mortality Disparity
FY21 Performance Measure: SOM 2 – Maternal Mortality Disparity

OBJECTIVE: Eliminate the racial disparity in maternal and infant mortality rates by 2025.

According to America's Health Rankings (2019), Virginia ranks 22 overall for the health of women, and 18 for the overall health of women and children. The maternal mortality rate was 29.5 per 100,000 live births, compared to the U.S. rate of 29.6. Differences exist in the rate of maternal mortality by race and age group in Virginia:

Maternal Mortality, Virginia, Rate per 100,000 live births	
Race	
White	27.7
Black	52.6
Age Group	
15-24 years	10.0
25-34 years	19.6
35-44 years	46.2
Source: CDC WONDER Online Database, Mortality files, 2013-2017	

Strategy: Explore opportunities to develop and pilot racial equity curricula at Virginia colleges and universities providing medical, nursing, dental, and other clinical health professional training.
Domain: Women's/Maternal, Perinatal/Infant

Activity	Expected Completion Date	Responsible Staff
Conduct environmental scan of medical, dental, and nursing schools currently implementing racial equity trainings.	October 2020	Carla, Black Maternal/Infant Health (BMIH) Coordinator
Identify 1-3 national subject matter experts to provide technical assistance.	December 2020	Carla, BMIH Coordinator
Secure commitment from one or more medical, dental, or nursing schools interested in collaborating to develop and pilot racial equity training.	December 2020	Carla, BMIH Coordinator
Form state steering committee.	December 2020	Carla, BMIH Coordinator
Serve as convener or contract with national expert to serve as convener for task force to develop pilot curricula.	Ongoing	Carla, BMIH Coordinator

There is ongoing and mounting political will at the national level to address disparities in maternal and infant health outcomes experienced by Black women through policy and systems strategies, particularly in relation to provider-level factors such as implicit bias.

In parallel, Virginia is seeing increased energy and interest around tangible strategies such as mandated annual implicit bias training for current health professionals and incorporating racial equity as a mandatory part of curricula for future health professionals (e.g. through updated medical, nursing, and dental curricula).

In FY20, the Title V program will explore opportunities to partner with one or more institutions to develop and pilot racial equity training for future clinicians.

While there is known interest in such training, to date, our team is unaware of any colleges/universities with curricula in active development. In addition, health systems and schools of medicine are quickly onboarding and/or scaling diversity, equity, and inclusion efforts, there is great opportunity for the Title V program to serve as a convener, connector, and collaborator.

Strategy: Develop and mobilize strong interagency, multisector, and community partnerships to address disparities in maternal and infant mortality rates.
Domains: Maternal, Perinatal/Infant

Activity	Expected Completion Date	Responsible Staff
Ensure all program planning has an equity lens (including racial/ethnic and geographic disparities) and promotes inclusion and centering of community and marginalized voices.	Ongoing	Title V Team
By September 30, 2020, develop Shared Agenda for between Title V, the Virginia Neonatal Perinatal Collaborative, the Office of the Chief Medical Examiner, and other partners that aims to improve maternal and infant health across the Commonwealth through data-driven, evidence-based collaborative initiatives.	September 2020	Carla, BMIH Coordinator, OCME, VNPC, Title V partners

In FY20, the BMIH will support development of a Shared MCH Agenda for Maternal/Infant Mortality Disparity, in collaboration with a variety of Title V partners,to include the entities detailed below.

II. Office of the Chief Medical Examiner's Division of Death Prevention

The Division of Death Prevention is led by Dr. Ryan Diduk-Smith (Director). The Division is responsible for several epidemiological surveillance and fatality review programs, including the Maternal Mortality Review Team and Child Fatality Review Team, local and regional overdose and domestic violence review teams, the National Violent Death Reporting System, and the Overdose Data to Action project. The division is 100% federal funded through grants and cooperative agreements through the Centers and Disease Control and Department of Justice.

- *Ryan M. Diduk-Smith PhD, MPH, CHES* (Director, Division of Death Prevention) oversees the Office of the Chief Medical Examiner's Maternal Mortality Review Team and Child Fatality Review Team. She is responsible for administration, staff oversight, and supports the data abstraction, collection, and analysis of maternal mortality and child fatality data.

- *Melanie J. Rouse, PhD* (Maternal Mortality Programs Manager) is responsible for the implementation of the Maternal Mortality Review Team and related projects. She is responsible for the coordinating and facilitating the review team, data analysis, data entry in to CDC's MMRIA system, report writing, and data dissemination.

- *Dane De Silva, PhD* (Family Violence Programs Manager) is responsible for the implementation of the Child Fatality Review Team and related projects. He is responsible for coordinating and facilitating the CFRT, child fatality surveillance activities, report writing, data analysis and dissemination.

- *TBD* (Maternal Mortality Research Associate) is responsible for data collection, preliminary data analysis, data cleaning, and administrative support for all maternal mortality programs, including the Maternal Mortality Review Team.

- *TBD* (Child Fatality Research Assistant) is responsible for data collection, preliminary data analysis, data cleaning, and administrative support for the infant and child fatality programs, including the Child Fatality Review Team.

Both the Maternal Mortality and Child Fatality Review Teams and programs are based in this unit with oversight provided by Drs. Diduk-Smith, Rouse, and De Silva. Dr. Rouse provides the leadership for the maternal mortality programs and Dr. De Silva provides the leadership for the infant and child fatality programs. Dr. Diduk-Smith oversees all programming and supports the work of the MMRT and CFRT through administrative and data support. Both programs are highlighted below.

Snapshot of Program Accomplishments

- Maternal Mortality Review Team:
  - Dr. Melanie Rouse was an invited speaker at the following congressional hearings:
    - House Ways and Means Committee meeting on "Overcoming Racial Disparities and Social Determinants in the Maternal Mortality Crisis," May 2019
    - U.S. Dept. of Health and Human Services "Roundtable on Maternal Mortality," Sept. 2019
    - U.S. Commission on Civil Rights briefing regarding “Maternal Health Disparities” – Date TBD
  - The MMRT completed its Chronic Disease Review and published the report with recommendations in 2019.
  - Dr. Ryan Diduk-Smith presented at Academy Health and the American Public Health Association’s annual conference. The topic was Maternal Mortality in Virginia and Maternal Mortality and Chronic Disease.
  - The MMRT implemented the CDC’s MMRIA data tool successfully and is using it as a mechanism for collecting data from the review team.

- Child Fatality Review Team:
  - The CFRT finished its review of childhood drowning deaths and a report with recommendations was completed in 2019. Recommendations from the report were used in the 2020 General Assembly Session.
  - The Infant and Child Fatality data collection tool was revised and implemented in late 2018. This tool allows for the in-depth collection of all deaths of children, 0-17, living in Virginia. This tool will be revised and implemented based on evaluation results in early 2021.
  - The CFRT provided data and recommendations from the Citizens Review Panel to the Department of Social Services for their 2020 report.

FY21 Application Overview: MCH Data Capacity

State Priority: MCH Data Capacity
FY21 Performance Measure: SOM 2 – Maternal Mortality Disparity

Objective: Eliminate racial disparities in maternal and infant mortality rates by 2025.

Strategy: Sustain and expand data capacity within the Office of the Chief Medical Examiner.
Domains: Maternal, Perinatal/Infant

Activity	Expected Completion Date	Responsible Staff
The OCME will provide data to DPHD related to maternal health, infant and child health, and health disparities for use in data briefs and other materials. The OCME will also serve as a subject matter expert and will review data briefs and other materials as requested by DPHD once developed, before dissemination of the materials.	Ongoing	Division of Population Health Data (DPHD), Dr. Dane De Silva (CFRT), Dr. Melanie Rouse (MMRT), MMRT Research Associate, CFRT Research Assistant

Child Fatality Review Team

Using data from the Infant and Child Surveillance program the OCME will provide data Tittle V, community-based, and Virginia Department of Health partners when requested. The Infant and Child Surveillance program will continue to be the hallmark data program for child fatality, which not only includes data collection, but also data analysis and subject matter expert input, when requested.

The addition of a Family Violence Research Associate will allow for the expansion of the CFRT program to include more in-depth data collection and analysis. Current efforts of the CFRT only focus on the most current data available each year and data only relevant to the review being conducted by the review team. Bringing in a CFRT Research Associate will allow current tools to be amended and implemented more data can be collected and allow for a more comprehensive database in future years. Additionally, the addition of the CFRT Research Associate will give the Family Violence Programs Manager more ability to focus efforts on data analysis, policy development, and data dissemination, as the research associate will be responsible for many of the current administrative tasks managed by the Programs Manager.

Maternal Mortality Review Team

Using data from Maternal Mortality Surveillance Program, the OCME will provide data Tittle V, community-based, and Virginia Department of Health partners when requested. The Maternal Mortality Surveillance Program be the hallmark data program for maternal mortality, which not only includes data collection, but also data analysis and subject matter expert input, when requested.

The addition of a MMRT Research Associate will allow for the expansion of the MMRT program to include more in-depth data collection and analysis. Current efforts of the MMRT only focus on the most current data available each year and/or the topic being reviewed. Due to statutory regulations, data collection from 2015-2017 was halted so that the review team could focus on 2018 data and move forward with more current data. Hiring a MMRT Research Associate will allow for a new tool to be developed so that the 2015-2017 data can be collected and allow for a more comprehensive database in future years. Additionally, the addition of the MMRT Research Associate will give the Maternal Mortality Programs Manager more ability to focus efforts on data analysis, policy development, and data dissemination, as the research associate will be responsible for many of the current administrative tasks managed by the Programs Manager.

FY21 Application Overview: Maternal & Infant Mortality Disparity

State Priority: Maternal Mortality Disparity
FY21 Performance Measure: SOM 2 – Maternal Mortality Disparity

Objective: Eliminate racial disparities in maternal and infant mortality rates by 2025.

Strategy: Sustain state maternal mortality and child fatality review teams.
Domains: Maternal, Perinatal/Infant

Activity	Expected Completion Date	Responsible Staff
Coordination and facilitation of bi-monthly MMRT and CFRT Meetings.	Ongoing	Dr. Dane De Silva (CFRT), Dr. Melanie Rouse (MMRT)
Conduct epidemiological surveillance activities.	Ongoing	Dr. Dane De Silva (CFRT), Dr. Melanie Rouse (MMRT), MMRT Research Associate, CFRT Research Assistant

Maternal Mortality Review Team
Coordination and facilitation of bi-monthly MMRT meeting: Activities under this activity include case selection for each meeting, requesting records from health, social, and community based agencies that will be used in the review, review of those records, and determination of inclusion or exclusion in the review, as well as scanning the record for additional information that could be collected from other providers for use. After each review team meeting, data from the review team meeting is into the MMRIA system by the Maternal Mortality Programs Manager and MMRT Research Associate. The Programs Manager is also responsible for maintaining the recommendations from each review meeting and compiling and review the recommendations quarterly for applicability and appropriateness based on the review topic and current data trends.

Conduct epidemiological surveillance: Activities under this activity will include collection of comprehensive data using a MMRT data tool. The tool will be developed by the Maternal Mortality Programs Manager and Maternal Mortality Research Associate using the Infant and Child Fatality and Domestic Violence tools available in the Division of Death Prevention as the model for the new tool. The research associate will be responsible for collecting data using the tool and entering the data in the MMRT Surveillance Database. The will also work with the Programs Manager to identify data trends, conduct data analysis, and evaluate the tool and the data for quality assurance purposes.

Child Fatality Review Team
Coordination and facilitation of bi-monthly CFRT meeting: Activities under this activity include case selection for each meeting, requesting records from health, social, and community based agencies that will be used in the review, review of those records, and determination of inclusion or exclusion in the review, as well as scanning the record for

additional information that could be collected from other providers.

Conduct epidemiological surveillance: Activities under this activity will include collection of comprehensive data using the already developed Infant and Child Fatality Surveillance Tools. The Child Fatality Research Associate will be responsible for collecting data using the tool and entering the data in the CFRT Surveillance Data Base. They will also work with the Programs Manager to identify data trends, conduct data analysis, and evaluate the tool and the data for quality assurance purposes.

FY21 Application Overview: Community, Family, & Youth Leadership

State Priority: Community, Family & Youth Leadership
FY21 Performance Measure: SOM 2 – Maternal Mortality Disparity

Objective: Eliminate racial disparities in maternal and infant mortality rates by 2025.

Strategy: Explore expanding community engagement in state maternal mortality and child fatality review.
Domains: Maternal, Perinatal/Infant

Activity	Expected Completion Date	Responsible Staff
The OCME will engage the community through multidisciplinary workgroups, review team meetings, and other activities where appropriate.	Ongoing	Dr. Dane De Silva (CFRT), Dr. Melanie Rouse (MMRT), Dr. Ryan Diduk-Smith
The OCME will develop a proof on concept paper that will systematically explore the efficacy and feasibility of including patient or family interviews in the review process or how to include these perspectives in the work that is being done.	September 30, 2021	Dr. Dane De Silva (CFRT), Dr. Melanie Rouse (MMRT), Dr. Ryan Diduk-Smith
Develop action plan to operationalize community leadership in MMRT and CFRT, in partnership with other Title V partners. Consider equity considerations (e.g. power dynamics, dedicated space).	September 30, 2021	Dr. Dane De Silva (CFRT), Dr. Melanie Rouse (MMRT), Dr. Ryan Diduk-Smith, Title V partners.
Identify barriers to community-based organizations (CBOs) delivering preventive, evidence-informed interventions to reducing maternal/infant health disparities.	Ongoing	Title V Team

Child Fatality Review Team

The OCME will engage the community through multidisciplinary workgroups, review team meetings, and other activities where appropriate. This is work is done through the Child Fatality Review Team. The team is chaired by Virginia's Office of the Chief Medical Examiner and includes representation from education, social service and community service boards, psychiatry, injury prevention, health promotion, pediatrics, and other relevant agencies. The purpose of the team is to review topic specific cases and work to provide policy and programmatic recommendations to address the studied topic. Furthermore, the Family Violence Programs Manager sits on a variety of community boards and workgroups addressing child death.

The OCME will also develop a proof of concept paper that will systematically explore the efficacy and feasibility of including patient or family interviews in the review process. There is value in hearing from those that may be personally affected by infant and child death and interviewing individuals or families could be beneficial to the program. Since this is not an activity that has not been done before and due to statuary limitations, this concept must be explored to understand feasibility and efficacy. The proof of concept paper will also explore how to collaborate with agencies such as the Virginia Neonatal Perinatal Collaborative or Citizens Review Panel to address equity and work to address health disparities in infant and child death.

Maternal Mortality Review Team

The OCME will engage the community through multidisciplinary workgroups, review team meetings, and other activities where appropriate. This is work is done through the Maternal Mortality Review Team. The team is chaired by Virginia's Office of the Chief Medical Examiner and Office of Family Health Services and the team includes representation from education, social service and community service boards, psychiatry, injury prevention, health promotion, obstetrics and gynecology, maternal fetal medicine, and other relevant agencies. The purpose of the team is to review topic specific cases and work to provide policy and programmatic recommendations to address the studied topic. Furthermore, the Maternal Mortality Programs Manager sits on a variety of community boards and workgroups addressing child death.

The OCME will also develop a proof of concept paper that will systematically explore the efficacy and feasibility of including patient or family interviews in the review process. There is value in hearing from those that may be personally affected by maternal death and interviewing individuals or families could be beneficial to the program. Since this is not an activity that has not been done before and due to statuary limitations, this concept must be explored to understand feasibility and efficacy. The proof of concept paper will also explore how to partner with agencies such as the Virginia Neonatal Perinatal Collaborative or Citizens Review Panel to address equity and work to address health disparities in infant and child death.

The Maternal Mortality Surveillance Program will assist with identification of barriers to community-based organizations (CBOs) delivering preventive, evidence-informed interventions to reducing maternal/infant health disparities.

FY21 Application Overview: Upstream/Cross-Sector Strategic Planning

---

State Priority: Community, Family & Youth Leadership
FY21 Performance Measure: SOM 2 – Maternal Mortality Disparity

Objective: Eliminate racial disparities in maternal and infant mortality rates by 2025.

Strategy: Continue to engage cross-sector partners and address social determinants of health in development of MMRT and CFRT recommendations.
Domains: Maternal, Perinatal/Infant

Activity	Expected Completion Date	Responsible Staff
For both MMRT and CFRT recommendations, identify opportunities for alignment with Title V investments and partners to address community, environmental, healthcare setting, and provider factors contributing to maternal and child deaths. This can be achieved through the recommendation development during the CFRT and MMRT review process.	September 30, 2021	Dr. Dane De Silva (CFRT), Dr. Melanie Rouse (MMRT), Dr. Ryan Diduk-Smith
Continue to include cross-sector partners for input on recommendations (e.g. housing, transportation, recreation, CBOs) through their inclusion in the MMRT and CFRT teams.	Ongoing	Dr. Dane De Silva (CFRT), Dr. Melanie Rouse (MMRT)
Maintain engagement in monthly VNPC-led Maternal & Infant Sister Agency Workgroup meetings to (1) identify shared goals, priorities, and strategies, (2) eliminate silos across state sister agency maternal and infant leads, and (3) meaningfully collaborate on shared deliverables of interest to improve maternal and infant health outcomes in Virginia.	Ongoing	Carla, OCME, DPHD, VNPC
Collaborate with state sister agencies, community partners, and consumers to identify drivers of disparities in maternal mortality and infant mortality within Virginia.	Ongoing	Carla, OCME, DPHD, VNPC

Child Fatality Review Team

The goal of the CFRT is to develop recommendations that are sustainable, attainable, and measurable. They are also vetted thoroughly to ensure that suggested agencies and programs support the recommendation and would work towards implementing all or some of the recommendation in their scope of practice. During this grant cycle, one goal of the CFRT will be align goals, as they are able with Title V investments and ensure the recommendations address community, environmental, healthcare setting factors identified in the review. The CFRT will also continue to engage (and identify if needed) community partners to address social determinants of health and work towards health equality.

Maternal Mortality Review Team

The goal of the MMRT is to develop recommendations that are sustainable, attainable, and measurable. They are also vetted thoroughly to ensure that suggested agencies and programs support the recommendation and would work towards implementing all or some of the recommendation in their scope of practice. During this grant cycle, one goal of the MMRT will be align goals, as they are able with Title V investments and ensure the recommendations continue address community, environmental, healthcare setting factors identified in the review. This is already an activity in the Maternal Mortality Review Team. The MMRT will also continue to engage (and identify if needed) community partners to address social determinants of health and work towards health equality.

The OCME will collaborate with sister agencies to identify drivers of disparities in maternal and infant mortality. This work will include working with partners to evaluate the implementation of past recommendations and explore how to move recommendations into action.

Budget Update

Title V MCH funds provide support for staffing, travel, software, office supplies, and for further development and implementation of the OCME dashboard. These are necessary costs to support the two teams and their related activities.

Consumer/Family Engagement & Partnership

The CFRT and MMRT contribute to consumer and family engagement and partnership through the continued efforts or reducing child and maternal mortality. The impacts of child and maternal mortality are far reaching, including links to reduce mental health, educational attainment, poverty, and other socioeconomic and disparities that greatly influence a person's wellbeing. Additionally, the work of both the CFRT and MMRT has identified key risk factors that affect child and maternal mortality and the higher number of risk factors, the greater the likelihood of a fatal event. Risk factors include:

Maternal Mortality:

- Chronic diseases
- Chronic mental illness
    - Depression
    - Anxiety
- Chronic substance use disorder
- Intimate partner violence

Child Fatality:

- Housing instability
- Financial instability
- Parental substance abuse
- Low educational attainment
- Criminal activity of the parent(s)
- Prenatal care

Emerging Issues

How has COVID-19 impacted work?

COVID-19 has impacted the work of the Maternal Mortality and Child Fatality Review Teams in a couple of ways. First, there have been delays in receiving case records due to limited staff on site and/or office closings. This has subsequently caused delays in case abstraction and review. Secondly, due to restrictions on in-person meetings, all Maternal Mortality and Child Fatality Review Team meetings will be held virtually until further notice. This has limited the number of cases we are able to review in a single meeting to allow for a more effective and efficient virtual meeting.

Emerging Program Needs

In an effort to fulfill the requirements outlined in the Virginia State Code, the Maternal Mortality Review Team elected to skip the full Team review of the 2015, 2016, and 2017 pregnancy-associated deaths. This was done so that the Team could be more current in the cases that are being reviewed and in the reporting of maternal mortality data to State officials. However, all data for 2015, 2016, and 2017 will be collected and entered into the MMRIA system. Moving to more current case review, while necessary, has created a backlog of cases that need to be abstracted into the database. As such, there is a need for a research assistant that can perform data entry for the backlogged cases, as well as, assist the Team with other administrative items.

Key National Trends/Evidence

As the focus on maternal mortality and child and infant mortality has increased, review teams across the U.S. have found significant racial and ethnic disparities in mortality ratios between Black and White populations. This has led to an increase in focus on the social/environmental determinants that contribute to these deaths, including systemic racism, personally mediated racism and discrimination. In an effort to reduce these disparities, the CDC has encouraged states to explore incorporating the community perspective and family interviews. The Virginia MMRT and CFRT plans to perform a proof of concept to explore the best way to incorporate both the community perspective and family interviews as a part of our efforts to reduce racial disparities in maternal and child mortality in Virginia.

III. Reproductive Health Program

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

- Adolescent Health
- Resource Mothers
- Virginia Contraceptive Access Initiative
- Title X Family Planning
- State Funding of Certain Abortions

The Adolescent Health Program is led by Madeline Kapur, MPH, MSW (Adolescent Health Coordinator). The Resource Mothers Program is led by Consuelo Staton, MEd. (State Resource Mothers Coordinator).

FY21 Application Overview: Maternal Mortality Disparity

State Priority: Maternal Mortality Disparity

FY21 Performance Measure: SOM 2 – Maternal Mortality Disparity

Objective: Eliminate racial disparities in maternal and infant mortality rates by 2025.

Strategy: Work with stakeholders to increase access to doula services among women of color.

Domains: Women's/Maternal, Perinatal/Infant

Activity	Expected Completion Date	Responsible Staff
Develop and finalize regulations related to a state certification process for doulas in Virginia	December 2020	Emily, Consuelo
Launch a searchable database listing state-certified doulas	March 2021	Emily, Consuelo
Develop a plan for removing financial barriers for doulas among women of color	September 2021	Emily, Consuelo, Carla
Maintain and strengthen partnerships with state Medicaid agency to explore a doula benefit	September 2021	Carla
Explore workforce development scholarships and outreach for aspiring doulas with a demonstrated commitment to eliminating racial disparities in maternal//infant mortality. This may strengthen the pipeline of doulas serving women of color and assure adequate access.	September 2021	Carla

In 2020, the Virginia General Assembly passed a bill requiring Virginia to develop a state certification program and database for doulas working in the Commonwealth. During FFY21, VDH intends to work with stakeholders to finalize regulations guiding this process. Once the regulations are finalized, VDH will leverage existing resources and partnerships to launch a searchable database to allow members of the public to easily find a doula that meets their needs. While this infrastructure is being launched, VDH will also work to develop an action plan to make doulas more accessible to women of color. Increasing access to trained, culturally-competent doulas would directly address the documented racial/ethnic disparities in maternal mortality by providing support to women during the prenatal, birthing, and postpartum period. This plan will be finalized in September 2021 after fielding input from stakeholders and reviewing data provided by the Division of Population Health Data.

The Virginia General Assembly also passed a bill requiring the Department of Medical Assistance Services (DMAS) to conduct a rate study to determine appropriate reimbursement rates for doula services provided to Medicaid recipients. The Title V Director has been working to strengthen relationships across MCH programs with DMAS; she has been been invited to serve on DMAS' workgroup and to join a team participating in a virtual learning series on leveraging midwifery-led care to address disparities and equity in Medicaid.

In addition to reducing financial barriers for women seeking doulas, the Title V program will explore opportunities to reduce financial barriers to becoming a doula, particularly for doulas with demonstrated commitment to eliminating maternal/infant mortality disparities. This may involve collaborating on pipeline initiatives with historically-Black colleges and universities (HBCUs) and other partners.

State Priority: Reproductive Justice & Support
FY21 Performance Measure: SPM 4 – Pregnancy Intention: Mistimed pregnancy- wanted to become pregnant

later or never

Objective: Reduce the rate of mistimed pregnancies from 25.3% (PRAMS 2018) to 21.8% by 2025.

VA PRAMS data for 2018 showed that 44.5% of respondents had an unintended pregnancy, while 25.3% had a mistimed pregnancy (wanted to become pregnant later/never). There were observed differences by race and ethnicity:

Pregnancy Intention	White, non-Hispanic	Black, non-Hispanic	Hispanic
Unintended Pregnancy	37.8%	65.5%	49.2%
Mistimed pregnancy- wanted to become pregnant later/never	20.7%	38.3%	27%

Strategy: Work with stakeholders to remove policy, financial, and training barriers to contraceptive access.
Domain: Women's/Maternal, Adolescent

Activity	Expected Completion Date	Responsible Staff
Facilitate biannual LARC stakeholder workgroup meetings	Ongoing	Emily
Administer the Virginia Contraceptive Access Initiative	Ongoing until June 2022	Emily, Janelle Anthony (Family Planning Quality Assurance Nurse Supervisor)
Evaluate the impact of the Virginia Contraceptive Access Initiative	Ongoing until June 2023	Emily, Janelle, Nika Anwell (Special Projects Analyst, Division of Population Health Data)
Support efforts to increase the number of pharmacists prescribing and dispensing contraception	Ongoing	Emily

The LARC Stakeholder Workgroup is a network of agencies working to reduce unintended pregnancies among women of childbearing age and increase access to quality comprehensive family planning services. This workgroup was specifically developed to increase access to the moderately and most effective contraceptive methods, including during the immediate postpartum period. This workgroup holds biannual virtual meetings and includes over 70 members from a variety of community-based health centers, governmental organizations, hospital systems, payers, and community members. VDH intends to continue facilitating this network during FFY21, and work with partners to identify opportunities for provider trainings and public education.

During FY19, VDH launched the Virginia LARC Initiative, a $6 million pilot program designed to increase access to hormonal LARCs among low-income women. In 2020, the Virginia General Assembly voted to continue this program through SFY22 and expand it to include all FDA-approved methods of contraception for eligible patients. Given the positive public health impact of making family planning services available to patients regardless of ability to pay, VDH anticipates that the Virginia Contraceptive Access Initiative (formerly known as the Virginia LARC Initiative) will

achieve positive health outcomes. To demonstrate this, VDH intends to monitor both patient-level and aggregate-level data as the program progresses.

VDH maintains contracts with eighteen community agencies to offer contraception to qualifying patients, and then reimburses participating providers using TANF funds. As of July 31, 2020, VDH has provided funding for 3,986 patient encounters. The majority of patients (59%) were 100% or below the federal poverty level. Given that 52% of patients identify as Hispanic/Latino and 15% identify as Black/African American, the LARC Initiative is also addressing the documented ethnic/racial disparities in accessing comprehensive family planning services, particularly among Latinx communities.

Because TANF funds only support provider reimbursements for contraception, LARC insertions, and LARC removals, administrative support for the Virginia Contraceptive Access Initiative is funded by VDH's federal Title V Maternal and Child Health Block Grant. The VDH Reproductive Health Unit manages all programmatic components of the Virginia Contraceptive Access Initiative, including reviewing subrecipient invoices, entering patient data into the REDCap system, administering contracts, and monitoring program impact and expenditures.

The Virginia General Assembly has allocated money to the Virginia Contraceptive Access Initiative through June 30, 2022. The full impact of this pilot program will not be apparent until well after its conclusion, given that unintended pregnancy, teen pregnancy, and abortion rates are released on a two-year delay. After the pilot program ends, VDH intends to continue monitoring this data through its Office of Information Management and Division of Population Health Data. Furthermore, VDH has entered an agreement with Vanderbilt University to conduct a formal evaluation of VDH's efforts at the conclusion of the program. VDH anticipates lower teen pregnancy and abortion rates among areas with a high concentration of patients served through the Virginia LARC Initiative. In the meantime, VDH intends to track and report the following information:

- Demographic information about patients served, including race, ethnicity, and income;
- Number of patients served with a substance use diagnosis;
- Geographic analysis of patient residence and provider zip codes; and
- Patient satisfaction.

In 2020, the Virginia General Assembly passed a bill allowing pharmacists to prescribe and dispense specific medications to patients, including naloxone, epinephrine, prenatal vitamins, and contraception. During the summer of 2020, VDH worked with the Board of Pharmacy and other stakeholders to develop protocols for pharmacists to use when offering these services. These protocols will likely be finalized by the end of the year. During FFY21, VDH intends to work with stakeholders to roll out these protocols, and provide support and education to pharmacists as they begin to offer this service. VDH anticipates that this project will need continual support over the next several years to educate pharmacists on this policy change and encourage participation in this public health initiative. VDH will continue to work with the Board of Pharmacy to identify and respond to needs as they arise, but immediate needs will likely include provider and public education campaigns. Ultimately, Virginia's new prescribing law has the potential to make contraception more readily available to women of reproductive age, particularly in rural areas where retail pharmacies may be more accessible than family planning providers.

Strategy: Explore opportunities for providing support to families seeking fertility services and families experiencing miscarriage.
Domain: Women's/Maternal

Activity	Expected Completion Date	Responsible Staff
Assess Title V administrative and financial capacity for responding to the needs identified in the Title V needs assessment regarding fertility and miscarriage support	December 2020	Emily
Develop a plan for supporting families seeking fertility services and miscarriage that incorporates a reproductive justice lens	September 2021	Emily

Although at least 10-15% of pregnancies end in miscarriage, many families do not have a space to openly discuss pregnancy loss and the feelings associated with it. Feelings may include a combination of sorrow, confusion, relief, and blame, and due to the shame associated with miscarriage, many feel hesitant to share their experiences with others. Families experiencing infertility also lack a space to share their experiences, which is then paired with a lack of affordable infertility services beyond basic services provided in Title X family planning clinics. Due to stigma and lack of services, both miscarriage and infertility can lead to emotional isolation among families. In the Title V Needs Assessment, focus group participants highlighted these issues as needed additional support. During FFY21, the reproductive health team will build on the work of the needs assessment by assessing the capacity of the Title V project to provide support around these issues and then developing a concrete plan for doing so.

Budget Update

In 2020, the Virginia General Assembly voted to extend and expand the Virginia Contraceptive Access Initiative, authorizing the program to continue offering contraception to low-income and uninsured Virginians for the next two years. As a result, Title V monies are still needed to continue administering the program. Likewise, VDH's initiates around doulas have not received state funding, therefore Title V monies are needed to support staff time and effort on this work.

Challenges & Barriers

The COVID-19 pandemic has led to a drop in patients accessing family planning services. Although Governor Northam explicitly named family planning services as an essential service during Virginia's initial stay-at-home order, patients were understandably reluctant to leave their homes and workplaces for preventive care visits. Furthermore, clinic staff were often pulled to assist with the COVID-19 response effort, and as a result, fewer appointment slots were available for family planning visits. While many providers are now taking advantage of telehealth platforms, some contraceptive methods such as the IUD, implant, and shot still require an in-person visit. VDH is encouraging sites to use telehealth whenever possible and prioritize in-person visits for patients whose visits require a physical exam.
To protect the health of both staff and clients, Virginia has ceased offering home visiting services in the home during the COVID-19 pandemic. Home visiting programs like Resource Mothers are encouraged to offer services virtually through doxy.me, a secure telehealth platform. Doxy.me licenses have been purchased for all Resource Mothers sites, and all sites have received training on using the program. Resource Mothers is working with the Children's Hospital of Los Angeles, the program developer of AIM4TM, to develop strategies for offering AIM4TM electronically during the pandemic. However, due to lack of equitable broadband access across the Commonwealth, not all sites are able to take advantage of telehealth and not all families are able to support telehealth on their mobile devices. VDH is still exploring ways to address these barriers.

IV. Dental Health Program Overview

The Division of Prevention and Health Promotion's Dental Health Program is led by Tonya McRae Adiches, RDH (Dental Health Programs Manager).

JoAnn Wells, BSHS, RDH, serves as the Maternal, Infant, and Adolescent Oral Health Consultant. Kami Piscitelli, BSDH, RDH, serves as the Special Needs Oral Health Coordinator.

The Division of Prevention and Health Promotion's Dental Health Program (DHP) provides:

- Educational activities and resources to a wide variety of partner groups to promote proper oral hygiene and support prevention services and access to dental care (CDC Oral Health Outcome Improvement Grant and State General Funds);
- Direct clinical preventive services and assistance with establishing a dental home (State General Funds);
- Quality assurance reviews to assure a competent public health oral health workforce (State General Funds); and
- Surveillance and evaluation activities to monitor and track dental disease rates and trends and for Program assessment of effectiveness and planning (CDC Oral Health Outcome Improvement Grant and HRSA Oral Health Workforce Grant).

The DHP 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).

The DHP has many internal partners including other VDH MCH programs and the statewide Virginia Health Catalyst (VHC) (formerly the Virginia Oral Health Coalition). VHC is a non-profit organization that serves as the only statewide coalition in the Commonwealth focused on oral health as an integral component of overall health and wellness. It is a diverse group working to ensure that all Virginians have equitable access to comprehensive health care that includes oral health through policy change, public awareness and innovative programs. The VHC works closely with VDH to implement grant objectives and has in-depth knowledge of the Virginia Oral Health Plan and the Virginia Oral Health Report Card, foundations that prioritizes oral health activities statewide. VHC has access to a diverse network of key, statewide stakeholders, and the unique ability to share oral health information with both key partners and the public. Catalyst staff understand the need to continually promote oral health at the local level, support local initiatives to affect meaningful change, and to evaluate efforts to ensure ongoing, comprehensive support for structural sustainability.

Program activities aimed at increasing oral health care for pregnant women, infants, children, and individuals with special healthcare needs within the DHP are the Perinatal and Infant Oral Health Program, Bright Smiles for Babies Fluoride Varnish Program, and the Dental Preventive Services Program. These programs are funded by State General Funds.

The Perinatal and Infant Oral Health Program aims to improve access to oral health care for pregnant women and infants who are most at risk for disease through integration of dental services and information into the primary care delivery system. Additionally, this program allows for expansion of the existing Virginia Oral Health Surveillance System to include data collection, analysis, and reporting of indicators regarding pregnant women and infants.

Programs for children are described within the Child Health application.

FY21 Action Plan Overview: Oral Health

State Priority: Oral Health
FY20 Performance Measure: NPM 13.1 - Percent of women who had a dental visit during pregnancy

OBJECTIVE: By June 30, 2025, increase the percent of women who had a dental visit during pregnancy from 50.8% (PRAMS 2018) to 52.9%.

VA PRAMS data for 2018 showed that 50.8% of respondents had a preventive dental visit during pregnancy. There were 14.3% of respondents that needed to see a dentist about a problem and 23.2% of respondents had no insurance to cover dental care.

Strategy: Maintain and expand existing MCH-focused dental education programs to improve oral health for individuals across the lifespan, to include advising on oral health integration in primary care settings, education for home visitors, school-aged oral health education, and emerging needs of adolescents.
Domains: Women/Maternal, Child, Adolescent

Activity	Expected Completion Date	Responsible Staff
Maintain salary support for an experienced oral health educator to focus on maternal, infant and adolescent oral health	Ongoing	Tonya Adiches – Dental Health Programs Manager
Support and advise statewide preventive services teams on oral health integration in primary care settings	Ongoing	JoAnn Wells - Maternal, Infant, and Adolescent Oral Health Consultant (MIAOHC)
Continue to provide education and trainings aimed at perinatal and infant oral health including education for home visitors and other family support workers	Ongoing	MIAOHC
Continue to review School-aged Oral Health Curriculum and revise, as needed, based on emerging issues (HPV, Vaping) and current Standards of Learning (SOL) requirements	Ongoing	MIAOHC
Continue to utilize current information obtained through literature review regarding the need for oral health education for adolescents on emerging issues, assess the individual needs of schools in each of the 5 Health Planning Districts	March 2021	MIAOHC
Plan and implement educational initiatives and trainings including development of educational material and social media content related to adolescent oral health	Ongoing	MIAOHC
Evaluate initiatives and trainings to ensure that goals are met	Ongoing	MIAOHC

In FY19, VDH worked to increase access to care for pregnant women and young children through the Federal Perinatal and Infant Oral Health Quality Improvement Grant. While this work was impactful, there remains a need to continue successful activities related to perinatal oral health and to integrate educational initiatives into the program that also target adolescents. Thus, MCH funds were approved to support a Maternal, Infant, and Adolescent Oral Health Consultant (MIAOHC).

During FY20, through the work of a dedicated MCH-funded MIAOHC, VDH continued to rely on a proven remote supervision dental hygienist model to integrate dental services and education into primary care settings; to support home visitors, community health workers and other client support workers in educating their clients on the benefits of oral health and to coordinate oral care; to collaborate with key partners and local stakeholders to maximize reach and effectiveness of oral health messaging; and to train dental and non-dental professionals on the importance of oral health care for overall wellness with the goal of improving access to oral health care for pregnant women and infants who are most at risk for dental disease.

While this work continues, new programming specifically aimed at advancing the oral health of adolescents began in FY20. Activities included updating the School-aged Oral Health Curriculum to include emerging topics for adolescents including vaping, and HPV exposure and vaccination. In FY21, these activities will continue as trainings and educational material related to these new topics of focus will be developed to highlight the importance of vape cessation and HPV prevention to combat oral cancer, as well as early detection of this disease in youth and young adults.The MIAOHC will also provide pertinent MCH related information to partners as a member of the Early Dental Home Workgroup and Project Immunize Virginia. The Early Dental Home Workgroup consists of partners from dentistry, early childhood education, and perinatal and pediatric health, as well as state agencies that offer social and health support services. The workgroup identifies promising practices and techniques to increase the number of young kids and pregnant women who access dental care. Project Immunize Virginia (PIV) is a team of energetic and innovative health professionals, business, and community members that believe every community in the Commonwealth can be free of vaccine-preventable disease by increasing immunizations across the lifespan. PIV achieves this by promoting partnerships and using effective strategies among its member organizations throughout the Commonwealth.

Strategy: Sustain network of 5 regional Oral Health Alliances and distribute mini-grants for implementation of systems change and data-sharing initiatives to improve the oral health of all Virginians, with emphasis on pregnant women, and children and adolescents aged 1-17.
Domains: Women/Maternal, Child, Adolescent

Activity	Expected Completion Date	Responsible Staff
Re-evaluate the need to continue current community-led strategies to improve oral health in regions or develop new strategies	January 2021	VHC
Support development and implementation of project work plans to support regionally identified projects	February 2021	VHC
Disseminate information to state level partners and other regional alliance members to inform statewide activities and planning	February 2021	VHC
Disseminate micro grants to support alliance efforts	April 2021	VHC

VDH will continue to partner with the VHC to provide backbone support and facilitative leadership training to 5 Regional Alliances (South Hampton Roads, Northern Virginia, Richmond/Petersburg, Southside, and Central Virginia) to conduct regional oral health needs assessments, develop and implement regional project work plans, and share region-specific data among state and local partners. Staffs will also work together to develop and disseminate communications, to include white papers addressing MCH populations.

Strategy: Convene statewide groups focused on targeted oral health issues (e.g. Water Equity Taskforce, Early Dental Home workgroup, Future of Oral Health workgroup), facilitate collaboration and workplan development, and provide leadership and oversight to guide initiatives.

Domains: Women/Maternal, Child, Adolescent

Activity	Expected Completion Date	Responsible Staff
Continue to seek out diversity in appropriate state-wide organizational and community partners to participate in a Water Equity Taskforce (WET)	Ongoing	VHC
Continue to convene a water equity workgroup and host meetings virtually	Ongoing	VHC
Continue to develop and implement a workplan to support identified goals around water equity in Virginia	Ongoing	VHC
Continue convening the Early Dental Home workgroup, including providing oversight regarding program direction, participating in discussions related to allocation and management of resources, and sharing responsibility for the identification and maximization of community ownership to sustain the EDH workgroup's projects beyond the grant year	Ongoing	Tonya Adiches – Dental Health Programs Manager, VHC
Continue to identify existing groups working on HPV in Virginia and approach these groups about VHC participating as a collaborative partner	Ongoing	VHC
Ensure oral health initiatives are integrated into the workplans and projects conducted by existing HPV workgroups, with specific focus on dental visits and oral cancer education and screenings for children under 17, pregnant women, and their families	Ongoing	VHC
Convene the Virginia Oral Health Summit focused on community engagement to provide trauma-informed care, oral health and systemic health, and health equity education to providers	October 2021	VHC
Continue to convene the Future of Oral Health Work Group focused on the future of oral health care delivery in Virginia following the COVID-19 pandemic and considering other environmental changes, upcoming trends in healthcare, and policy forecasts	June 2021	VHC

VDH will continue to partner with VHC to convene a statewide workgroup focused on the future of oral health care delivery in Virginia following the COVID-19 pandemic and considering other environmental changes, upcoming

trends in healthcare, and policy forecasts. The VHC will engage a wide variety of partners to assemble participants including the Department of Medical Assistance Services, an MCO, maternal health providers, dental providers, and other community partners, while also leveraging the Catalyst's Clinical Advisory Board (CAB) to provide expertise on the statewide future-focused workgroup. The VHC will also engage other clinical expertise, as needed, to offer additional technical assistance and guidance to the workgroup. HRSA Oral Health Workforce Grant funds will be leveraged to implement a pilot program aimed at putting the workgroups ideas into action through a contract with a safety-net site to carry out future-focused projects including developing teledentistry capabilities to improve access to care.

VDH continues to partner with the VHC to convene a state-wide group focused on enhancing water equity in Virginia. The Water Equity Taskforce (WET) aims to enhance water equity across Virginia to ensure all residents have access to safe fluoridated tap water. In addition to DHP staff, WET engages a cross-sector of partners including representatives from the Office of Drinking Water, the Virginia Department of Forestry, the Virginia Department of Social Services, as well as rural and urban safety-net dental providers, professional dental and dental hygiene associations, and service organizations for health youth and low-income families. WET currently has two workgroups that were formed, one on access and affordability and the other on consumer literacy. A priority for the group is creation of a Virginia Water Equity Roadmap to serve as a framework for water equity information, priorities, and activities in Virginia.

VHC will also continue convening the Early Dental Home (EDH) workgroup and collaborate with existing groups working on HPV to ensure oral health is integrated into their approach and goals. Additionally, the VHC will expand community engagement and provide trauma-informed care, oral health and systemic health, and health equity education to providers at the Virginia Oral Health Summit. Annually, the Summit reaches nearly 250 providers, public health stakeholders and caregivers, who attend to learn skills to improve the health and wellbeing of the individuals they serve. In 2021, the summit seeks to highlight best practices and the expertise of state and national experts so that attendees can work collectively to increase equitable access to quality health care, with a focus on oral health.

Snapshot of Program Accomplishments

- VDH completed an action plan for integrating oral health into MCH activities by identifying strategies and partners for addressing 3 MCH population oral health needs in Virginia - women, infants, and children. This includes providing support to the Virginia Health Catalyst (VHC) to facilitative leadership training to 6 Regional Oral Health Alliances.
- 204 dental providers participated in VDH-sponsored continuing education courses regarding the oral health care of ISHCN, early childhood, and/or perinatal/pregnant women. In addition, the ISHCN program coordinator provided various oral health education courses attended by 161 lay health workers/home visitors/family educators and 48 medical professionals.

Data-Informed Strategies

A survey of WIC clients completed as part of another grant program demonstrated that the number of pregnant women aware of the comprehensive Medicaid dental benefit decreased between 2017 and 2018. This informs a need to improve awareness among pregnant women and their caregivers about the comprehensive Medicaid pregnancy dental benefit. Furthermore, studies are demonstrating the health- and cost-savings in utilizing community health workers and home visiting models to route pregnant women and children to oral health care providers. Additionally, data from the Virginia Oral Health Report Card, which measures Virginia against the nation on nine oral health indicators, is leveraged to engage regional oral health alliance leadership around efforts to improve

community health. A literature review regarding oral health found that vaping and HPV are important topics to add to oral health education for adolescents and young adults.

Inclusion of Family Voices

Work plan activities included in Strategies 1 and 2 were partially predicated on information gained from surveys of caregivers and community health workers, who work one-on-one with the community, to lift up concerns and barriers that their loved ones and client families faced regarding oral health. Regional oral health alliances also provide an opportunity for families, community health providers, and population groups leadership to lead changes in health improvement and awareness, with backbone support from the Virginia Health Catalyst.

Health Equity

Convening regional alliances across the state allows for the development of initiatives and activities that target the unique needs of communities and allow for equitable distribution of resources based on local level needs across all geographic locations in the state. The provision of fluoride through community water fluoridation provides a means of delivering the benefits of a proven cavity reducing intervention to all people of a community regardless of race, income, educational attainment or other factor that affects equitable care.

Budget Update

In FY20, MCH funds supported the salary of the ISHCNOH Coordinator and MIAOH Consultant, billing support for the Commonwealth's clinical prevention programs, and 25% of both a dental epidemiologist and evaluator to assist with surveillance and evaluation. Funding also supported the development of regional oral health alliances through the VHC.

For FY21, MCH funds will continue to support the positions above. Approximately $200,000 in funds will be allotted to the VHC to support grant-funded activities that they are uniquely qualified to carry out including supporting the regional oral health alliances and convening statewide stakeholders to impact systems change.

Challenges & Barriers

Regional and grassroots leadership are vital to advance the grant goals and policy changes that increase access to oral health care for pregnant women, children, and families. Thus, VHC continues to engage community leaders through its regional oral health alliances; these alliances are provided backbone support to address the unique issues they face and a platform to ensure their efforts are heard among state leaders and align with statewide initiatives.

Furthermore, fluoridation promotion efforts have demonstrated a broader need to improve water system infrastructure and public awareness and trust in public drinking water. Thus, the MCH funding will continue to support convening of a statewide water task force and other necessary groups, as identified, to address public health equity concerns.

Consumer/Family Engagement & Partnership

The federal PIOHQIE grant required an advisory group made up of stakeholders interested in perinatal, infant and children's oral health, who represented a variety of constituencies and clients. The quarterly convening of this group provided a platform for information sharing and partnering to implement changes in oral health for these populations.

It was in this setting that sustaining the work of the PIOHQIE grant and adding strategies related to adolescent oral health was lifted up as a priority and the groundwork for the MIAOH consultant was laid. This group will continue to advise the work of this position.

VHC convenes groups who represent and serve families, youth, caregivers, and women through its regional alliances, Early Dental Home Workgroup, and trainings for home visitors. These partners conduct needs assessments and provide feedback on the issues that pregnant women, children, and families face when impacting oral health care. Of note, VHC is currently working with a home visiting organization to ensure they are able to help clients understand the Medicaid pregnancy dental benefit and find a provider who can provide them with dental care. The home visiting organization has a key role in VHC's Early Dental Home Workgroup, which will continue to convene with support from MCH grant funding. Additionally, VHC is providing a forum for community partners to present at the annual Virginia Oral Health Summit about innovative projects that have increased access to oral health care in the communities they serve.

V. Virginia Neonatal-Perinatal Collaborative (VNPC)

VDH receives non-match general funds through the General Assembly to support the VNPC. In FY19, the Title V-funded Maternal/Infant Health Coordinator provided administrative and fiscal/operational support for the VNPC and served on the Steering Committee. The MCH epidemiology team provided data support.

Beginning in 2020, administrative and operational leadership for the VNPC was moved to Virginia Commonwealth University (VCU).

VCU hired Shannon Pursell, the previous Maternal/Infant Health Coordinator, to serve as VNPC Director of Operations.

A pass-through contract was established between VDH and VCU to administer state funds for the VNPC. Jennifer MacDonald (Director, Division of Child and Family Health) manages this contract. She assumed Ms. Pursell's seats on the Steering and Executive Committees in FY20. In FY21, the Title V Director will begin sitting on the Executive Committee.

Planned activities are detailed below:

FY21 Application Overview: Maternal Mortality Disparity

State Priority: Maternal Mortality Disparity
FY21 Performance Measure: SOM 2 – Maternal Mortality Disparity

OBJECTIVE: Eliminate the racial disparity in maternal and infant mortality rates by 2025.

Strategy: Maintain Title V representation on the Virginia Neonatal Perinatal Collaborative's Steering and Executive Committees, and develop a shared visioning and planning document specific to the VDH-VNPC relationship.
Domain: Women's/Maternal, Perinatal/Infant

Activity	Expected Completion Date	Responsible Staff
Jointly compile, review, analyze, and summarize available state and local data relevant to maternal and infant mortality and morbidity.	September 2021	Jennifer, Carla, VNPC, DPHD
Craft a shared vision plan.	September 2021	Jennifer, Carla, VNPC, DPHD
Prioritize 2-3 key strategic projects for the 5-year grant cycle.	September 2021	Jennifer, Carla, VNPC, DPHD
Maintain DCFH representation on the VNPC Steering Committee and continue to administer state General Fund contract.	Ongoing	Jennifer
Maintain Title V representation on the VNPC Executive Committee.	Ongoing	Carla
Continue to support VNPC data capacity.	Ongoing	Meagan, DPHD

Strategy: Launch CDC Project LOCATe by June 2022.
Domain: Women's/Maternal, Perinatal/Infant

Activity	Expected Completion Date	Responsible Staff
In Year 1, compile, review, analyze, and summarize available state and local data.	June 2021	VNPC, DPHD, Jen, Carla
Secure buy-in from relevant state and hospital stakeholders.	June 2021	VNPC, DPHD, Jen, Carla
Identify needs for training, education, and systems supports.	June 2021	VNPC, DPHD, Jen, Carla
In Year 2, develop full implementation plan.	June 2022	VNPC, DPHD, Jen, Carla
Develop and launch training and education for state and hospital partners.	June 2022	VNPC, DPHD, Jen, Carla
Formally launch Project LOCATe.	June 2021	VNPC, DPHD, Jen, Carla

Strategy: Launch health disparities dashboard by June 2022.
Domain: Women's/Maternal, Perinatal/Infant

Activity	Expected Completion Date	Responsible Staff
In Year 1, in partnership with VHHA and VNPC, create health disparities dashboard and load data.	June 2021	VNPC
Train hospitals on use of dashboard.	June 2021	VNPC
Launch public-facing dashboard.	June 2021	VNPC
In Year 2, analyze and summarize data.	June 2022	VNPC
Begin using data to inform strategic activities/projects and select projects.	June 2022	VNPC

Strategy: Launch health disparities dashboard by June 2022.
Domain: Women's/Maternal, Perinatal/Infant

Activity	Expected Completion Date	Responsible Staff
In Year 1, create stillbirths dashboard and load hospital data.	June 2021	VNPC
Train hospitals on use of dashboard.	June 2021	VNPC
Launch public-facing dashboard.	June 2021	VNPC
In Year 2, analyze and summarize data.	June 2022	VNPC
Begin using data to inform strategic activities/projects and select projects.	June 2022	VNPC

Perinatal/Infant Health

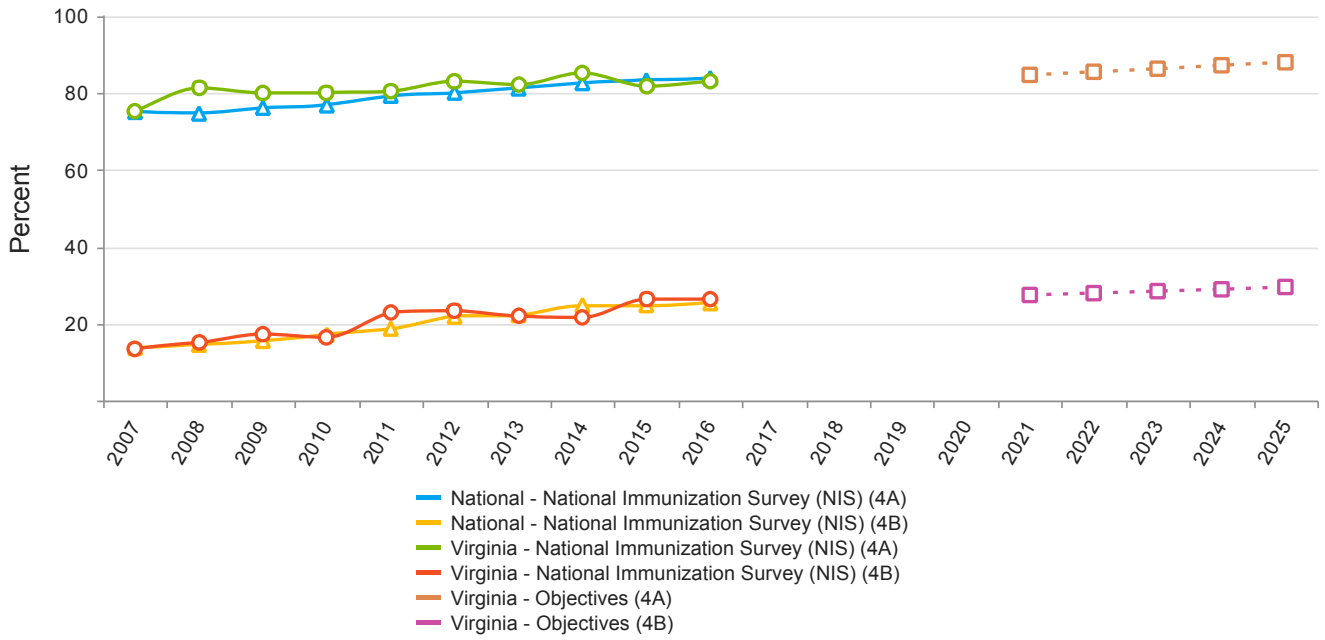
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2017	5.9	NPM 4 NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2017	1.9	NPM 4 NPM 5
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2017	97.6	NPM 4 NPM 5

National Performance Measures

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

Indicators and Annual Objectives



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2019
Annual Objective	
Annual Indicator	82.9
Numerator	73,338
Denominator	88,459
Data Source	NIS
Data Source Year	2016

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	84.6	85.4	86.2	87.1	87.9

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

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2019
Annual Objective	
Annual Indicator	26.4
Numerator	22,710
Denominator	85,942
Data Source	NIS
Data Source Year	2016

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	27.5	28.0	28.5	29.0	29.6

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Development of a coordinated action plan of gap-filling activities for breastfeeding programming across VDH divisions

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	Yes	Yes	Yes	Yes	Yes

State Outcome Measures

SOM 1 - Infant Mortality Disparity: Infant Mortality Disparity Ratio

Measure Status:	Active

State Provided Data		
	2018	2019
Annual Objective		
Annual Indicator	2.2	2
Numerator	9.6	9.7
Denominator	4.4	4.9
Data Source	VDH OIM	VDH OIM
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	1.8	1.7	1.6	1.5	1.4	1.3

State Action Plan Table

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

Priority Need

Community, Family, & Youth Leadership: Provide dedicated space, technical assistance, and financial resources to advance community leadership in state and local maternal and child health initiatives.

NPM

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

Objectives

1. Increase the number of infants ever breastfed from 82.9% (NIS 2016) to 87.9% by 2025; 2. Increase the number of infants breastfed exclusively through 6 months from 26.4% (NIS 2016) to 29.6% by 2025

Strategies

Solicit community voice to inform identification of key needs for breastfeeding, parenting, and childcare supports for Black mothers, in preparation for offering mini-grants to support development of baby-friendly communities.

ESMs	Status
ESM 4.1 - Development of a coordinated action plan of gap-filling activities for breastfeeding programming across VDH divisions	Active

NOMs

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

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

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

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

Priority Need

MCH Data Capacity: Maintain and expand state MCH data capacity, to include ongoing needs assessment activities, program evaluation, and modernized data visualization and integration.

NPM

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

Objectives

1. Increase the number of infants ever breastfed from 82.9% (NIS 2016) to 87.9% by 2025; 2. Increase the number of infants breastfed exclusively through 6 months from 26.4% (NIS 2016) to 29.6% by 2025.

Strategies

Complete evaluation of Five-Star Breastfeeding-Friendly Hospital Recognition Program.

ESMs	Status
ESM 4.1 - Development of a coordinated action plan of gap-filling activities for breastfeeding programming across VDH divisions	Active

NOMs

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

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

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

State Action Plan Table (Virginia) - Perinatal/Infant Health - Entry 3

Priority Need

Maternal and Infant Mortality Disparity: Eliminate the racial disparity in maternal and infant mortality rates by 2025.

SOM

SOM 1 - Infant Mortality Disparity: Infant Mortality Disparity Ratio

Objectives

Eliminate the racial disparity in maternal and infant mortality rates by 2025.

Strategies

Explore opportunities to develop and pilot racial equity curricula at Virginia colleges and universities providing medical, nursing, dental, and other clinical health professional training.

Develop and mobilize strong interagency, multisector, and community partnerships to address disparities in maternal and infant mortality rates.

Sustain state maternal mortality and child fatality review programs.

Work with stakeholders to increase access to doula services among women of color.

Maintain Title V representation on the Virginia Neonatal Perinatal Collaborative's Steering and Executive Committees, and develop a shared visioning and planning document specific to the VDH-VNPC relationship.

Launch CDC Project LOCATe by June 2022.

Launch health disparities dashboard by June 2022.

Launch VNPC stillbirths dashboard by June 2022.

Increase capacity of youth-serving agencies to implement AIM4TM, an evidence-based pregnancy prevention program designed for parenting teens.

Assure Resource Mothers staff are trained in the Growing Great Kids curriculum, a skills-driven program designed to promote healthy child development and strengthening protective factors for families in a home visiting setting.

Support training, support, and evaluation for home visiting programs, to include MIECHV, Healthy Start, and Early Impact Virginia.

State Action Plan Table (Virginia) - Perinatal/Infant Health - Entry 4

Priority Need

MCH Data Capacity: Maintain and expand state MCH data capacity, to include ongoing needs assessment activities, program evaluation, and modernized data visualization and integration.

SOM

SOM 1 - Infant Mortality Disparity: Infant Mortality Disparity Ratio

Objectives

Eliminate the racial disparity in maternal and infant mortality rates by 2025.

Strategies

Sustain and expand data capacity within the Office of the Chief Medical Examiner’s related to maternal, infant, and child health.

State Action Plan Table (Virginia) - Perinatal/Infant Health - Entry 5

Priority Need

Community, Family, & Youth Leadership: Provide dedicated space, technical assistance, and financial resources to advance community leadership in state and local maternal and child health initiatives.

SOM

SOM 1 - Infant Mortality Disparity: Infant Mortality Disparity Ratio

Objectives

Eliminate the racial disparity in maternal and infant mortality rates by 2025.

Strategies

Explore expanding community engagement in state maternal mortality and child fatality review.

State Action Plan Table (Virginia) - Perinatal/Infant Health - Entry 6

Priority Need

Upstream / Cross-Sector Strategic Planning: Eliminate health inequities arising from social, political, economic, and environmental conditions through strategic, nontraditional partnerships.

SOM

SOM 1 - Infant Mortality Disparity: Infant Mortality Disparity Ratio

Objectives

Eliminate the racial disparity in maternal and infant mortality rates by 2025.

Strategies

Continue to engage cross-sector partners and address social determinants of health in development of MMRT and CFRT recommendations.

State Action Plan Table (Virginia) - Perinatal/Infant Health - Entry 7

Priority Need

Finances as a Root Cause: Increase the financial agency and well-being of MCH populations.

SOM

SOM 1 - Infant Mortality Disparity: Infant Mortality Disparity Ratio

Objectives

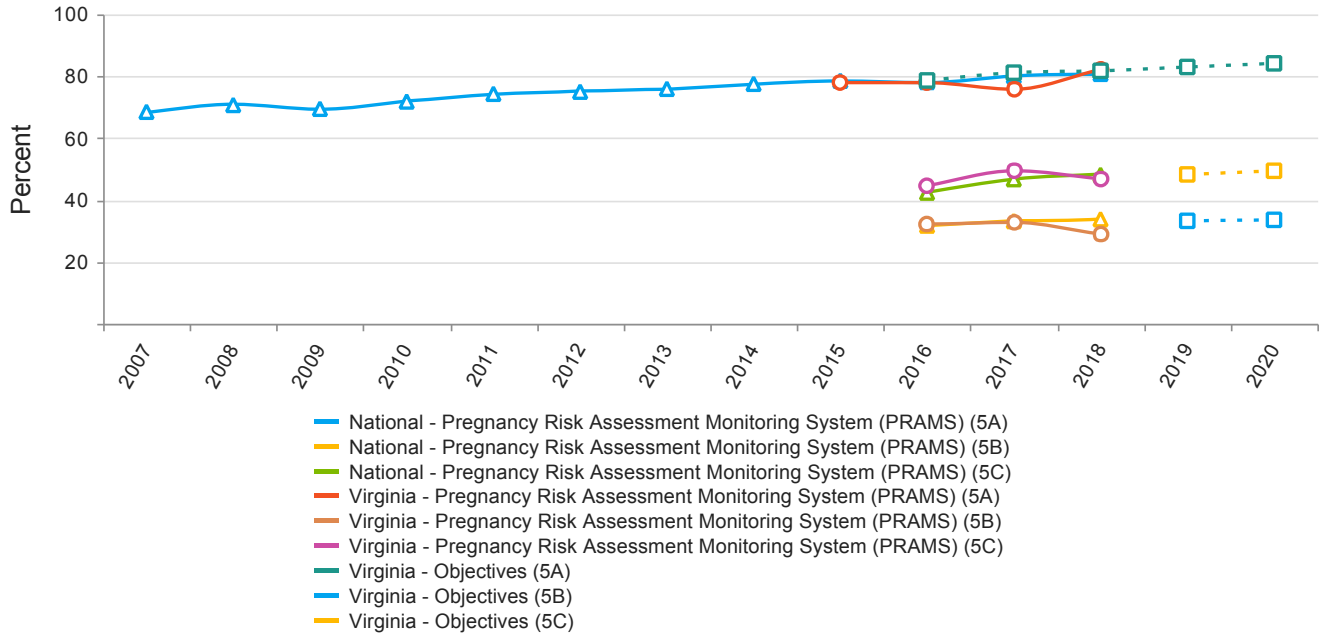
Eliminate the racial disparity in maternal and infant mortality rates by 2025.

Strategies

Explore opportunities to provide stable financial education to home visiting clients.

2016-2020: National Performance Measures

2016-2020: 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 Indicators and Annual Objectives



2016-2020: NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2017	**2018**	**2019**
Annual Objective	81	81.6	82.8
Annual Indicator	78.0	78.0	82.0
Numerator	73,007	73,211	75,207
Denominator	93,567	93,856	91,692
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2016	2018

State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective	78.5	81	81.6	82.8
Annual Indicator			75.9	82
Numerator				
Denominator				
Data Source			VA PRAMS	VA PRAMS
Data Source Year			2017	2018
Provisional or Final ?	Final		Final	Final

2016-2020: NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2018	**2019**
Annual Objective		33.3
Annual Indicator	32.0	28.8
Numerator	28,740	25,307
Denominator	89,922	87,734
Data Source	PRAMS	PRAMS
Data Source Year	2016	2018

State Provided Data			
	2017	**2018**	**2019**
Annual Objective			33.3
Annual Indicator	73.3	75.7	73.8
Numerator			
Denominator			
Data Source	VA PRAMS	VA PRAMS	VA PRAMS
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

2016-2020: NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2018	**2019**
Annual Objective		48.2
Annual Indicator	44.6	46.9
Numerator	39,580	40,840
Denominator	88,829	87,067
Data Source	PRAMS	PRAMS
Data Source Year	2016	2018

State Provided Data			
	2017	**2018**	**2019**
Annual Objective			48.2
Annual Indicator	79.6	84.7	83.1
Numerator			
Denominator			
Data Source	VA PRAMS	VA PRAMS	VA PRAMS
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 5.2 - Number of visits to the SafeSleepVA.com website

Measure Status:			**Active**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective	150	200	250
Annual Indicator	1,373	2,756	2,628
Numerator			
Denominator			
Data Source	VDH-OFHS Communications Specialist	VDH-OFHS Communications	VDH-OFHS Communications
Data Source Year	2017	2018	2019
Provisional or Final ?	Final	Final	Final

2016-2020: ESM 5.3 - Number of individuals counseled/educated about Safe Sleep environments

Measure Status:			**Active**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective		10,000	10,000
Annual Indicator	9,924	20,216	22,658
Numerator			
Denominator			
Data Source	Maternal/Infant Health Program - LHD Reports	Maternal/Infant Health Program - LHD Reports	Maternal/Infant Health Program - LHD Reports
Data Source Year	2017	2018	2019
Provisional or Final ?	Final	Final	Final

2016-2020: 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	
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			500
Annual Indicator		562	823
Numerator			
Denominator			
Data Source		VDH Maternal and Infant Health Program documents	VDH Maternal and Infant Health Program documents
Data Source Year		2019	2019
Provisional or Final ?		Final	Final

2016-2020: ESM 5.5 - Interdisciplinary Workforce Development - Number of Local Health Departments (LHD) attending VDH technical assistance for safe sleep environment.

Measure Status:		Active	
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			35
Annual Indicator			35
Numerator			
Denominator			
Data Source			VDH Maternal and Infant Health Program documents/a
Data Source Year			2019
Provisional or Final ?			Final

2016-2020: ESM 5.6 - Interdisciplinary Workforce Development - Number of home visitors completing Early Impact Virginia training modules that discuss safe sleep environment.

Measure Status:			**Active**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			375
Annual Indicator			243
Numerator			
Denominator			
Data Source			VDH Home visiting programs
Data Source Year			2019
Provisional or Final ?			Final

Perinatal/Infant Health Domain
FY19 Annual Report

The FY19 workplan for the Perinatal/Infant Health Domain included the following performance measures:

1. Safe Sleep

Strategies within the FY19 Perinatal/Infant Health workplan were implemented by the Maternal and Infant Health Coordinator, Title V-funded local health districts, and Division of Child and Family Health's Early Child Health (ECH) Unit. Complementary efforts were implemented by the Office of the Chief Medical Examiner, the Newborn Screening Program, and the Division of Prevention and Health Promotion's Injury and Violence Prevention Program (IVPP). Activities completed during the reporting period are detailed below.

State Priority: Safe Sleep - Increase safe sleep practices for infants.

FY19 Performance Measure: NPM 5 - Percent of infants placed to sleep on their backs

---

Objective

For the FY19 application cycle, MCHB expanded the definition of the safe sleep national performance measure from one component (i.e. back to sleep) to three components, to include:

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

The proposed objective was:

- 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%.

NPM 5A - Percent of infants placed to sleep on their backs was 82.0%, fairly near the target set for reporting year 2019 which was 82.8%.

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface was 28.8%, not meeting the target set for reporting year 2019 of 33.3%. When looking at the VA PRAMS question "In the past 2 weeks, how often has your baby slept alone in his or her own crib or bed," those who always/often slept alone in his or her own crib or bed was 73.8%.

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding was 46.9%, not meeting the target set for reporting year 2019 of 48.2%. When looking at the VA PRAMS question "How did your baby usually sleep in the past 2 weeks - With a blanket, With toys cushions or pillows, or With crib bumper pads," those who did not sleep with a blanket, With toys cushions or pillows, or With crib bumper pads was 83.1%.

Related National Outcome Measures

The national outcome measures (NOMs) relevant to this NPM include:

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

Significance of NOM 9.3: Postneonatal deaths, which occur from one month up to one year after birth, account for approximately one-third of all infant deaths in the U.S. Postneonatal mortality is generally related to Sudden Unexpected Infant Death (SUID)/Sudden Infant Death Syndrome (SIDS), unintentional injuries and congenital malformations. Similar to overall infant mortality, infants of non-Hispanic black (3.65) and ASIAN (3.5) women had the highest postneonatal mortality rates of any group—more than twice those for nonHispanic white women (1.71) in 2013.

Related Healthy People 2020 Objectives:

- *Maternal, Infant, and Child Health (MICH) Objective 1.5: Reduce the rate of postneonatal deaths (between 28 days and 1 year). (Baseline: 2.2 postneonatal deaths per 1,000 live births occurred between 28 days and 1 year of life in 2006, Target: 2.0 postneonatal deaths per 1,000 live births)*

Significance of NOM 9.5: Sleep-related SUIDs are the leading cause of death in infants from one month up to one year (postneonatal deaths) and account for approximately 15% of all infant deaths. SUID rates vary greatly by race and ethnicity. In 2013, SUID rates were highest for infants born to non-Hispanic black mothers and American Indian/Alaska Native (173 and 170 SUIDs per 100,000 live births, respectively); these rates were more than twice the rate among infants born to non-Hispanic whites (85 SUIDs per 100,000 live births). SUIDs account for 33% of the overall infant mortality gap between American Indian/Alaska Native and non-Hispanic whites and 15% of the gap between non-Hispanic blacks and non-Hispanic whites. To reduce SUIDs, the American Academy of Pediatrics recommends safe sleep practices, such as placing babies to sleep on their backs on a separate firm sleep surface without soft objects or loose bedding, as well as other protective practices such as breastfeeding and smoking cessation.

Related Healthy People 2020 Objectives:

- *Maternal, Infant, and Child Health (MICH) Objective 1.9: Reduce the rate of infant deaths from sudden unexpected infant deaths (includes SIDS, Unknown Cause, Accidental Suffocation, and Strangulation in Bed). (Baseline: .93 per 1,000 live births in 2006, Target: .84 infant deaths per 1,000 live births)*

Significance of NOM 9.1: Infant mortality, or the death of a child within the first year of life, is a sentinel measure of population health that reflects the underlying well-being of mothers and families, as well as the broader community and social environment that cultivate health and access to health-promoting resources. After a period of stagnation from 2000 to 2005, the U.S. infant mortality rate has continued to decline to record low levels below 6 per 1,000 live births. However, significant disparities continue to persist between racial groups, especially for infants born to non-Hispanic black, American Indian/Alaskan Native, and Puerto Rican women. The infant mortality rate among non-Hispanic blacks is more than twice that of non-Hispanic whites. Leading causes of infant mortality include prematurity, birth defects, and sudden unexpected infant deaths. Infant mortality continues to be an extremely complex health issue with many medical, social, and economic determinants.

Related Healthy People 2020 Objectives:

- *Maternal, Infant, and Child Health (MICH) Objective 1.3: Reduce the rate of all infant deaths (within 1 year).*

(Baseline: 6.7 infant deaths per 1,000 live births within the first year of life in 2006, Target: 6.0 infant deaths per 1,000 live births)

Progress Updates

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.***

This work was implemented by the MIH Coordinator, Title V-funded LHDs, and the Early Childhood Health Unit.

MIH Coordinator 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.

In FY17, 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. Some LHDs began providing safe sleep education concurrently with other local MCH initiatives, such as smoking cessation counseling services or the IVPP Low-Income Safety Seat Distribution and Education Program (LISSDEP). Other LHDs began reaching out to local day care providers and began train-the-trainer programs, ensuring staff were educated about safe sleep and then encouraging them to have the same discussion with the parents and caregivers.

In FY18 and FY19, a large network of diverse partners, including LHDs, continued to collaborate to identify best practices regarding education and outreach for providers and families on safe sleep practices. This network included hospitals, AAP, home visiting programs, community-based organizations, and family representatives.

In FY19, 24 of the state's 35 LHDs identified safe sleep as a local MCH priority and were engaged in community outreach and education. For example, AAP materials were distributed to pediatricians and licensed daycare providers across the state, classes were established with pre/post-tests and conducted during car seat safety classes, WIC registration, positive pregnancy tests confirmed, the ideas have been endless how each of the LHDs have addressed Safe Sleep education. These LHDs distributed pack-n-plays to moms, grandparents, and families that didn't have an identified safe sleep environment. Prior to receiving the pack-n-plays, families were required to attend an educational workshop. Within LHDs with a home visiting program or active partnership with a program, education continued during home visits; this allowed staff to monitor use of pack-n-plays and provide in-home reinforcement of safe sleep messaging.

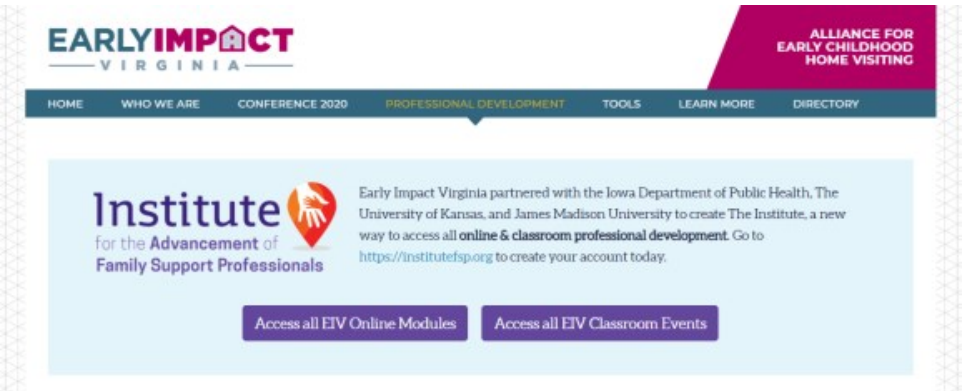
Early Childhood Health Unit

In addition to LHD work, block grant funds provided partial salary support for the Early Child 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.

It is noteworthy FY17 was the first year that Virginia collected infant safe sleep data for MIECHV sites. At that time, data indicated that 74.9% of infants enrolled in MIECHV home visiting were always placed to sleep on their backs, without bed sharing or soft bedding. Interest in continually monitoring safe sleep supports at Virginia's 18 MIECHV sites informed the proposed ongoing FY20 and FY21 workforce development activities.

The program maintains safe sleep education training modules for home visitors through the Institute for the Advancement of Family Support, in partnership with Early Impact Virginia.



<u>Evidence-Based Strategy Measures</u>

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).

For FY19 and FY20, ESMs were revised to align with work implemented by LHD staff funded with Title V, state, and home visiting funds:

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

<u>ESM 5.2</u>: In FY19, the program recorded 2,628 visits to the SafeSleepVA,com website.

<u>ESM 5.3</u>: 22,658 individuals were counseled/educated about Safe Sleep environments.

ESM 5.4: 823 of providers (homevisitors, doctors, nurses, health educators, etc.) educated about Safe Sleep environments and resources provided at www.safesleepva.com

ESM 5.5: 35 of 35 Local Health Departments (LHD) attended VDH technical assistance for safe sleep environment

ESM 5.6: 243 home visitors completed Early Impact Virginia training modules that discuss safe sleep environment.

Other Programmatic Activities

Office of the Chief Medical Examiner

OCME continued to lead maternal mortality and state fatality review with Title V funds. These activities are described in detail in the FY21 Application.

Newborn Screening and Birth Defects Surveillance Programs

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 (DCLS) sustain the dried blood spot screening program. Other programs receive CDC and HRSA funding. Title V funds provide partial salary and special project support.

The Code of Virginia mandates that all Virginia infants are screened for thirty-three disorders tested through dried blood spot (DBS) screening, Critical Congenital Heart Disease (CCHD) and hearing loss screening within 24-48 hours of birth and/or before discharge from the hospital. The Virginia Newborn Screening program consists of DBS newborn screening, the Early Hearing Detection and Intervention (EHDI), and CCHD follow-up teams.

- The Virginia EHDI Program monitors the newborn hearing screening of all babies born within the Commonwealth of Virginia, as well as hearing rescreening and diagnostic records for all infants' birth to 36 months that reside in the Commonwealth of Virginia. The VA EHDI program provides technical assistance and follow-up to ensure early identification of hearing loss in children through newborn hearing screening and audiological examinations. EHDI also refers diagnosed infants to Early Intervention (EI) and maintains contracts with state institutions to assure family-to-family support and a hearing aid load bank.

- The Virginia DBS NBS team track and follow-up on all out-of-range results for 31 inherited disorders, facilitates access to specialty services for further testing and confirmation of diagnosis, and infants that are diagnosed with a newborn screening disorder are referred to Care Connection for Children Centers (CCC) for care coordination services. The DBS program also maintains contracts with four regional medical centers to assure diagnosis and treatment of infants who screen positive for a dried blood spot genetic disorder.

- The CCHD team primarily confirms diagnosis reported into the Virginia Congenital and Anomalies Reporting and Education System (VaCARES) from hospital facilities, refers diagnosed infants to CCC programs and performs QA/QI by analyzing CCHD data to assure that reporting is consistent, accurate and complete. VaCARES is an ongoing birth defect surveillance system. Hospitals and healthcare providers passively report into VaCARES information system on children up to two years old. Birth defects data is reported annually to the Centers for Disease Control. CCHD NBS program activities fall under this umbrella.

Program Logos, Branding, and Communications

Early Hearing Detection and Intervention Program
Dried Blood Spot Newborn Screening Program
Websites:

- *General Newborn Screening Program: http://www.vdh.virginia.gov/newborn-screening/*
- *EHDI: http://www.vdh.virginia.gov/early-hearing-detection-and-intervention/*
- *DBS-NBS: http://www.vdh.virginia.gov/dried-blood-spot-newborn-screening/*
- *CCHD: http://www.vdh.virginia.gov/critical-congenital-heart-disease/*
- *VaCARES Birth Defects Surveillance: http://www.vdh.virginia.gov/vacares/*

Products

- *EHDI: Shared Plan of Care*
  http://www.vdh.virginia.gov/content/uploads/sites/109/2019/10/ParentsGuideSharedPlanofCareforChildrenw
  ringLoss-WEB9-2019.pdf/

FY19 Program Updates

Early Hearing Detection and Intervention Program (EHDI)
The Virginia EHDI program recruited parents and family members of infants and children who are deaf or hard of hearing to be members of the Virginia EHDI Advisory Committee (EHDI-AC) and now represent 25% of the Virginia EHDI AC membership. One additional member of the committee is deaf, as is one of the parents, making the representation by parents and adults who are deaf 27.3%.

Regionally based 1-3-6 Family Educators continue to provide education and support to families via a contract with the Center for Family Involvement (CFI) at Virginia Commonwealth University (VCU). CFI is also contracted to stand-up and support EHDI Learning Communities throughout the state. Learning Communities are soundly established in all regions in the state: Northern Virginia, Central Virginia, Southwest Virginia, Roanoke, Blue Ridge and Hampton Roads and leadership has switched to community and parent stakeholders in two regions of the state. All Learning Communities contributed to the Shared Plan of Care, an initiative implemented as a result of HRSA funding deliverable.

“What It Means to Hold Space,” April 2019: This meeting focused learning how to apply trauma informed care principles when needed for the exploration of the potential impact of early diagnosis of hearing loss in children. Objectives included support communication and build relationships among parent and professionals, identify a variety of relational practices, increase knowledge of ways to improve support for families, and explore the practice of holding space for feeling, healing, acceptance and growth. Parents, audiologists, Early Interventionists, counselors, home visitors, hospital staff, teachers of the deaf and hard of hearing and other healthcare providers were invited to attend.

CARE Project Family Retreat, May 2019: Virginia EHDI, Virginia Hands & Voices, and the CARE Project collaborated to host the first CARE Project family retreat in Virginia. The retreat’s aim was to support families of children (ages 0-3 years) who are deaf or hard of hearing and the agenda consisted of informational seminars, family-to-family bonding time, social activities, and breakout groups. This three day retreat occurred in Richmond,

Virginia and was supported by volunteers who assited in childcare, interpretation, and general help. There has been an increased collaboration with midwives who typically do not conduct hearing screening due to cost of equipment and lack of training. The Virginia EHDI program is working to obtain OAE equipment to distribute to 13-15 birthing centers across the state so Certified Professional Midwives (CPM) have access to screening equipment. Targeted Congential Cytomegalovirus (cCMV) screening legislation passed in the 2019 Virginia General Assembly. Planning for that implementation started in March 2019 and is ongoing. Estimated go-live date is September 2020.

Dried Blood Spot Newborn Screening (NBS DBS)
Expanded screening and follow-up operations to seven days/week (January 2019).

Full implementation of Pompe and Mucopolysaccharidosis Type I (MPS I) screening went live 1/1/2019. Planning for the implementation of Spinal Muscular Atrophy (SMA) and X-linked adrenoleukodystrophy (XALD) is ongoing with a target implementation date early summer 2020.

Public Health Nurses continue to co-locate at Division of Consolidated Laboratory Services (DCLS) to increase collaboration, coordination of services and knowledge among NBS DBS staff.

Collaboration continues with the Virginia Immunization Program to access the Virginia Immunization Information System (VIIS) to increase the program's ability to locate infants who may have an abnormal/critical screen result and demographic information in the LIMS system is incorrect.

A web portal for physicians was stood up in May 2019 to ensure timely lookup of DBS NBS results, in lieu of waiting for mailed results.

Critical Congenital Heart Disease (CCHD) Screening and Quality Assurance
CCHD follow-up and QA activities moved to the umbrella of the Birth Defects program in 2018. In this capacity, the program was able to utilize established resources to re-start activities, as a lack of resources prevented the program from being fully functional 2017-2018. A part-time CCHD coordinator was hired in Fall 2019. The program's main objective is catch-up on confirmation of cases from 2017-2019.

Birth Defects
Zika Surveillance and Prevention: The Zika Pregnancy Registry (ZPR) was established and maintained during this time. Program followed up on infants up to 2 years of age and was completed in September 2019.

The Virginia ZPR program also participated in a national study sponsored by the CDC and March of Dimes to conduct a survey of women who are enrolled in the US Zika Pregnancy & Infant Registry (USZPIR) to assess the kinds of care their baby is receiving, challenges they may face in caring for their baby, and barriers to receiving health care and support services. Virginia was one of two states that were able to fully assist and participate in the survey. (Carla- please let me know if you want a copy of it)

The Zika Birth Defect Surveillance Program (ZBDS) was also established and maintained during this time. To date, all 2016 and 2017 cases that were reported into the Virginia Congenital Anomalies Reporting and Education System (VaCARES) and met CDC case definitions have been reviewed, abstracted and sent to CDC for confirmation (~1200 cases). Health care providers of all confirmed 2017 cases were contacted to see if referrals to the CYSHCN CCCs and CDCs were appropriate, and if so, were made. This project ended in August 2019. As a result of Zika funding, an "active birth defect surveillance" (ABDS) module has been incorporated in VaCARES and has enabled the program to input Zika related data and transfer to CDC. The module will allow the program to easily expand capabilities to collect and document more detailed data on emerging issues and/or other core birth defects

that need further investigation, as Zika did.

Top FY19 accomplishments include:

- EHDI
  - The Virginia EHDI Program is considered a national model regarding family engagement
  - Soundly Established Learning Communities in six regions of the state
  - Out of the Learning Community, a Shared Plan of Care for infants 0-1 has been finalized for parents, health care providers and Early Interventionists. http://www.vdh.virginia.gov/content/uploads/sites/109/2019/10/ParentsGuideSharedPlanofCareforChilc WEB9-2019.pdf
  - EI data sharing agreement close to finalization.
  - Increased collaboration with midwifery community.
  - Incorporated texting into the program's follow-up process and model.
  - EHDI Holding Space event
  - EHDI Care Project Family Retreat
- DBS
  - Expanded operations to 7d/w including holidays January 1, 2019
  - Planned and implemented two new conditions to the DBS panel: Pompe and MPS I. (Jan 2019)
  - Initiated NOIRA and is planning to add an additional 2 new disorders to Virginia's panel: SMA and X-ALD
  - Web portal live May 1, 2019 so licensed health care providers can access NBS results more easily.
  - DBS NBS Policy and Procedures drafted and completed.
- CCHD
  - Re-establishment of QA/QI activities Birth Defects
  - ZPR established, maintained and met all CDC grant requirements. Two year follow-up ended Sept 2019.
  - Zika birth defect surveillance established, maintained and will meet all CDC requirements by end of project period (August 2019)
  - Active birth defect module incorporated into VaCARES to further programmatic data collection needs.

Breastfeeding and Newborn Screening Provider Modules

VDH partners with the University of Virginia Office of Continuing Medical Education to maintain and promote breastfeeding and newborn screening provider training modules. The modules are hosted on branded online portals (Breastfeeding Friendly Consortium and Newborn Screening Education).

Breastfeeding Modules

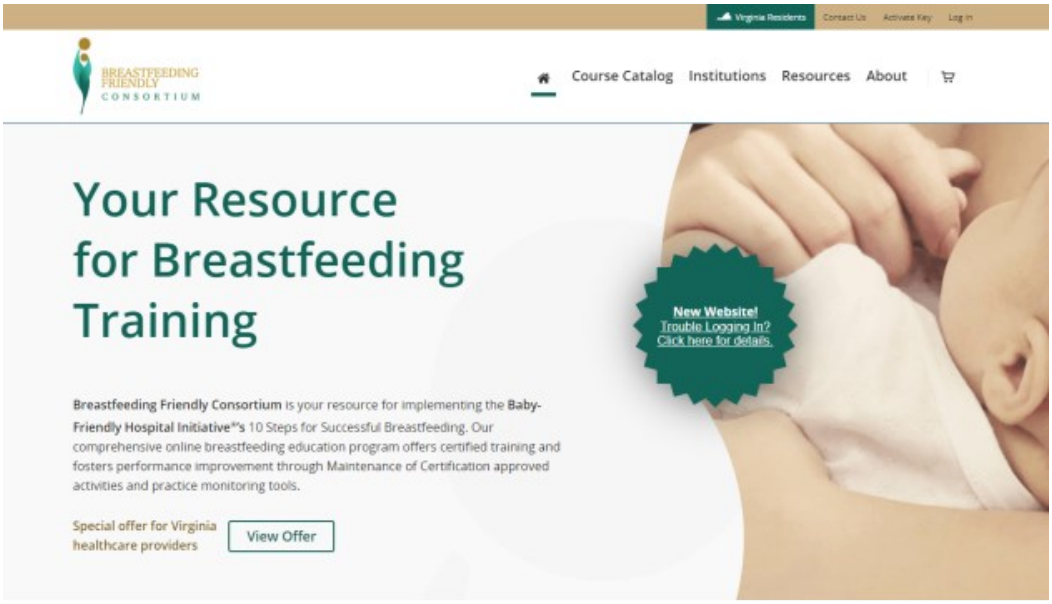
Title V funds maintain the Breastfeeding Friendly Consortium, an online breastfeeding training portal provided in partnership with the University of Virginia Office of Continuing Medical Education and the Virginia Chapter of the

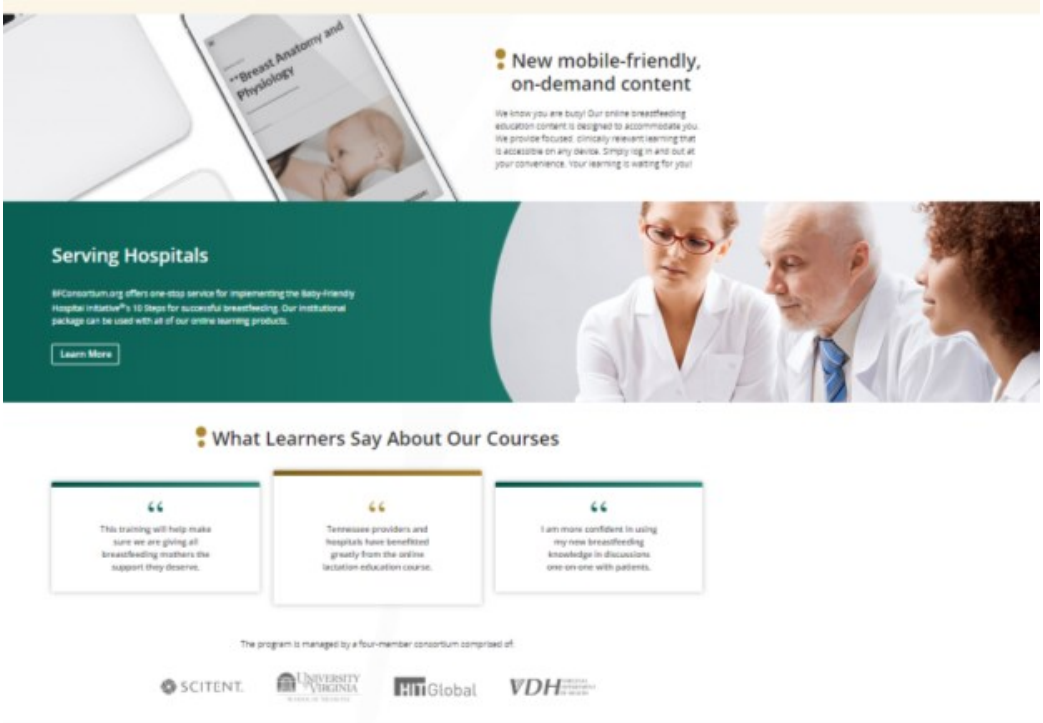
American Academy of Pediatrics. The Breastfeeding Friendly Consortium is an online resource for implementing the **Baby-Friendly Hospital Initiative®'s** 10 Steps for Successful Breastfeeding.

This comprehensive online breastfeeding education program offers certified training and fosters performance improvement through Maintenance of Certification approved activities and practice monitoring tools.

The content offers valuable continuing education credit for physicians, nurses, dietitians, IBCLCS, and midwives, including up to 20 hours of continuing education credit as well as MOC Part 2 and Part 4 opportunities. Topics include current trends in infant feeding; labor, delivery, and the immediate postpartum period; preterm and late-preterm infants; the Baby Friendly Hospital Initiative; and more. Content includes case-based scenarios and is available in a mobile-friendly, on-demand format.

Title V funds provide access to continuing education credits (CEUs) for Virginia providers at no cost. Providers from other states may also take courses for a fee.





Newborn Screening Modules

Title V funds also fund the ongoing maintenance of 'Newborn Screening Education,' an online continuing education portal for newborn screening modules.

Breastfeeding-Friendly Designation

Virginia Maternity Care Breastfeeding-Friendly Designation

The Virginia Maternity Center Breastfeeding-Friendly Designation Program recognizes hospital breastfeeding best practices. Hospitals are awarded with one star for every two steps achieved in the "10 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 current awardees can be found here, along with more details on recognition criteria. Additional agency efforts to promote breastfeeding are detailed on the VDH breastfeeding website. This program will undergo an evaluation in FY21.

Prior Effort: Virginia Maternity Care Quality Improvement Collaborative (VMQIC)

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, 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 VMQIC provided support for facilities interested in participating in the Virginia Maternity Center Breastfeeding-Friendly Designation Program (i.e. the "5-Star Breastfeeding Program"). The goal was to support facilities in achieving 4 or 5 stars (equivalent to 8 of the 10 Steps to Successful Breastfeeding) to build capacity of Virginia facilities to later seek Baby-Friendly USA Designation.

By May 2018, 11 facilities had achieved 4 or 5 stars and eight additional facilities had applied and achieved at least one star. Seven participating maternity facilities achieved Baby-Friendly USA Designation by July 2018.

The VMQIC was a joint undertaking of the Office of Family Health Services (OFHS) Division of Community Nutrition and Division of Prevention and Health Promotion. It was funded through the Centers for Disease Control and Prevention (CDC) State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health cooperative agreement (i.e. CDC-1305).

When CDC-1305 funding ended in 2018, staff from the Division of Child and Family Health (including the Division

Director, Title V Director, and Maternal and Infant Health Coordinator) began meeting with the Division of Community Nutrition to restructure support for core breastfeeding efforts. The team is committed to collaborating to identify and address needs for both community-based breastfeeding supports and hospital-oriented quality improvement initiatives.

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 for the VMQIC. The VBAC is led by the Division of Community Nutrition's State Breastfeeding Coordinator; the Title V Director is a member, and various Title V program staff are invited to participate.

Perinatal/Infant Health Domain
FY21 Application

The FY21 workplan for the Perinatal/Infant Health Domain includes the following performance measures:

1. Infant Mortality Disparity Ratio
2. Breastfeeding

Funded programmatic efforts for perinatal and infant health will be shared by the Division of Child and Family Health's new Black Maternal & Infant Health Program / Breastfeeding Coordinator, Maternal and Infant Health Coordinator, and the Early Childhood Health Unit. Activities will also be completed by Title-V funded local health districts (LHDs). These entities and their proposed activities for the upcoming grant period are detailed below.

I. Black Maternal & Infant Health Program

The new Program Coordinator will report to the Title V Director (Carla Hegwood, MPH). The position will support implementation of the emerging Black Maternal & Infant Health Program. The position will also support development of a coordinated plan for addressing breastfeeding across the Divisions of Child & Family Health, Community Nutrition, and Prevention & Health Promotion.

This program is detailed in the Women's/Maternal application.

FY21 Application Overview: Maternal & Infant Mortality Disparity

State Priority: Maternal & Infant Mortality Disparity
FY21 Performance Measure: SOM 2 – Infant Mortality Disparity

Objective: Eliminate the racial disparity in maternal and infant mortality rates by 2025.

According to America's Health Rankings (2019), Virginia ranks 23 overall for the health of infants, and 18 for the overall health of women and children. The infant mortality rate was 5.9 per 1,000 live births, compared to the U.S. rate of 5.9. Differences exist in the rate of infant mortality by race and ethnicity in Virginia:

Infant Mortality, Virginia, Rate per 1,000 live births	
Race	
Asian	4.1
Black	9.9
Hispanic	4.2
White	4.8
Source: CDC WONDER Online Database, Linked Birth/Infant Death files, 2015-2016	

The following strategy is detailed within the Women's Health application:

- ***Strategy: Explore opportunities to develop and pilot racial equity curricula at Virginia colleges and universities providing medical, nursing, dental, and other clinical health professional training.***
  Domain: Women's/Maternal, Perinatal/Infant

FY21 Application Overview: Community, Family, and Youth Leadership

---

State Priority: Community, Family, and Youth Leadership
FY21 Performance Measure: NPM 4A - Percent of infants who are ever breastfed; NPM 4B - Percent of infants breastfed exclusively through 6 months

OBJECTIVES: 1. Increase the number of infants ever breastfed from 82.9% (NIS 2016) to 87.9% by 2025; 2. Increase the number of infants breastfed exclusively through 6 months from 26.4% (NIS 2016) to 29.6% by 2025

VA PRAMS data for 2018 showed that 89.4% of respondents ever breastfed, 24.6% breastfed for 1-10 weeks, and 56.2% were breastfeeding at the time of the survey. There were some differences observed in continuation by race:

Breastfeeding	White, non-Hispanic	Black, non-Hispanic	Hispanic
Ever breastfed	89.0%	81%	98.2%
Breastfed for 1-10 weeks	21.3%	32.7%	28.9%
Breastfeeding at time of survey	61.3%	38.6%	51.9%

Strategy: Solicit community voice to inform identification of key needs for breastfeeding, parenting, and childcare supports for Black mothers, in preparation for offering mini-grants to support development of baby-friendly communities.
Domain: Perinatal/Infant

Activity	Expected Completion Date	Responsible Staff
Coordinate with WIC- and PHHS-funded breastfeeding programs and identify gap-filling activities to advance equity.	Ongoing	Carla, Black Maternal/Infant Health (BMIH) Coordinator
Conduct environmental scan of successful collective impact models for community-level investments and supports for healthy mothers and babies, particular for Black families (e.g. Best Baby Zones, Health Equity Zones).		Carla, BMIH Coordinator
Develop catalog of potential evidence-based interventions addressing identified needs for breastfeeding, parenting, and childcare supports.	September 2021	BMIH Coordinator
Conduct outreach and community TA sessions to prepare non-traditional partners and CBOs to successfully compete for funding opportunities.	December 2021	BMIH Coordinator
Release RFA for mini-grants that allows communities to choose from catalog or design their own intervention addressing identified needs.	December 2021	BMIH Coordinator
Conduct focus groups. Recruit Community Advisors to provide ongoing input into program design, convenve quarterly, and provide stipends for participation.	Ongoing	BMIH Coordinator
Coordinate with local health districts and CHAs as appropriate.	Ongoing	BMIH Coordinator

The incoming BMIH Coordinator will serve as a convener of Central Office breastfeeding staff from WIC (based in the Division of Community Nutrition) and PHHS (based in the Division of Prevention and Health Promotion). These staff will jointly identify gap-filling activities to advance equity and develop a coordinated plan for addressing breastfeeding across divisions. This may involve establishing or expanding contracts with state and regional breastfeeding organizations.

The Title V Needs Assessment results emphasize the need for a variety of community-level supports for pregnant and parenting women, but additional information is needed to better understand the specific needs of Black women as a subgroup, particularly for breastfeeding and childcare supports. Once onboarded, the BMIH Coordinator will (1) work to convene focus groups and a group of Community Advisors to inform future work and (2) explore various collective impact models for community-level investments and supports for healthy mothers and babies, particular for Black families (e.g. Best Baby Zones, Health Equity Zones) and work with the Community Advisors to develop a Virginia-specific model.

Mini-grants will be made available to schools, community organizations, churches, healthy communities coalitions, and other parties to address identified breastfeeding, childcare, and parenting support needs. A suggested list of

evidence-informed interventions will be provided to interested parties, and technical assistance will be available to assist communities in developing innovative and successful proposals.

Local health districts will be encouraged to support and coordinate with these community-led projects, where appropriate.

II. Title V Maternal & Infant Health Coordinator

The Division of Child and Family Health's Maternal and Infant Health (MIH) Coordinator position is currently vacant. This position is 100% funded by Title V. The Title V Director has developed a suggested scope of work that is responsive to emerging gaps identified through the needs assessment.

Emerging needs include:

- Exploring state capacity and models for care coordination for pregnant women,
- Tracking policy shifts, opportunities, and innovations related to health insurance coverage and social determinants of health that impact pregnant and parenting women,
- Tracking and supporting innovations related to prenatal/maternity care during COVID-19,
- Tracking shifts in availability of maternal/prenatal care in each of the 35 LHDs, and
- Partnering with state and local stakeholders to address substance use,
- Exploring opportunities to partner internally to address STI transmission (particularly chlamydia) and high rates of new HIV diagnoses (particularly among women ages 25-44 and Black women),
- Through ongoing needs assessment activities, exploring of families' needs for support and education during the perinatal period (e.g. community-based support groups for new moms, Centering Pregnancy, father-inclusive initiatives/education) and within the first year (e.g. parenting-related programs, maternal mental health support),
- Supporting implementation of the Pathway to Coordinated Care for Infants and Families (PCC) state plan, and
- Working with local health districts to strengthen coordination of services with local hospitals, FQHCs, and providers.

FY21 Application Overview: MCH Data Capacity

State Priority: MCH Data Capacity
FY21 Performance Measure: NPM 4A - Percent of infants who are ever breastfed; NPM 4B - Percent of infants breastfed exclusively through 6 months

OBJECTIVE: 1. Increase the number of infants ever breastfed from 82.9% (NIS 2016) to 87.9% by 2025; 2. Increase the number of infants breastfed exclusively through 6 months from 26.4% (NIS 2016) to 29.6% by 2025.

Strategy: Complete evaluation of Five-Star Breastfeeding-Friendly Hospital Recognition Program.
Domain: Perinatal/Infant

Activity	Expected Completion Date	Responsible Staff
Complete evaluation of current program.	September 2021	Maternal/Infant Health (MIH) Coordinator
Review best practices from other states.	September 2021	MIH Coordinator

The incoming Maternal and Infant Health Coordinator will complete and evaluation of the state Five-Star Breastfeeding Hospital Initiative, to include review of breastfeeding recognition models from states such as California and North Carolina.

III. Resource Mothers Program

The Resource Mothers Program is led by Consuelo Staton, MEd. (State Resource Mothers Coordinator). The program sits within the Division of Child and Family Health's Reproductive Health Unit.

Resource Mothers is a home-grown, community-based program designed to support teens during their pregnancy and until their child turns 1. By providing educational and practical support to these young clients, VDH aims to prevent rapid repeat unintended pregnancy, empower teen parents, and ultimately improve maternal and child health outcomes.

FY21 Application Overview: Maternal & Infant Mortality Disparity

State Priority: Maternal & Infant Mortality Disparity
FY21 Performance Measure: SOM 2 – Maternal Mortality Disparity

Objective: Eliminate the racial disparity in maternal and infant mortality rates by 2025.

Strategy: Increase capacity of youth-serving agencies to implement AIM4TM, an evidence-based pregnancy prevention program designed for parenting teens.
Domain: Perinatal/Infant

Activity	Expected Completion Date	Responsible Staff
Ensure that at least 80% of Resource Mothers clients receive AIM4TM curriculum	Ongoing	Emily, Consuelo
Assess training needs among RM staff and offer supplemental training as needed	Ongoing	Emily, Consuelo

During FY19, VDH worked to increase the capacity of the Resource Mothers Program to offer evidence-based programs to pregnant and parenting teens. Resource Mothers is a home-grown, community-based program designed to support teens during their pregnancy and until their child turns 1. By providing educational and practical

support to these young clients, VDH aims to prevent rapid repeat unintended pregnancy, empower teen parents, and ultimately improve maternal and child health outcomes. All Resource Mothers staff received training on the AIM 4 Teen Moms (AIM4TM) curriculum, an evidence-based positive youth development program designed to increase protective factors and prevent pregnancy. During FY21, VDH intends to continue this work by collecting and monitoring program data and offering regular training opportunities to new staff. VDH will monitor sites to ensure that at least 80% of Resource Mothers clients receive the AIM4TM program as it was originally designed.

Strategy: Assure Resource Mothers staff are trained in the Growing Great Kids curriculum, a skills-driven program designed to promote healthy child development and strengthening protective factors for families in a home visiting setting.
Domain: Perinatal/Infant

Activity	Expected Completion Date	Responsible Staff
Ensure all Resource Mothers staff are trained in the GGK curriculum	Ongoing	Emily, Consuelo
Monitor sites and provide support as needed	Ongoing	Emily, Consuelo

During FY19, VDH worked to increase the capacity of the Resource Mothers Program to offer evidence-based programs to pregnant and parenting teens. During FFY21, all Resource Mothers staff will continue to receive training on Growing Great Kids (GGK), a program designed to promote healthy child development and strengthening protective factors for families in a home visiting setting. GGK is a skills-driven curriculum that provides program staff with research-informed, strength-based, and solution-focused training that helps teen parents develop parenting, family strengthening, and essential life skills. The GGK trainings are designed to build staff competencies for nurturing parental resiliency, advancing individual and family functioning, nurturing parents' problem-solving skills, and enabling parents to construct protective barriers. The GGK curriculum is culturally inclusive and embraces family diversity.

During FFY21, all Resource Mothers staff will be trained in the GGK curriculum, and VDH will monitor sites to ensure that 100% of Resource Mothers Clients will receive GGK curriculum programming.

Challenges

To protect the health of both staff and clients, Virginia has ceased offering home visiting services in the home during the COVID-19 pandemic. Home visiting programs like Resource Mothers are encouraged to offer services virtually through doxy.me, a secure telehealth platform. Doxy.me licenses have been purchased for all Resource Mothers sites, and all sites have received training on using the program. Resource Mothers is working with the Children's Hospital of Los Angeles, the program developer of AIM4TM, to develop strategies for offering AIM4TM electronically during the pandemic. However, due to lack of equitable broadband access across the Commonwealth, not all sites are able to take advantage of telehealth and not all families are able to support telehealth on their mobile devices. VDH is still exploring ways to address these barriers.

IV. Early Childhood Health Unit

The Division of Child and Family Health's Early Childhood Health Unit is led by Andelicia Neville (Early Childhood Health Supervisor). The unit administers the agency's home visiting programs, including the Healthy Start/Loving Steps grant and the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant.

The unit houses the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant. MIECHV 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. Virginia's MIECHV program has 18 evidenced-based home visiting sites and 2 centralized intake centers. The program focuses on providing parental education and support to reduce infant mortality, prevent child abuse/neglect, and improve health outcomes for child and mother.

The unit also oversees the Healthy Start/Loving Steps grant. This grant has two sites (Crater Health District and Eastern Virginia Medical School in Norfolk) that provide home visiting services to at-risk families. The goal of Healthy Start is to reduce infant mortality and perinatal health disparities by delivering high-quality, effective prevention strategies to individuals, families and communities.

Bethany Geldmaker, PhD (Early Childhood Health Consultant) is based within this unit; she provides leadership for the Virginia Developmental Screening Initiative and Virginia Mental Health Access Program (VMAP). Both programs are detailed in the Child Health Domain narrative. Early and continuous developmental screening is an emerging area of opportunity for alignment with other Title V investments.

Coordination of Title V and MIECHV Needs Assessments

Staff from VDH and Early Impact Virginia (the community-based co-lead for MIECHV) worked to ensure coordination between the 2020 MIECHV and Title V needs assessments, to include:

1. Sharing existing data housed by each organization (e.g., capacity of home visiting programs, infant mortality rates, etc.);
2. A common definition of need/at-risk families that would benefit from home visiting;
3. Developing and revising data collection tools collaboratively; and,
4. Sharing primary data collected for each individual needs assessment.

In addition, Early Impact Virginia (EIV) coordinated with other statewide needs assessments efforts (e.g. Preschool Development Grant, CAPTA, and Head Start efforts). EIV shared all findings with the Title V team. This assisted with ensuring families and providers were not over-burdened with focus groups during overlapping periods of data collection.

FY21 Application Overview: Maternal & Infant Mortality Disparity

---

State Priority: Maternal & Infant Mortality Disparity
FY21 Performance Measure: SOM 1 – Infant Mortality Disparity

Objective: Eliminate the racial disparity in maternal and infant mortality rates by 2025.

Strategy: Support training, support, and evaluation for home visiting programs, to include MIECHV, Healthy Start, and Early Impact Virginia.
Domain: Perinatal/Infant

Activity	Expected Completion Date	Responsible Staff
Partner with Early Impact Virginia (EIV) to provide ongoing training and TA to home visitors on promotion of safe sleep practices.	Ongoing	Andelicia Neville (Early Childhood Health Supervisor)
Procure and disseminate gap-filling telehealth support for home visitors and clients to facilitate in response to COVID-19, as needed.	Ongoing	Andelicia, Consuelo
Explore opportunities to evaluate and present adapted models and outcomes of virtually-delivered home visiting services to further the MCH evidence base.	Ongoing	Andelicia, Consuelo, EIV

The Early Childhood Health Unit will continue to monitor and 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, the Early Childhood Unit committed to leveraging Title V funding to assess the extent to which safe sleep was being addressed by VDH home visiting programs and, if needed, implement a QI project. This included assessing safe sleep curricula being 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). As of June 2019, 84% of MIECHV sites reported safe sleep measures were adhered to by families served and 89% of Healthy Start sites reported safe sleep measures adhered to by families served.

Safe sleep is addressed in all evidenced-based curriculums used by home visitors, including Growing Great Kids and Parents As Teachers (PAT). The Early Childhood Health Supervisor has partnered with the Resource Mothers program to bring the Growing Great Kids (GGK) evidenced-based curriculum to home visitors in both the Resource Mothers programs and Healthy Start programs. The GGK curriculum provides structured, evidenced-based activities and developmentally-appropriate resources to home visitors. This curriculum is also used by Healthy Families America model programs in Virginia.

In partnership with Early Impact Virginia (EIV), the central organization that represents all of the home visiting model programs in Virginia, all home visitors will be provided access to training modules on safe sleep promotion.

The Early Childhood Health Unit partners with EIV on continuous quality improvement and providing support to the 18 MIECHV sites. EIV has been tasked with conducting and writing the MIECHV Needs Assessment; they will also be collaborating closely with Title V needs assessment team and will be sharing quantitative and qualitative data. Through our collaboration with EIV, home visitors are afforded access to a variety of relevant training topics (including safe sleep promotion) through the 'Institute' web-based training site.

FY21 Application Overview: Finances as a Root Cause

State Priority: Finances as a Root Cause
FY21 Performance Measure: SOM 1 – Infant Mortality Disparity

Objective: Eliminate the racial disparity in maternal and infant mortality rates by 2025.

Strategy: Explore opportunities to provide stable financial education to home visiting clients.
Domain: Perinatal/Infant

Activity	Expected Completion Date	Responsible Staff
Identify gaps in availability of financial education programs for home visiting clients.	Ongoing	Carla, Andelicia
Onboard financial education contractors to sustainably fill gaps.	Ongoing	Carla, Andelicia

Financial education has been offered to home visiting clients in the past, but there has been turnover among partners providing this service and there isn't consistent availability. The Title V Director and Early Childhood Unit Supervisor will work to develop a plan ensure financial education is consistently available to all home visiting clients.

Finances as a Root Cause

Lack of household wealth is related to financial instability and increased instability re: related social needs such as healthy food, housing, and transportation. Such stressors may contribute to high levels of anxiety and depression and can influence household dynamics in ways that interfere with healthy early child development; they are also risk factors for ACEs.

Currently, Title V-funded programs at the state and LHD level do implement activities aimed at reducing financial barriers to optimal health. For example, programs may prioritize low-income families for enrollment, offer services on an income-based sliding scale, support families with navigating Medicaid enrollment, and provide direct financial assistance or free or low-cost supplies (e.g. Pack n' Plays, child safety seats). These efforts help to meet immediate needs.

However, there is increasing national focus among MCH experts regarding the relationships between wealth disparities and health disparities. While Virginia-specific data is limited, there is evidence that racial/ethnic wealth disparities may be a root cause of financial barriers experienced.

Virginia's Title V program is interested in finances as a root cause of poor MCH outcomes – or, put another way, economic determinants of health.

Income is a commonly-utilized indicator, but income is not necessarily an indicator over overall household financial stability. As demonstrated by COVID-19's impact on the nation's overall economic stability, a household's monthly or annual income does not reflect the household's ability to navigate an unexpected emergency such as an illness, car repair, or unemployment.

Household wealth may be a more meaningful indicator. Another potentially meaningful indicator may be a household's reported ability to successfully navigate a $300 emergency.

There are system- and policy-level priorities to explore implementing in Virginia, such as paid parental leave and universal daycare. However, at the individual and family levels, the Title V program is interested in exploring opportunities to move one step upstream from meeting immediate/emergency needs to providing financial education. This is a tangible first step that may allow Title V programs to begin building evidence around how finances impact our families.

Budget Update

Title V MCH funds provide salary support for the Early Childhood Health Unit and full support for the MIH Coordinator, in addition to funding for a variety of maternal/infant health special projects.

Consumer/Family Engagement & Partnership

Virginia's home visiting programs utilize parent surveys to get input from families on educational materials, activities, cultural sensitivity, and services provided. This is done annually and findings are shared with the programs Advisory Board and host agency. Concerns are addressed by the program.

Fatherhood engagement and inclusion are strongly encouraged in all home visiting models in Virginia. Activities and home visits are to be inclusive and inviting to those fathers who wish to participate. Some home visiting programs enroll fathers as the primary caregiver.

Parental involvement on advisory boards is not only encourage but required by some home visiting models. Former participants and or parents of small children in the community are encouraged to participate on advisory boards. Their insight and perspective is well received and respected.

Emerging Issues

The Early Impact Virginia (EIV) Executive Management Team recently submitted a proposal for home visiting in Virginia (titled *The Virginia Plan for Home Visiting: A Proposed Framework*) to the Governor's Children Cabinet for consideration. On 5/14/19, the draft proposal was accepted. This proposal defines home visiting in Virginia and offers guidelines to what constitutes evidenced-based home visiting services.

Trauma-informed care remains an emerging issue, both in terms of how trauma impacts providers (e.g. How can providers best be equipped to treat clients/patients with history of trauma? What tools or training do they need?) and how patients can best be supported (e.g. How does a history of trauma impact a client's ability and willingness to seek care? How might true needs be masked during visits?).

Perinatal/Infant Health Work Detailed in Other Sections

Note that following strategies are detailed in the Women's/Maternal application and are thus not repeated within the Perinatal/Infant application:

Priority: Maternal and Infant Mortality Disparity

- ***Explore opportunities to develop and pilot racial equity curricula at Virginia colleges and universities providing medical, nursing, dental, and other clinical health professional training*** *(Black Maternal/Infant Health Program; Domains: Women's/Maternal, Perinatal/Infant)*
- ***Develop and mobilize strong interagency, multisector, and community partnerships to address disparities in maternal and infant mortality rates*** *(Black Maternal/Infant Health Program; Domains: Maternal, Perinatal/Infant)*
- ***Sustain state maternal mortality and child fatality review teams*** *(Office of the Chief Medical Examiner; Domains: Maternal, Perinatal/Infant)*
- ***Work with stakeholders to increase access to doula services among women of color*** *(Reproductive Health Unit; Domains: Maternal, Perinatal/Infant).*
- ***Maintain Title V representation on the Virginia Neonatal Perinatal Collaborative's Steering and Executive Committees, and develop a shared visioning and planning document specific to the VDH-VNPC relationship*** *(VNPC; Domain: Women's/Maternal, Perinatal/Infant)*
- ***Launch health disparities dashboard by June 2022*** *(VNPC; Domain: Women's/Maternal, Perinatal/Infant)*
- ***Launch VNPC stillbirths dashboard by June 2022*** *(VNPC; Domain: Women's/Maternal, Perinatal/Infant)*

Priority: MCH Data Capacity

- ***Sustain and expand data capacity within the Office of the Chief Medical Examiner's related to maternal, infant, and child health*** *(Office of the Chief Medical Examiner; Domains: Maternal, Perinatal/Infant).*

Priority: Community, Family & Youth Leadership

- ***Explore expanding community engagement in state maternal mortality and child fatality review*** *(Office of the Chief Medical Examiner; Domains: Maternal, Perinatal/Infant).*

Priority: Upstream/Cross-Sector Strategic Planning

- ***Continue to engage cross-sector partners and address social determinants of health in development of MMRT and CFRT recommendations*** *(Office of the Chief Medical Examiner; Domains: Maternal, Perinatal/Infant).*

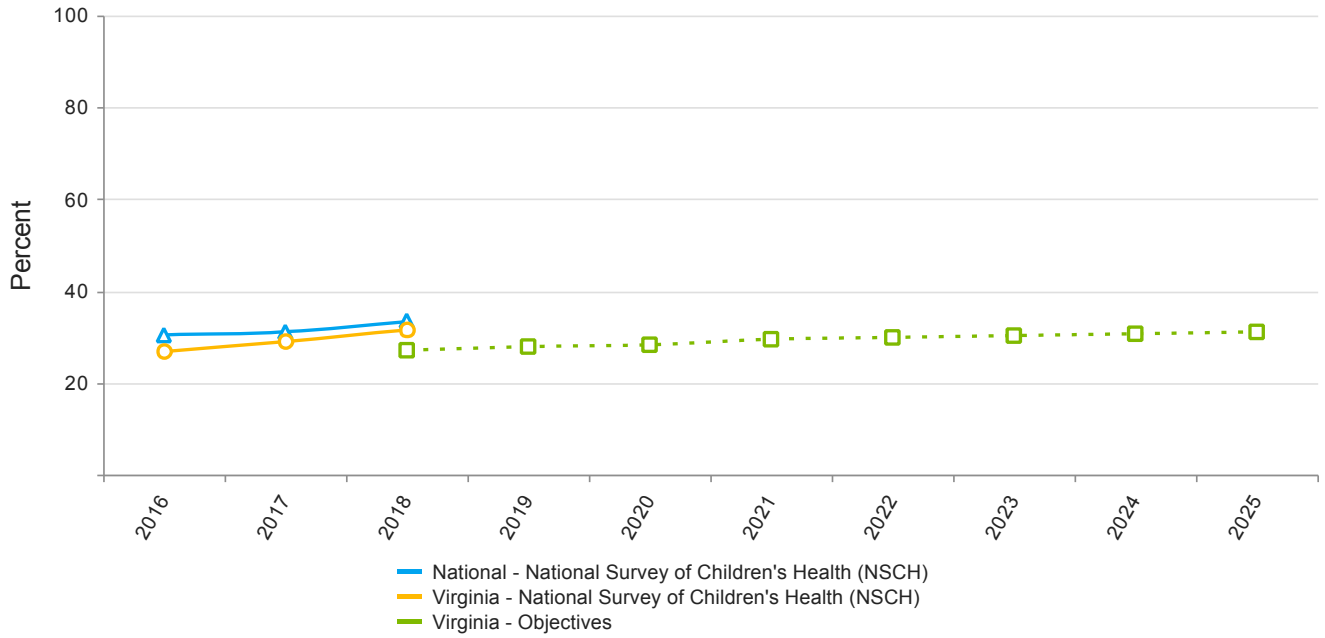
Child Health

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 or Not Reportable	NPM 6
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2017_2018	10.4 %	NPM 13.2
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	NVSS-2018	14.0	NPM 7.1
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2018	32.0	NPM 7.1
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2016_2018	9.9	NPM 7.1
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2016_2018	11.6	NPM 7.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	91.1 %	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
Indicators and Annual Objectives



Federally Available Data				
Data Source: National Survey of Children's Health (NSCH)				
	2016	**2017**	**2018**	**2019**
Annual Objective			27.1	27.9
Annual Indicator		26.8	29.1	31.4
Numerator		67,562	59,469	54,036
Denominator		252,334	204,083	171,987
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

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						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	28.3	29.5	29.9	30.3	30.7	31.1

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	2018	2019
Annual Objective	7	15	20
Annual Indicator	15	30	30
Numerator			
Denominator			
Data Source	VDH Division of Child and Family Health	VDH Division of Child and Family Health	VDH Division of Child and Family Health
Data Source Year	2016-2017	2017-2018	2018-2019
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	25.0	35.0	50.0	100.0	100.0	100.0

ESM 6.2 - 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

State Provided Data			
	2017	2018	2019
Annual Objective			0
Annual Indicator			Yes
Numerator			
Denominator			
Data Source			VDH Division of Child and Family Health
Data Source Year			2019
Provisional or Final ?			Final

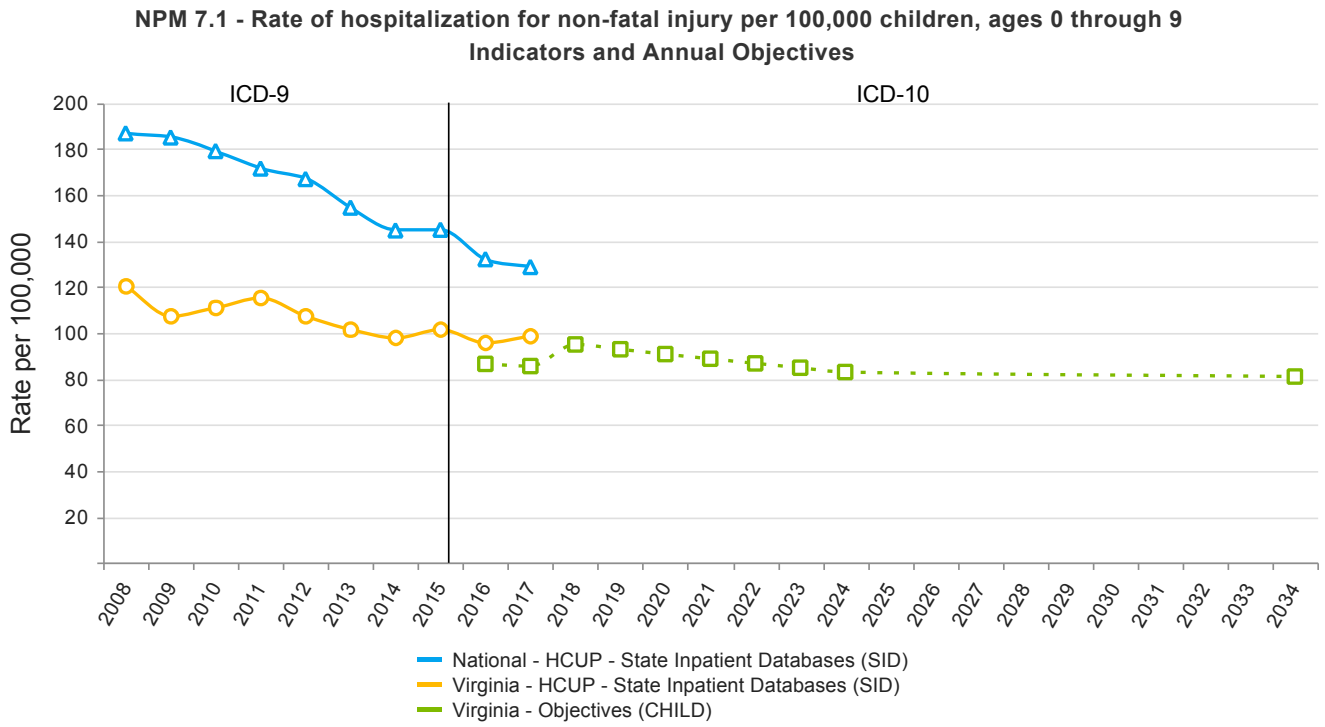
Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

ESM 6.3 - 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	2018	2019
Annual Objective	100	125	200
Annual Indicator	0	0	100
Numerator			
Denominator			
Data Source	VDH Division of Child and Family Health	VDH Division of Child and Family Health	VDH Division of Child and Family Health
Data Source Year	2016-2017	2017-2018	2018-2019
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	250.0	300.0	350.0	400.0	425.0	430.0



Note: ICD-10-CM beginning in 2016; previously ICD-9-CM with 2015 representing January - September

Federally Available Data				
Data Source: HCUP - State Inpatient Databases (SID)				
	2016	**2017**	**2018**	**2019**
Annual Objective	86.5	85.5	94.9	92.8
Annual Indicator	87.0	101.5	95.4	98.6
Numerator	899	785	982	1,013
Denominator	1,033,738	773,528	1,029,557	1,026,897
Data Source	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD
Data Source Year	2014	2015	2016	2017

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	90.7	88.7	86.7	84.8	82.9	81.0

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	2018	2019
Annual Objective		0	10	15
Annual Indicator	0	0	0	12
Numerator	0	0	0	3
Denominator	60	60	53	25
Data Source	Office of Family Health Services, VDH	Office of Family Health Services, VDH	VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Provisional	Final

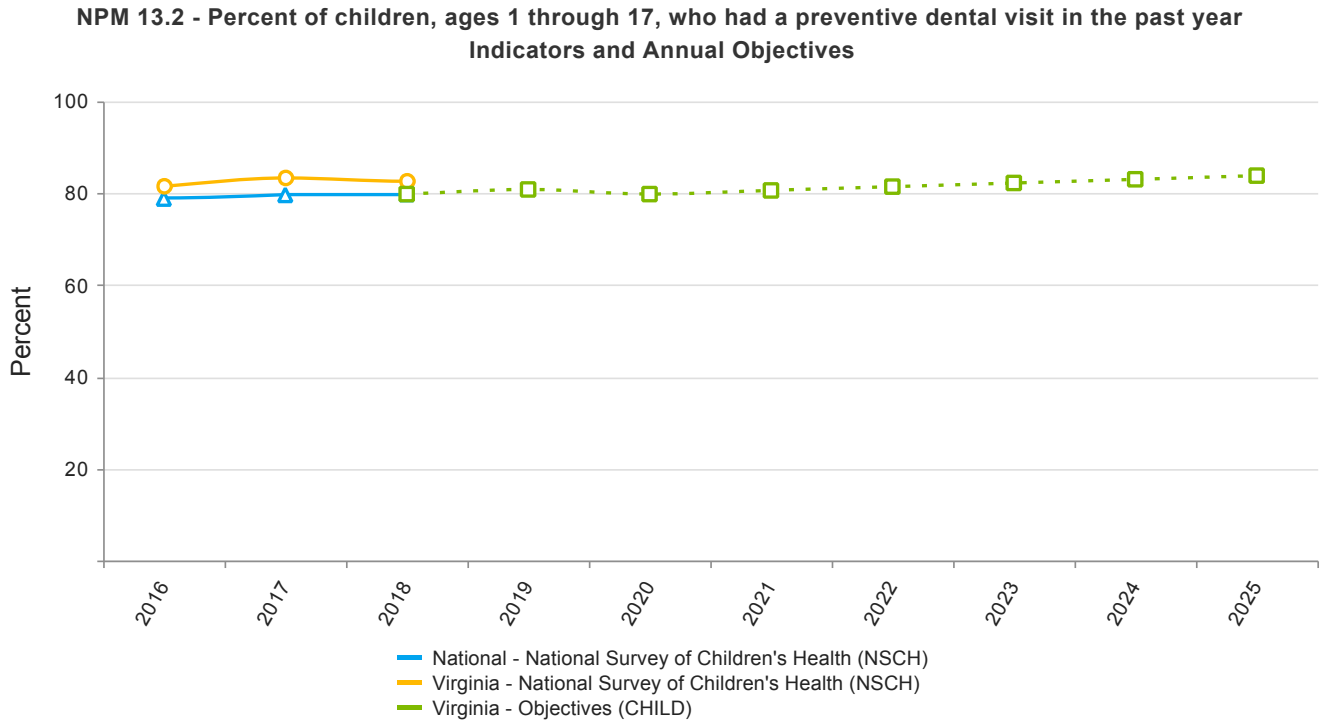
Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	20.0	25.0	30.0	35.0	40.0	45.0

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

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			2,549
Annual Indicator		2,596	1,560
Numerator			
Denominator			
Data Source		VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program
Data Source Year		2018	2019
Provisional or Final ?		Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	2,549.0	2,549.0	2,549.0	2,549.0	2,549.0	2,549.0



NPM 13.2 - Child Health

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH)				
	2016	**2017**	**2018**	**2019**
Annual Objective			93.2	80.7
Annual Indicator		81.4	83.1	82.4
Numerator		1,407,907	1,448,110	1,463,318
Denominator		1,729,004	1,741,839	1,775,616
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

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	2018	2019
Annual Objective			79.7	80.7
Annual Indicator		77.8	78.4	78.9
Numerator				
Denominator				
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	79.7	80.5	81.3	82.1	82.9	83.7

Evidence-Based or –Informed Strategy Measures

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

Measure Status:			Active
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			6
Annual Indicator		3	4
Numerator			
Denominator			
Data Source		VDH Oral Health Program documentation	VDH Oral Health Program documentation
Data Source Year		2018	2019
Provisional or Final ?		Final	Final

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	6.0	6.0	6.0	6.0	7.0	7.0

State Action Plan Table

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

Priority Need

Oral Health: Maintain and expand access to oral health services across MCH populations.

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, 2025, increase the percent of children (ages 1 through 11) who had a preventive dental visit in the past year from 78.9% (NSCH 2017-2018) to 83.7%.

Strategies

Continue to educate dental providers and caregivers on oral care and treatment for ISHCN and very young children.

Maintain online dentist directory for Commonwealth of Virginia dentists willing to see ISHCN and very young children (<3 years).

Maintain and expand existing MCH-focused dental education programs to improve oral health for individuals across the lifespan, to include advising on oral health integration in primary care settings, education for home visitors, school-aged oral health education, and emerging needs of adolescents.

Sustain network of 5 regional Oral Health Alliances and distribute mini-grants for implementation of systems change and data-sharing initiatives to improve the oral health of all Virginians.

Convene statewide groups focused on targeted oral health issues (e.g. Water Equity Taskforce, Early Dental Home workgroup, Future of Oral Health workgroup), facilitate collaboration and workplan development, and provide leadership and oversight to guide initiatives.

ESMs	Status
ESM 13.2.1 - Number of Regional Oral Health Collaborative Projects 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

Mental Health: Promote mental health across MCH populations, to include reducing suicide and substance use.

NPM

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

Objectives

By June 30, 2025, 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 81.0.

Strategies

Provide an injury prevention curriculum to maternity hospitals, local prevention partners, and libraries statewide.

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

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

MCH Data Capacity: Maintain and expand state MCH data capacity, to include ongoing needs assessment activities, program evaluation, and modernized data visualization and integration.

NPM

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

Objectives

By June 30, 2025, 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 81.0.

Strategies

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.

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

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 4

Priority Need

Upstream / Cross-Sector Strategic Planning: Eliminate health inequities arising from social, political, economic, and environmental conditions through strategic, nontraditional partnerships.

NPM

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

Objectives

By June 30, 2025, 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 81.0.

Strategies

Serve on interagency team convened by Title V Director focused on the intersection between child health and transportation.

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

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 5

Priority Need

Strong Systems of Care for All Children: Strengthen the continuum supporting physical/socio-emotional development (i.e. screening, assessment, referral, follow-up, coordinated community-based care).

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, 2025, increase the percent of children (ages 10-71 months) receiving a developmental screening using a parent-completed screening tool from 29.1% (NSCH 2016-2017) to 31.1%.

Strategies

Partner with the Virginia Early Childhood Foundation to support six regional Smart Beginnings Coalitions in advancing developmental screening.

Convene stakeholders to develop a Shared MCH Agenda for Developmental Screening, with shared goals, metrics, and coordinated strategies to 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 - Completion of actionable 2-year plan (FY19-FY20) for strengthening the comprehensive, complex developmental screening system of care for children 0-8	Active
ESM 6.3 - Number of hits to the VDH web pages by individuals seeking information about the importance of regular developmental screening and Bright Futures	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

2016-2020: National Performance Measures

Child Health Domain
FY19 Annual Report

The FY19 workplan for the Child Health Domain included the following performance measures:

1. Oral Health
2. Injury Hospitalization
3. Early and Continuous Screening - Developmental Screening

Strategies within the FY19 Child Health workplan were implemented by the Division of Prevention and Health Promotion's Dental Health (DPH) and Injury and Violence Prevention (IVPP) Programs and the Division of Child and Family Health's Early Childhood Health Unit. Summaries of activities completed during the reporting period are presented by performance measure below.

Complementary efforts were implemented by the Office of the Chief Medical Examiner. These entities and their efforts are detailed in the 'Other Programmatic Activities' section below.

Oral Health

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

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

---

Objective

For the FY19 application, the objective was:

- 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%.

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year was 82.4%. Among children 1-11 years old, 78.9% had a preventive dental visit, which did not meet the target set for reporting year 2019 of 80.7%.

Related National Outcome Measures

The national outcome measures (NOMs) relevant to this NPM include:

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

Significance of NOM 14: Tooth decay (cavities) is among the most common chronic conditions of childhood. Untreated tooth decay can lead to pain and infections which may result in problems with eating, speaking, learning and playing. Children with poor oral health tend to miss more school and get lower grades than those who do not. Tooth decay can be prevented through recommended preventive dental care, including flouride varnish and dental

sealants, community water flouridation, and oral hygeine practices, including brushing and flossing.

Related Healthy People 2020 Objectives:

- Oral Health of Children and Adolescents (OH) 1.1: Reduce the proportion of children ages 3-5 who have dental caries experience in their primary or permanent teeth, (Baseline: 33.3%, Target: 30.0%),
- 1.2: Reduce the proportion of children ages 6-9 who have dental caries experience in their primary or permanent teeth (Baseline: 54.4%, Target: 49.0%)
- 1.3: Reduce the proportion of adolescents aged 13 to 15 years with dental caries experience in their permanent teeth (Baseline: 53.7%, Target: 48.3%)

Progress Updates

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 delivery of preventive dental services for MCH populations.

The Dental Health Program (DHP) 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).

The Dental Health Program (DHP) is described in more detail within the Women's/Maternal Annual Report.

Top FY19 accomplishments specific to children, including children with special health care needs, included:

- The Northern Virginia Oral Health Alliance's Children's Workgroup reviewed data and identified 25 pediatricians in the region with a high volume of Medicaid-enrolled children and began to reach out to them to understand their current oral health screening, assessment, and referral practices. They also shared information and resources to improve integrated care and referrals to dental homes.
- Virginia Health Catalyst issued three microgrants of $5,000 (one in Northern Virginia and one in South Hampton Roads) to implement the Brush, Book, Bed program, an American Academy of Pediatrics-developed initiative to educate families and children about the importance of oral health at an early age. The third microgrant supports an inclusion and de-sensitivity initiative to help aid in preventing dental care-related trauma for children with special health care needs in Virginia.
- Virginia's State Oral Health Program (SOHP) has years of oral health surveillance experience including data collection from multiple populations. However, statewide Individuals with Special Health Care Needs (ISHCN) oral health data had not been collected in Virginia and limited open-mouth ISHCN oral health data is available nationally. The SOHP administered the first Virginia ISHCN Basic Screening Survey June – August 2019 by calibrated public health dental hygienists from the SOHP and the Virginia Department of Behavioral Health and Developmental Services. Thirteen examiners screened 425 ISHCN in 13 health districts. Staff analyzed the data, and findings are being prepared for publications to share with partners, participating venues, ASTDD, and funders. ISHCN BSS process information and oral health data from Virginia could be valuable to other states wishing to conduct such surveys and for comparison with similar data.
- The SOHP also maintains a web-based listing of dental providers who report serving ISHCN and children

under three years of age including listings for approximately 40% of all licensed dentists residing in Virginia. The primary goal of this directory, as well as ongoing dental provider educational courses offered for dentists wanting to increase their skills in dental care of ISHCN, is to increase access to dental providers in Virginia.

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

The HRSA Perinatal and Infant Oral Health Quality Improvement Expansion (PIOHQIE) Grant ended in July 2019 but, with Title V MCH funding, a new program, the Maternal, Infant and Adolescent Oral Health Program was developed to continue important activities related to children through age 17. Activities completed this grant year that relate to this strategy include:

- The MIA consultant served on the Virginia Human Papillomavirus (HPV) Immunization Taskforce and played a unique role in promoting the HPV vaccine and providing data on emerging trends as it relates to HPV and oropharyngeal cancer (OPC) to dental providers and other non-medical community health workers, and promote overall health by incorporating HPV-related oropharyngeal cancer awareness strategies into oral health promotion efforts and school health curricula.
- The RSDHs provided 90 oral screenings, 84 fluoride varnish applications, 112 oral health education, and 50413 dental referrals in WIC and other health department clinics for the (Age 6-17) population.
- The MIA Consultant has submitted a poster presentation titled “Working with Non-traditional Partners for Adolescent Oral Health: The Human Papillomavirus (HPV) Initiative” to present at the 2020 AMCHP Annual Conference in Crystal City, Virginia on March 21-24. The new track for this year’s poster session is “Adolescent and Young Adult Health”. HPV in oral health is an emerging topic for adolescents and young adults and therefore is an ideal topic for the conference poster session.
- The MIA consultant serves on the Tobacco Free Alliance of Virginia to utilize oral health collaboration to create an addition to the “Saving Smiles Series, Give Teen Something to Smile About” leading to an additional section regarding Vaping. The MIA Consultant has met with the Health/PE Coordinator who has agreed to pilot upon completion in several school districts.

In addition, the Individuals with Special Health Care Needs (ISHCN) oral health program completed the following:

- The ISHCN project staff along with collaborative partners provided five continuing education courses for 113 dental providers regarding dental treatment for individuals of all ages with special health care needs. Each of the courses were 11-hours in length and offered for no fee in five separate regions of the state.
- On the day before the dental provider courses, SOHP and DBHDS staff also provided five courses for 63 DBHDS Direct Support Professionals regarding oral health care for individuals with special health care needs.
- As of November 20, 2019, 2,303 dentists have an active account on the SOHP web-based listing of dental providers who report serving ISHCN and children under three years of age.
- The SOHP Special Needs Oral Health Coordinator personally provided education for 396 medical and dental professionals, lay health workers, caseworkers, teachers, families, and individuals about oral health care for ISHCN and young children through 13 presentations and 4 exhibit booths.
- A SOHP remote-supervised dental hygienist worked in the Southwest VA Care Connection for Children medical specialty clinics 14 days and provided 191 ISHCN with oral screenings and 153 with fluoride varnish applications as an extension of the Bright Smiles for Babies program.
- The SOHP conducted an ISHCN Basic Screening Survey (BSS) to assess barriers to dental care and document the current oral health status of ISHCN. The goals are to use this information to improve access to dental services for ISHCN by expanding components of SOHP oral health initiatives and share the findings with partners with power to impact positive changes in access to dental care for this priority population. The

survey was administered June – August 2019 by calibrated public health dental hygienists from the SOHP and the Virginia Department of Behavioral Health and Developmental Services. Thirteen examiners screened 425 ISHCN in 13 health districts. Staff analyzed the data, and findings are being prepared for publications to share with partners, participating venues, ASTDD, and funders.

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.

This strategy is detailed within the Women's/Maternal Annual Report.

Evidence-Based Strategy Measures

The strategies proposed in the FY19 workplan aligned with the following ESM(s):

- 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)

These are detailed within the Women's/Maternal Annual Report.

Injury & Violence Prevention

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

FY19 Performance Measure: NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9

Objective

For the FY19 application, the proposed objective was:

- 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.

NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9 was 98.6 per 100,000, still above the target set for reporting year 2019 which was 92.8 per 100,000.

Related National Outcome Measures

The national outcome measures (NOMs) relevant to this NPM include:

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

Significance of NOM 15: Although the risk of death for children declines sharply beyond infancy, there were still over 6,000 deaths among U.S. children ages 1 through 9 in 2014. Unintentional injury continues to be the leading

cause of death in children 1 to 9 years. Other leading causes include congenital malformations, malignant neoplasms, and homicide.

Related Healthy People 2020 Objectives:

- *Maternal, Infant, and Child Health (MICH) Objective 3.1: Reduce the rate of child deaths aged 1 to 4 years. (Baseline: 29.4 deaths among children aged 1 to 4 years per 100,000 population occurred in 2007, Target: 26.5 deaths per 100,000 population)*
- *Maternal, Infant, and Child Health (MICH) Objective 3.2: Reduce the rate of child deaths aged 5 to 9 years. (Baseline: 13.8 deaths among children aged 5 to 9 years per 100,000 population occurred in 2007, Target: 12.4 deaths per 100,000 population)*

Significance of NOM 16.1: Although the risk of death declines sharply in early childhood, mortality rates begin to increase again in adolescence. Over 12,000 deaths occurred among U.S. children ages 10 through 19 in 2014. The leading causes of illness and death among adolescents and young adults are largely preventable. Unintentional injury continues to be the leading cause of death in adolescents 10 to 19 years, accounting for 36% percent of all deaths, followed by suicide (18%), homicide (13%), and malignant neoplasms (8%).

Related Healthy People 2020 Objectives:

- *Objective Maternal, Infant, and Child Health (MICH) 4.1: Reduce the rate of adolescent deaths aged 10 to 14 years. (Baseline: 16.5 deaths among adolescents aged 10 to 14 years per 100,000 population occurred in 2007, Target: 14.8 deaths per 100,000) Related to Objective Maternal, Infant, and Child Health (MICH) 4.2: Reduce the rate of adolescent deaths aged 15 to 19 years. (Baseline: 60.3 deaths among adolescents aged 15 to 19 years per 100,000 population occurred in 2007, Target: 54.3 deaths per 100,000)*

Significance of NOM 16.3: Suicide is the second leading cause of death for adolescents ages 15 through 19 years. In 2014, there were over 2,000 deaths due to suicide among adolescents ages 15 to 19 years, or 9.8 deaths per 100,000. Suicide and suicidal ideation is often indicative of mental health problems and stressful or traumatic life events. In 2015, 18 percent of high school students reported they had thought seriously about committing suicide in the past year. While females are more likely to report considering suicide, males are more likely to succeed in committing suicide. The suicide mortality rate for males is nearly three times that of females.

Related Healthy People 2020 Objectives:

- *Mental Health and Mental Disorders (MHMD) Objective 1: Reduce the suicide rate. (Baseline: 11.3 suicides per 100,000 in 2007, Target: 10.2 suicides per 100,000)*
- *Mental Health and Mental Disorders (MHMD) Objective 2: Reduce suicide attempts by adolescents. (Baseline: 1.9 suicide attempts per 100 occurred in 2009, Target: 1.7 suicide attempts per 100)*

Progress Updates

The Virginia Department of Health, Division of Prevention and Health Promotion, Injury and Violence Prevention (IVP) Program is led by Lisa Wooten, MPH, BSN, RN (IVP Program Supervisor).

In Virginia, injury is a leading cause of death and hospitalizations for children, adolescents, and adults. Injuries and violence affect everyone—regardless of age, race, or economic status. Often, survivors are faced with life-long

physical, mental, and financial problems. The good news is, injuries and violence are often preventable, and effective primary prevention strategies that are evidence based, informed, and organizationally adopted are successful for vulnerable populations.

The goal of the VDH Injury and Violence Prevention Program (IVPP) is to prevent and reduce the consequences of unintentional injuries and acts of violence, addressing risk factors and protective factors at the population health level through practice and policy change.

The program seeks to build solid infrastructure to improve the health of Virginians by increasing awareness and action to reduce unintentional and intentional injuries; and to provide technical assistance to local and state partners to assess the burden of injury, assure interventions and facilitate policy development. Title V-funded and non-funded IVPP staff continue to lead these programs.

Child Health Efforts

The IVPP statewide Low Income Safety Seat Distribution and Education Program leverages Title V grant funds to remove financial barriers for income eligible families and high risk populations statewide through a network of 154 distribution sites by providing no cost child safety seat devices, in addition to proper installation and usage education. The program provides transportation safety awareness as it relates to Virginia Child Passenger Safety Law (Code of Virginia, Chapter 10, Article 13). Title V-funded and non-funded IVPP staff continue to lead these programs.

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

Top FY19 accomplishments included:

- Disseminated one injury prevention prenatal curriculum for dissemination to maternity hospitals, local health departments, and community prevention programs
- Distributed child safety seats with parent/guardian installation and usage education to eligible families
- Hosted gatekeeper trainings for school based mental health professionals
- Equipped healthcare providers with the primary prevention skills in reducing Neonatal Abstinence Syndrome through evidence based models

Program Logos, Branding, & Communications:

The IVPP Title V team partners with the OFHS Communications Team to assist with programmatic material design, and dissemination of injury and violence prevention public awareness and targeted campaigns.

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

In FY18, IVPP completed the development of Project Patience, an evidence informed initiative supporting statewide delivery of prenatal and postpartum education on child maltreatment and infant injury prevention, in preparation for dissemination in FY19.

Project Patience is an evidence informed initiative supporting statewide delivery of prenatal and postpartum education on child maltreatment and infant injury prevention for newborn and infant caregivers. Project Patience focuses on providing technical assistance to maternity hospitals, libraries, local health departments, and community comprehensive maternity case management programs and be trained in educating community participants in injury prevention. The program is framed by Bright Futures, American Academy of Pediatrics, National Traffic Highway Safety Administration, and Centers for Disease Control and Prevention. In FY19, IVPP partnered with the Virginia Department of Behavioral Health and Developmental Services Prevention program and with the VDH Program Manager overseeing the local health department public health nursing network to expand its FY20 dissemination plan among the local health districts, libraries, and maternity hospitals.

Continued Project Patience activities are included in Title V's FY21 Application.

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.
Limited Title V and non Title V funded staff/volunteer staff, working in the health departments provide the services of applicant screenings, programmatic reporting, and dissemination and education training sessions. Low Income Safety Seat Distribution and Education site staff are housed in Health Departments of thirty-one of the thirty-five Health Districts. The remaining non-participating Health Districts include Eastern Shore, Prince William, Three Rivers, and Pittsylvania/Danville. (The Pittsylvania/Danville Health District will become operational December 2019.) MCH funded and non funded sites, support efforts in providing safety seats to income eligible clientele following education in correct usage and installation of the restraints.

In FY21, Title V staff will explore capacity for local health districts to address this strategy using their allotted Title V funds.

Strategy 3: Equip healthcare providers with primary prevention skills for reducing Neonatal Abstinence Syndrome through the evidence-based model Project ECHO.

IVPP partners with the University of Virginia to facilitate Project ECHO (Extension for Community Healthcare Outcomes), a technology-enabled collaborative learning and capacity building model which connects specialists and subspecialists to primary care providers and clinicians in rural and underserved areas throughout the Commonwealth to deliver best practice care for complex conditions like Neonatal Abstinence Syndrome.

Evidence-Based Strategy Measures

The strategies proposed in the FY19 workplan aligned with the following ESM(s):

- ESM 7.1 – number of maternity centers with prenatal courses including Virginia's Injury Prevention Curriculum
- ESM 7.2 – number of child safety seats disseminated through the LISSDEP network
- ESM 7.3 – number of healthcare providers receiving Project ECHO content in reducing the impact of NAS

ESM 7.1: Number of maternity centers with prenatal courses including Virginia's Injury Prevention Curriculum

During FY19, IVPP worked with 25 hospitals to continue technical assistance in the readiness for adopting Project Patience. During the course of the year, 3 Bon Secours maternity hospitals agreed to infuse the VDH curriculum into their current Love and Learn maternity hospital education. In addition, 1 VDH local health district in Alexandria Virginia adopted Project Patience contents in Violence Prevention, Abusive Head Trauma prevention. Work was expanded into one implementation plan for Henrico County, Virginia libraries for FY20.

Project Patience dissemination activities were included in the FY20 and FY21 Applications. The total deliverable goal for implementation is expected to actualize in FY20.

ESM 7.2: Number of child safety seats disseminated through the LISSDEP network

IVPP leveraged MCH funds to disseminate child safety seats through the Low Income Safety Seat Distribution and Education Program (LISSDEP) network. During FY19, 1,342 convertible safety seats and 218 boosters, totaling 1,560 distributed to income eligible families. The LISSDEP network experienced a decrease in eligibility applications by clientele during the FY. The program continued its programmatic evaluation to determine the root cause.

ESM 7.3: Number of healthcare providers receiving Project ECHO® content in reducing the impact of NAS

IVPP contracted with the University of Virginia to facilitate the NAS Project ECHO® project in FY19. Based on a hub and spoke model, Project ECHO® is free to health care providers, and delivered right to their clinic through a virtual platform. Providers are exposed to a community of learners, and are offered continuing medical education units, opportunity to present de-identified cases, and access to a virtual community of tools and resources. Partially funded and non funded MCH staff provided technical assistance to the University of Virginia in curriculum development and delivery of the Project ECHO® model with fidelity and integrity.

Curriculum content for FY19 was inclusive of maternal discharge planning from the injury lens, pharmacotherapy for stabilization of the mother, and prevention of maternal substance use prenatal and postnatal for harm reduction.

Activities continued in the FY20 work plan and included the following NAS Project ECHO sessions:

- December 5, 2018, 20 participants.
- December 19, 2018, 16 participants.
- January 9, 2019, 15 participants.
- January 23, 2019, 8 participants.
- February 6, 2019, 9 participants.
- February 20, 2019, 5 participants.
- March 6, 2019, 8 participants.
- March 20, 2019, 10 participants.
- April 3, 2019, 7 participants.
- April 17, 2019, 8 participants.
- May 1, 2019, 6 participants.
- May 15, 2019, 7 participants.

Total of 12 Project NAS ECHO sessions:

- 119 participants

- 60 Unique participants
- 17 Health Centers/Clinics who participated
- Virginia Regions Represented: Southwest, Northeast, Central and Southeast

Participants in the University of Virginia NAS Project ECHO included a multidisciplinary group from throughout the Commonwealth including, medical doctors, nurse practitioners, licensed counselors, nurse managers, lactation consultants, and NICU RN's and neonatologists. NAS Project ECHO content was delivered to providers with as many as 483 miles between them. The topics taught at Project ECHO NAS sessions were SAMSHA approved effective interventions for Opioid Use Disorder, including medication assisted treatment. The Substance Abuse and Mental Health Services Administration (SAMSHA) developed the clinical guidelines to meet the urgent needs among professionals who care for women with Opioid Use Disorder and substance exposed infants for reliable, useful, and accurate information that can be applied in clinical practice to optimize the outcome for both mothers and infants.

Topics for these specialized Project ECHO sessions included:

- Prenatal Screenings and Assessments
- Initiating Pharmacotherapy for Opioid Use Disorder
- Changing Pharmacotherapy During Pregnancy
- Managing Pharmacotherapy Over the Course of Pregnancy
- Pregnant Women with Opioid Use Disorder and Comorbid Behavioral Health Disorders
- Addressing Polysubstance Use During Pregnancy
- Planning Prior to Labor and Delivery
- Peripartum Pain Relief
- Screening and Assessment for Neonatal Abstinence Syndrome
- Management of Neonatal Abstinence Syndrome
- Breastfeeding considerations for Infants at Risk for Neonatal Abstinence Syndrome
- Infant Discharge Planning

The University of Virginia NAS Project ECHO held bi-weekly labs from December 2018 to May 2019. The remaining of the contract period was spent to evaluate progress and develop additional content for the following FY.

Developmental Screening

State Priority: Early and Continuous Screening - Support optimal mental health and social-emotional development of all children.

FY19 Performance Measure: NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Objective

For the FY19 application, the proposed objective was:

- 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%.

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 was 31.4%, exceeding the target set for reporting year 2019 which was 27.9%.

Related National Outcome Measures

The national outcome measures (NOMs) relevant to this NPM/SPM include:

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

Significance of NOM 13: The early years are a critical period where experiences impact structural development of the brain and neurobiological pathways for functional development. Although early experiences do not determine children's ongoing development, interventions around school readiness and early childhood education can act as a protective factor against the future onset of adult disease and disability. Studies have shown that children's literacy and numeracy skills at school entry are a good predictor of later academic achievement, high levels of education and secure employment. Social gradients in language and literacy, communication and socioemotional functioning emerge early for children across socioeconomic backgrounds, and these differences persist into the school years. There are also disparities in the US as to who participates in an early childhood program. Children at risk of poor developmental and educational out

Related Healthy People 2020 Objectives:

- *Early and Middle Childhood (EMC) 1. (Developmental) Increase the proportion of children who are ready for school in all five domains of healthy development: physical development, socialemotional development, approaches to learning, language, and cognitive development.*

Progress Updates

Developmental screening represents an emerging priority for the state Title V program. Three ESMs have been developed to reflect planned FY19 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 pediatric care at the community level.

Developmental Screening as a State Priority

Virginia ranked 39th in the nation in 2018 for developmental screening rates for children under age five years, which was up from 42nd in 2017. Parent report of developmental screening hovers around 22% meaning that over 2/3 of young children in Virginia are not screened prior to school entry.

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

According to a report by the University of Virginia's Curry School of Education, one in three children in Virginia is not prepared to succeed in the areas of self-regulation, social skills, literacy, and/or math at the beginning of kindergarten. Being developmentally ready to learn and participate in classroom activities not only sets the stage for successful school entry but can have lifelong influence on well-being. The report found that "children who enter kindergarten behind their peers rarely catch up; instead, the achievement gap widens over time." Investing in

programs that prepare children to succeed in school and facilitate early intervention for those requiring additional support helps to prevent them from falling behind and experiencing poor educational outcomes, such as dropping out of high school.

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

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

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

The work of 2018 coalesced around a statewide Developmental Screening Initiative to help close the gap in developmental screening care for the children in the Commonwealth who are without access to supportive and coordinated screening services. The Virginia Developmental Screening Initiative is a new statewide initiative dedicated to improving developmental screening services in Virginia. The primary goal in moving forward on the work of the prior year was to develop a strategic developmental screening work plan with community stakeholders, through six regional hubs, to build a continuum of developmental and behavioral care to reduce barriers and gaps and promote equity for all young children and their families. In FY21, partnerships will be developed with the community's performing the screening and Child Development Centers who receive referrals to form a continuous seamless loop. The core outcome is for all children to be screened early and continuously for special health care needs. This work is funded entirely through Title V.

Top FY19 accomplishments included:

- In FY19, a series of internal brainstorming sessions and in-person state and regional stakeholder meetings were held with support from the staff from AMCHP and the National MCH Workforce Development Center.

Program Logos, Branding, and Communications:

The developmental screening program included two communications efforts. The first efforts incorporated the communication team and involved re-establishing the child health website on a new server and reconstructing the transferred parent videos. The videos are a B-5 approach to child health using Bright Futures and normal child development and screening. The second phase of work with the communication team will be to continue to build out a more interactive developmental screening web page as an extension of the work of the six regional developmental screening hubs. http://www.vdh.virginia.gov/brightfutures/

The second effort was the creation of a Developmental Screening Model following the fall 2018 stakeholder meeting. It provided input from partners and families as part of a visioning exercise. The exercise created visual models of an

ideal developmental screening system.

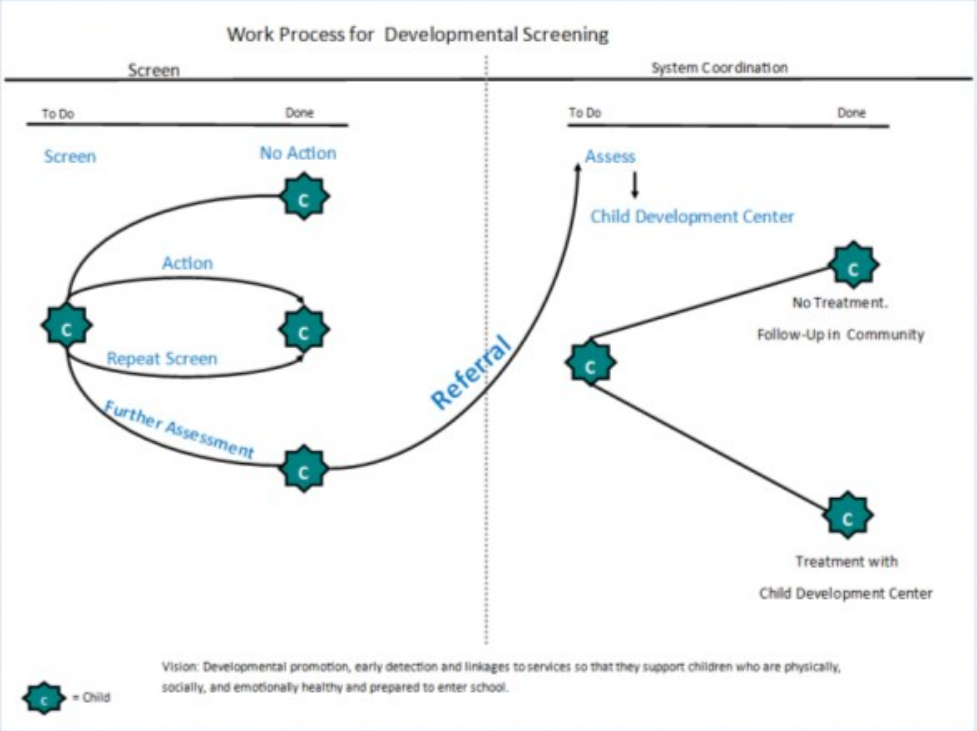


Diagram: Developmental Screening Initiative Model

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

Rxploration of the need and number of LHDs, community partners, and providers receiving developmental screening resources, training, and TA showed that at the local level, LHDs serve as a safety net for providing child health physicals and developmental screenings and play a key role in linking families to community resources to ensure continuity of care. In FY17, each LHD was provided with copies of the fourth edition of the Bright Futures Guidelines and accompanying reference materials. ECH staff have also conducted trainings on Bright Futures and ASQ tools for LHD staff. Sustaining the number of trained LHD staff is a priority.

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.

The state website was revised and updated to reflect the work around Bright Futures and medical home. A communications plan was developed with the communications team for implementation.

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

In FY17, an internal report was developed summarizing developmental screening efforts in Virginia. While the state has engaged in a variety of efforts, existing data reflect primarily grant or program requirements.

Virginia is slowly building a system around referrals, determined eligibility, and receipt of services primarily through Early Intervention and Child Development Centers. These are primarily due to program or grant requirements.

Data do exist for children accepted into service delivery for developmental delays. However, there is currently no centralized information on referrals for children with suspected delays not accepted into or who are ineligible for services and subsequently discharged back into the community.

Qualitative data point to a larger systems issue of care, connection, and coordination for comprehensive service delivery for at-risk children. This is particularly true for children of color. The lack of systemic supports for centralized referral and data are some of the barriers to building stronger systems of developmental care.

Examination of existing information and/or studies had too small of a sample size or paid insufficient attention to establishing causality and quality data; others did not sufficiently engage stakeholders appropriately, and as a consequence, results were never put to use.

There currently is no state mandate to report individual developmental screening; it is not included on school health physicals nor is it required for school entry, childcare programs cannot do a screening and referral without parent permission, and medical practices report not having sufficient staff time to pull and review records unless the information is electronically compiled. Without a centralized data or referral system, developmental screening information is not easily accessible. Little data exists to understand screening practices and referrals by personnel performing developmental screening. The questions that could not be answered from the environmental scan was primarily, “What is it about the design of the current system that is insufficient to meet the needs of the family and provider, and how can we improve it?”

More work remains to adequately capture and assess what happens to children following a developmental screen to ensure they get the care they need. There exists the need to examine further the system of developmental care to understand the need, desire, limitations, motivation, and importance of completing a screening and referral by the provider. It had been over a decade since a stakeholder group met to discuss developmental screening.

In FY19, the Title V team sought technical assistance from the National MCH Workforce Development Center.

As of 2020, the state still lacks a common agenda for providing comprehensive and coordinated care. A key next step is to bring stakeholders together to identify developmental screening needs from screening to referral aligned with national evidence-based recommendations.

In FY21, the Early Child Health Consultant and Title V Director will work jointly to reconvene state and regional partners to develop a Shared Agenda for Developmental Screening with partners from the Virginia Early Childhood Foundation, home visiting, social services, behavioral health, early child education, the state Family-to-Family program, AAP, Early Intervention, and Medicaid.

Through an iterative process, the stakeholder group plans develop shared goals, metrics, and recommendations for appropriate allocation of resources to help develop building blocks towards a seamless system of service delivery.

Evidence-Based Strategy Measures

The strategies proposed in the FY18 work plan aligned with the following ESM(s):

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

ESM. 6.1: ECH staff provided statewide training, technical assistance, and resources to LHD nurses that provide these services. Efforts focused on sustaining and expanding the number of LHD staff that have up-to-date knowledge and skills to provide developmental screenings using the revised ASQ3 and ASQSE2. Trainings permit continued technical assistance and support and prevent loss of staff knowledge and capacity due to turnover. Future activities may include: exploring billing practices for developmental screening reimbursement; exploring the feasibility of allotting a minimum thirty minutes of clinic time to working with each family to complete, score, and review results of screening tools; and ensuring LHD staff are equipped to link families to community resources for follow-up and referrals, as needed. VDH ECH staff also continued to participate in critical interagency initiatives related to developmental screening. For example, the Early Childhood Mental Health Advisory Board is a statewide multi-agency, multidisciplinary stakeholder group tasked with addressing infant and child mental health issues in Virginia. All key state agencies serving infants and children are represented, with multiple staff participating on behalf of each agency's various programs. Since its inception, the number of agencies represented has grown from four agencies to 24 agencies. Among the interests represented are advocacy, social services, health, education, behavioral health, early intervention, and parents/families. Early childhood special education professionals and clinical providers also offer input, including a psychologist, a pediatrician, and various rehabilitation associates (e.g. occupational, speech, and physical therapists).

ESM 6.2: VDH efforts focused on providing messaging and education to providers. Family-focused efforts have been largely limited to families of CSHCN; however, a number of partners are working together to educate parents on the importance of well-child visits. Specifically, ECH staff expanded engagement and education efforts to families of children with and without special healthcare needs. Promotion of the *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents* to LHD staff and external providers continued. Efforts included development and dissemination of messaging to providers via channels such as electronic newsletters and the VDH website. ECH staff developed and disseminated social media messaging targeting families and community members on the importance of regular child health check-ups linked to Bright Futures and normal child development and screening.

The OFHS Communications Team provided ongoing support and expertise in messaging and distribution. In FY18 and FY19, the web site migrated to a new platform necessitating the re-development of existing materials. This ESM will continue into the upcoming year with a revised communication plan under development with the hiring of a new internal webmaster. In addition, a plan was developed to incorporate CDC's *Know the Signs, Act Early*.

ESM 6.3: This ESM builds on early momentum with key partners to flesh out a 2-year state action plan to promote developmental screening. A planning meeting with key stakeholders took place in the Fall of 2018 and Spring of 2019. Outcomes from the meetings included:

- Exploring why screening matters with the recommendation to continue to begin meetings with this question to

penetrate more for the bigger why to make sure the details of the work driven by the important impacts on children, families, and communities;
- Compilation of a draft vision statement for the developmental screening initiative with visualizations based off the work in the room;
- Initiating mapping of the current state system through causal loop diagramming; and
- Beginning to think about how to contextualize data needs within a larger system.

Other Programmatic Activities

Office of the Chief Medical Examiner

OCME continued to lead child fatality review with Title V funds. These activities are described in detail in the FY21 Application.

Child Fatality Review

The Virginia State Child Fatality Review Team is unique when compared with child death review processes in other states. Virginia's Team does not review every child death every year, but instead chooses a specific type of child death on which to focus its review. For example, 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.

Reviews typically cover child deaths from certain causes or manners of death or injury patterns. The Team is tasked with developing recommendations for prevention, education and improved child death investigation.

Membership of the multi-disciplinary team is defined in statute and includes physicians and representatives from state and local agencies who provide services to families and children or who may be involved in the investigation of child deaths. The Team also appoints special advisors whose areas of specialization provide additional insight to the Team.

The Team is chaired by the Chief Medical Examiner and includes the following persons or their designees:
- Commissioner of Behavioral Health and Developmental Services
- Program Manager for Child Protective Services, Virginia Department of Social Services
- Superintendent of Public Instruction
- State Registrar of Vital Records
- Director of Criminal Justice Services

One representative from each of the following is appointed by the Governor to serve for three-year terms:
- Local law enforcement agencies
- Local fire departments
- Local departments of social services
- Medical Society of Virginia
- Virginia College of Emergency Physicians
- Virginia Chapter, American Academy of Pediatrics
- Local emergency medical services providers
- Attorneys for the Commonwealth

- Community services boards

In addition, special advisors are appointed to the Team based upon their area of expertise and include representatives from:

- Child advocacy
- Child psychiatry
- Forensic pathology
- Public health
- Juvenile justice
- Toxicology

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

Child Health Domain
FY21 Application

The FY21 workplan for the Child Health Domain includes the following performance measures:

1. Oral Health
2. Injury Hospitalization
3. Early and Continuous Screening - Developmental Screening

Bethany Geldmaker, PhD (Early Child Health Consultant) currently serves as the Title V Child Health Domain Lead.

Title V-funded efforts for child health will be implemented by the Dental Health Program Injury and Violence Prevention Program, emerging Child Health Program, and the Early Childhood Health Unit. These entities and their proposed activities for the upcoming grant period are detailed below.

I. Dental Health Program

The Division of Prevention and Health Promotion (DPHP)'s Dental Health Program is led by Tonya McRae Adiches, RDH (Dental Health Programs Manager).

A detailed overview is provided within the Women's Health Domain application.

Specific to children ages 1 through 17, including individuals with special health care needs (ISHCN):

- Bright Smiles for Babies (BSB) is a prevention and education initiative to reduce the prevalence of early childhood caries (ECC) in infants and toddlers, aged 6 months – 3 years of age. Children who are at high risk for ECC often experience barriers to accessing timely dental services. The BSB program eases barriers to care by providing preventive services primarily in non-dental settings where parents of young children are seeking other services (e.g. doctors' offices, WIC).
- The Dental Preventive Services Program aim is to prevent dental decay for children in the most susceptible permanent teeth, in the most vulnerable populations in Virginia. Low-income schoolchildren in targeted areas of the state receive dental services including oral health assessment, dental cleanings, dental sealants, fluoride varnish application, dental referral information, and oral health education.
- The Special Health Care Needs Oral Health Program aims to improve access to dental services for ISHCN by expanding components of the Dental Health Program's (DHP) oral health initiatives to include services focused on ISHCN. This is accomplished through educating medical/dental professionals, lay health workers, case workers, teachers, families, and individuals about oral health care for ISHCN through presentations, exhibit booths, and educational materials. With Title V funds, staff provide oral health education materials and support for dental and medical provider courses regarding the care of very young children, pregnant women, and ISHCN, as well as, maintain a current web-based listing of 2,300 dental providers who report serving ISHCN and children under three years of age, representing approximately 41% of Virginia's licensed dental providers residing in the Commonwealth of Virginia. Title V monies fully fund the ISHCN Program Coordinator's wages and benefits while PHHS funding supports all other programmatic costs including contracts with partner organizations, trainers, travel, supplies, and technology components.

FY20 Action Plan Overview: Oral Health

State Priority: Oral Health
FY21 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, 2025, increase the percent of children (ages 1 through 11) who had a preventive dental visit in the past year from 78.9% (NSCH 2017-2018) to 83.7%.

According to the National Survey of Children's Health (2017-2018) 65.6% of children age 1-5 years and 89.5% of children 6-11 years in Virginia had a preventive dental visit. Overall, 82.4% of children, ages 1 through 17, who had a preventive dental visit in Virginia.

Strategy: Continue to educate dental providers and caregivers on oral care and treatment for ISHCN and very young children.
Domain: Child

Activity	Expected Completion Date	Responsible Staff
Continue to provide up to five health districts with direct service provider oral health trainings and dental provider trainings regarding ISHCN and very young children (a total of 10 trainings)	Ongoing	Kami Piscitelli - Individuals with Special Needs Health Care Needs Oral Health Coordinator (ISHCNOHC)
Renew contracts with VDAF and VHC to plan and manage logistics to conduct trainings	October 2020	ISHCNOHC
Partner with contractors for project planning	October 2020	ISHCNOHC
Conduct oral health trainings regarding care for ISHCN and very young children	August 2021	ISHCNOHC
Evaluate trainings to ensure that goals are met	September 2021	ISHCNOHC

With support for trainings from other federal sources (PHHS), the MCH funded Individuals with Special Healthcare Needs (ISHCN) Oral Health Coordinator continues to provide trainings statewide to educate dental providers and care givers on oral care and treatment for ISHCN and very young children. The overall goal of the program is to increase awareness and education regarding the oral health of ISHCN for a wide variety of stakeholders and providers that have the potential to make a difference in access to oral health care in this population. In FY21, the program will involve two approaches including providing oral health in-service trainings to direct service providers (DSPs) working in DBHDS licensed group homes for ISHCN and providing continuing education (CE) courses to dental providers regarding oral care of ISHCN. Both parts of the program will be completed in up to five separate health districts in the Commonwealth of Virginia.

Strategy: Maintain online dentist directory for Commonwealth of Virginia dentists willing to see ISHCN and very young children (<3 years).
Domain: Child

Activity	Expected Completion Date	Responsible Staff
Update provider database that populates the ISHCN Online Directory of Dental Providers	Ongoing	ISHCNOHC
Partner with other Title V programs to promote directory to families, as appropriate	Ongoing	ISHCNOHC

The online dentist directory for Commonwealth of Virginia dentists willing to see ISHCN and very young children (< 3 years) will continue to be maintained and updated on a monthly basis as new dentists are educated and added to the directory or contact information changes are requested by individual dentists.

Snapshot of Program Accomplishments

- VDH expanded its oral health surveillance system by conducting an open-mouth basic screening survey (BSS) for ISHCN to capture data regarding the oral health status for ISHCN of all ages; to improve access to dental services for ISHCN; and to collaborate and share the findings widely with partners and other agencies with the power to impact positive changes in access to dental care for this priority population group. VDH successfully collected data from 425 ISHCN across the Commonwealth using both an open-mouth screening tool and an in-depth questionnaire. The findings from this survey are being used to shape programming and trainings for this population and to educate stakeholders on the oral health needs of ISHCN.
- Through a partnership with the Care Connection for Children pediatric medical specialty clinics in three Southwestern Virginia counties, a VDH remote-supervised dental hygienist provided preventive services. ISHCN at these clinics had the opportunity to receive these services 12 days out of the year. The number of services provided include 112 oral screenings, 106 fluoride varnish applications, 75 dental referrals, and oral health education for 115 parents/caregivers.

Data-Informed Strategies

During the summer of 2019, with CDC Oral Health Outcome Improvement Grant funds, VDH conducted a basic screening survey (BSS) of ISHCN that included and open-mouth screening and an in-depth questionnaire regarding oral health knowledge, access to dental care, oral hygiene practices, and health status. The goal of the survey was to capture data regarding the oral health status for ISHCN of all ages to use to crate trainings and programs to help to improve access to dental services for ISHCN, and to collaborate and share the findings widely with partners and other agencies with the power to impact positive changes in access to dental care for this priority population group. Thirteen dental hygienist examiners, from thirteen different Virginia health districts, were calibrated and collected data from 425 ISHCN Statewide over a 3-month period. The findings from this survey are being used to shape programming and trainings for this population and to educate stakeholders on the oral health needs of ISHCN. The final summary of this survey is attached.

II. Injury & Violence Prevention Program

The Virginia Department of Health, Division of Prevention and Health Promotion, Injury and Violence Prevention (IVP) Program is led by Lisa Wooten, MPH, BSN, RN (Injury and Violence Prevention Program Supervisor).

Injuries continue to be a leading cause of death in the US and Virginia. Injuries and violence can affect all Virginians. 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 through potentially modifiable factors, such as the environment, behavior change, policy, and use of safety devices.

The IVP aims to prevent and reduce the consequences of unintentional injuries and acts of violence, addressing risk factors and protective factors at the population health level through practice and policy change. The program seeks to build solid infrastructure to improve the health of Virginians by increasing awareness, action, and technical assistance for and by local and state partners to assess the burden of injury, assure interventions and facilitate policy development. Per the socioecological model, the IVP works to implement multi-level interventions (e.g. individual, relationship, community, societal) across sectors to influence those potentially modifiable variables, improve protective factors, equip the workforce to address primary prevention, reduce barriers for access to safety devices, and influence policy changes through a health equity lens. Title V-funded and non-funded IVPP staff continue to lead these programs.

IVP Program staff seeks family and consumer input and continues to utilize data on deaths and hospitalizations attributable to injury to inform programmatic activities.

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

Snapshot of Program Accomplishments

In addition to support general injury and violence prevention education, program accomplishments under Title V work include:

- Low Income Safety Seat and Distribution Program: The IVP Program leverages Title V funds to expand statewide Low Income Safety Seat Distribution and Education Program (LISSDEP) activities and remove financial barriers for income eligible families and high risk populations statewide through a network of 154 distribution sites by providing no cost child safety seat devices, in addition to proper installation and usage education. The program provides transportation safety awareness as it relates to Virginia Child Passenger Safety Law (Code of Virginia, Chapter 10, Article 13). Title V-funded and non-funded IVPP staff continue to lead these programs.

- Project Patience: The IVP Program leverages Title V funds to expand Project Patience, an evidence based and informed initiative supporting statewide delivery of prenatal and postpartum education on child maltreatment and infant injury prevention for newborn, infant, and childhood caregivers. Project Patience focuses on providing technical assistance to maternity hospitals, libraries, local health departments, and community comprehensive maternity case management programs staff to equip them with the skills to train their community participants in injury and violence prevention. The program uses the framework of Bright Futures, American Academy of Pediatrics, National Traffic Highway Safety Administration, and Centers for Disease Control and Prevention.

- Project ECHO®: Based on a hub and spoke model, Project ECHO® is a no-cost tele education platform that demonopolizes knowledge by exposing healthcare providers to a community of learners. The program provides continuing medical education units, opportunity to present de-identified cases, and access to a virtual community of tools and resources. The IVPP has leveraged Title V funds to expand Project ECHO: Neonatal Abstinence Syndrome prevention labs, equipping maternal and pediatric healthcare providers with the skills to provide case management and harm reduction services for women at risk for, or with a history of, substance misuse, abuse, and addiction during childbearing age; all with the goal for prevention of Neonatal Abstinence Syndrome.

FY21 Action Plan Overview: Mental Health

State Priority: Mental Health
FY20 Performance Measure: NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children ages 0-9

Objective: By June 30, 2025, 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 81.0.

According to America's Health Rankings (2019), Virginia ranks 6 overall for the health of children, and 18 for the overall health of women and children. The child mortality rate was 23.6 per 100,000 children ages 1-19, compared to the U.S. rate of 25.7. Differences exist in the rate of child mortality by gender, race/ethnicity, and age group in Virginia:

Child Mortality, Virginia, Rate per 100,000 children ages 1-19	
Gender	
Male	30.3
Female	16.6
Race	
White	22.4
Black	33.1
Hispanic	17.7
Asian	12.1
Age	
1-4 years	23.4
5-14 years	11.8
15-19 years	46.4
Source: CDC WONDER Online Database, Underlying Cause of Death, Multiple Cause of Death files, 2015-2017	

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 98.6 per 100,000 in 2017. Among age groups, the annual indicator was 210.8 for children less than one year of age, 108.9 among children ages 1-4, and 68.5 among children ages 5-9.

Strategy: Provide an injury prevention curriculum to maternity hospitals, local prevention partners, and libraries statewide.
Domain: Child

Activity	Expected Completion Date	Responsible Staff
Disseminate the injury prevention curriculum to all maternity hospitals, inclusive of materials for Baby TV channels	October 2020-September 2021	IVP Supervisor; Non-MCH Funded Position; Contractor company;VHHA
Provide maternity hospitals with continued technical assistance in implementing the injury prevention curriculum	October 2020-September 2021	IVP Supervisor; Non-MCH Funded Position
Disseminate the injury prevention curriculum to all local/regional libraries with child services programs	October 2020-September 2021	IVP Supervisor; Non-MCH Funded Position; LOVA
Disseminate the injury prevention curriculum to all local prevention partners, inclusive of local health departments, and WIC offices.	October 2020-September 2021	IVP Supervisor; Non-MCH Funded Position; LOVA

IVPP will continue the dissemination of Project Patience, an initiative supporting statewide delivery of prenatal and postpartum education on child maltreatment and infant injury prevention.

IVPP staff provides technical assistance in a train the trainer format so that prevention programs can in turn train their community members in childhood injury and violence prevention. The curriculum includes modules in child passenger safety, drowning prevention, poisoning prevention, traumatic brain injury prevention, injury by children's products prevention, safe sleep strategies, and prevention of shaken baby syndrome.

FY21 Action Plan Overview: MCH Data Capacity

State Priority: MCH Data Capacity

FY20 Performance Measure: NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children ages 0-9

Objective: By June 30, 2025, 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 81.0.

Strategy: 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.
Domain: Child

Activity	Expected Completion Date	Responsible Staff
Complete a needs/asset assessment and evaluation specific to the child safety seat distribution program, to include key accomplishments, identification of community-based organizations poised to serve as strategic partners, and assessment of 3-5 strategic needs. Assessment will link to safe sleep, WIC, tobacco, etc., network out access points, inclusive of (LHDs, faith-based and VDH Office of Health Equity), and have an equity consideration (connecting re: language/cultural + workforce to provide training)	October 2020-September 2021	IVP Supervisor; Transportation Safety Coord; 3 Non-MCH funded positions; Contractor company
Develop (1) a strategic communications plan around child safety seat distribution, with an emphasis on targeted populations of disparity	October 2020-September 2021	IVP Supervisor; Transportation Safety Coord; 3 Non-MCH funded positions; Contractor company
Develop a CPS training plan that includes outreach to community based organizations, with an emphasis on targeted populations (e.g. foster families; Black, Hispanic families; low-income families).	October 2020-September 2021	IVP Supervisor; Transportation Safety Coord; 3 Non-MCH funded positions; Contractor company
Continue distribution of child safety seats with parent/guardian installation and usage education to eligible families	October 2020-September 2021	Non-MCH funded position

Children continue to be a vulnerable population traveling and walking on roadways in Virginia, traveling nearly as much as adults on an average of 3.4 vehicle trips at 45-50 minutes each day. MV traffic related injuries remain to be a leading cause of death in Virginia for children 0-14 years of age. Those transporting children are often faced with increased number of registered vehicles with miles traveled, pedestrian traffic, and population size in communities. Through increased proper use of child restraint systems, child passenger safety (CPS) law enhancements, and strong existing infrastructure, the VDH CPS Program, in partnership with statewide transportation safety experts, continues to make progress in addressing the impact of motor vehicle traffic related injuries among children.

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 coordinates 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. Local health departments operating as LISSDEP distribution sites support program coordination and Child Passenger Safety education for indigent families that addressed the proper usage and installation of safety seats

IVP Program will continue dissemination of child safety seats through the LISSDEP network in support of income eligible families. Families are provided a no cost safety seat after receiving education and training in proper installation and usage. Families must demonstrate proficiency in skills mastered. Needs/asset assessment and evaluation findings specific to the child safety seat distribution program will allow opportunity for targeted outreach to subpopulations.

FY21 Action Plan Overview: Upstream/Cross-Sector Strategic Planning

---

State Priority: Upstream/Cross-Sector Strategic Planning
FY20 Performance Measure: NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children ages 0-9

Objective: By June 30, 2025, 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 81.0.

Strategy: Serve on interagency team convened by Title V Director focused on the intersection between child health and transportation.
Domain: Child

Activity	Expected Completion Date	Responsible Staff
Serve on an interagency team convened by the Title V Director focused on the intersection between child health and transportation. Focus will be on IVP Program planning for increasing pedestrian safety inclusiveness.	October 2020-September 2021	IVP Supervisor; Transportation Safety Coord; 3 Non-MCH funded positions; Contractor company
Complete Streets & urban planning as a long-term strategy / safe green space access	October 2020-September 2021	IVP Supervisor; Transportation Safety Coord; 3 Non-MCH funded positions; Contractor company

The VDH IVP Program will work in tandem with the Title V Director on an interagency team focused on the intersection between child health and transportation.

Budget Update

IVPP leverages Title V funds, along with state revenue funds and other federal funds, to oversee the development, implementation, and evaluation of various statewide injury prevention programs. Efforts focused on capacity-building (particularly regarding staffing), sustaining and expanding service delivery, and policy.

Equity Considerations

There is opportunity to place an additional emphasis on understanding racial inequities as it relates to safe transportation for children and access to transportation. According to Macy et al, race has been a significant predictor of age-appropriate restraint use after the consideration for parental/caregiver education, family income and economic status, and culture/information sources provided.

Consumer/Family Engagement & Partnership

IVP Program provides an opportunity for family and consumer input into LISSDEP. Staff continue to work with the Division of Population Health to construct an exit survey to evaluate programmatic education and technical support efforts. In the upcoming FY, the VDH Injury and Violence Prevention Program will continue family and consumer input expansion through its Project Patience and Youth Suicide Prevention initiatives.

Emerging Issues

The Coronavirus Disease 2019 (COVID-19) pandemic is affecting individuals, families, and communities on a worldwide scale. In Virginia, as of the end of May 2020, almost three months since the first COVID-19 case was reported in Virginia, there were 41,401 positive cases, 4,442 hospitalizations, and 1,338 deaths statewide (vdh.virginia.gov) To mitigate the spread of COVID-19 throughout the Commonwealth and the United States, state and federal policymakers announced 'stay at home' orders and social distancing guidelines, which led to school closures and more families working and spending greater amounts of time together at home. The pandemic not only can force individuals and families to alter their way of living and working, but outbreaks can also increase stress and anxiety, due to fear and worry of one's health or health of loved ones, difficulty sleeping or concentrating, worsening of chronic or mental health conditions, loss of a job or other economic support, responding to COVID-19 as a healthcare worker, essential worker, or first responder, social isolation and loneliness, or loss of loved ones (https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/managing-stress-anxiety.html). Recent studies have indicated that, during the COVID-19 pandemic and other major natural disasters, there is increased risk of family and interpersonal violence, including child abuse and neglect and intimate partner violence, greater risk of childhood injury, suicide, drug overdose, and other substance abuse and mental health issues.

It is critical to link families with young children with resources as it relates to childhood injury and violence prevention. Hospitals, prevention, and public health programs are reduced in their capacity to hold community level meetings with families to provide these resources and education. As such, the VDH IVP Program is working to enhance its community level interventions with virtual options for hospitals, transportation safety, and prevention programs to utilize when training community members in injury prevention. These methods come in the form of VDH IVP Program virtual instruction, technical assistance, hard copy toolkits, video and website landing pages, and evaluation options. In addition, VDH IVP continues to remain connected to national IVP stakeholders to understand emerging topics in injury and violence prevention.

III. Early Childhood Unit

The Division of Child and Family Health's Early Childhood Unit, which administers the Title V-funded state developmental screening initiative, as well as the HRSA-funded Virginia Mental Health Access Program for child/adolescent mental health program. These programs are led by Bethany Geldmaker, PhD, PNP (ECH Consultant).

Developmental screening represents an emerging priority for the state Title V program. 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. Virginia ranks 37th in the country for developmental screening care for children under age 5. The state has no centralized manner for collecting data, relying on parent report.

FY21 Action Plan Overview: Strong Systems of Care for All Children

State Priority: Strong Systems of Care for All Children
FY21 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, 2025, increase the percent of children (ages 10-71 months) receiving a developmental

screening using a parent-completed screening tool from 29.1% (NSCH 2016-2017) to 31.1%.

The percent of children, ages 9-35 months, who received a developmental screening using a parent-completed screening tool in the past year is 31.4% (2017-2018) in Virginia, compared to the U.S. at 33.5%.

Snapshot of Program Accomplishments

- Three planning meetings with facilitators from NC Work force Development and AMCHP were held in FY19. The meetings included over 40 stakeholders from key state agencies and organizations.
- In FY20, a contract was executed with the Virginia Early Childhood Foundation (VECF) to support six regional Smart Beginnings Coalitions in advancing developmental screening action plans. Hubs have begun meeting, and VECF has begun mapping and collecting screening data for each hub. VECF presented to a meeting of the Child Development Centers on opportunities to establish referral pathways from each hub to the corresponding center for assessment, as necessary.

Strategy: Partner with the Virginia Early Childhood Foundation to support six regional Smart Beginnings Coalitions in advancing developmental screening.
Domain: Child

Activity	Expected Completion Date	Responsible Staff
Smart Beginnings will continue to establish, convene, and lead local partners as "*Developmental Screening Hubs*," appropriate to each community footprint, aiming to engage all key stakeholders, to execute the activities identified in a 2020-2021 updated work plan to increase screening, through strengthened and coordinated local services and partnerships.	Ongoing	VECF
Smart Beginnings will employ at least one Screening Navigator to advance DSI priorities in their community.	Ongoing	VECF
Smart Beginnings will collaborate with local partners to address systems coordination priorities, such as: • Identify and track gaps in services and resources within the community • Remedy gaps and improve systems coordination to screen and refer children • Facilitate coordination across community systems toward timely assessment, referrals and follow-up • Emphasize equitable access,	Ongoing	VECF

screening and referral, and other related services for all children and families • Engage families, with emphasis on marginalized families, to inform appropriate and responsive services • Build capacity of early childhood care and education providers to facilitate and support family use of ASQ screens		
Advance messaging that increases community awareness related to DSI, such as • Increased awareness about the importance of ongoing screening, monitoring, referral, and follow-up regarding child development • Increased awareness about child development and services that support child development	Ongoing	VECF

In FY20, a contract was executed with the Virginia Early Childhood Foundation (VECF) to support six regional Smart Beginnings Coalitions in advancing developmental screening action plans. Through a renewed partnership agreement with VDH, the Virginia Early Childhood Foundation (VECF) will continue to support the work of Smart Beginnings partners in six communities across the Commonwealth to spearhead more comprehensive and coordinated use of ASQ screening at the local level. Each Smart Beginnings entity will continue to facilitate a local *Developmental Screening Hub* that convenes community leaders/partners to improve coordination of screening and referral services and supports across systems, build capacity to increase number of developmental screens administered, lead local efforts to assess and create solutions to local screening barriers and gaps, engage families with an emphasis on increasing equitable access and services, and otherwise identify innovative strategies that improve coordination of developmental services.

VECF plans to re-engage Smart Beginnings partners to serve the communities of South Hampton Roads, Greater Harrisonburg, Charlottesville-Albemarle, Southeastern Virginia, Southwestern Virginia, and Greater Roanoke.

Strategy: Convene stakeholders to develop a Shared MCH Agenda for Developmental Screening, with shared goals, metrics, and coordinated strategies to strengthen the continuum of child health care infrastructure for screening, assessment, referral, and follow-up for developmental screening.
Domain: Child

Activity	Partners	Expected Completion Date
1. Partner with VECF, F2F, EI, and DBHDS/DSS/DOE to develop a shared agenda for developmental screening (e.g. systems mapping and alignment of plans for training, funding, communication, metrics). 2. VMAP Linkages: Expand (1) use of ASQ / other developmental screening tools within primary care settings and (2) family navigation. 3. Map interagency child mental health activities and supports (0-5 and school entry), to include current workforce, identification of community-based organizations poised to serve as strategic partners, and identification of 2-3 strategic needs.	CDCs, DOE, DSS, DMAS, DBHDS, Home Visitors, VDH, Partnership of People with Disabilities, Head Start, VPI, AAP, FQHCs, etc.	By September 2021

Stakeholders will be convened, to include the Virginia Early Childhood Foundation, Family-to-Family, Early Intervention, and sister agencies (e.g. Department of Behavioral Health and Developmental Services, Department of Social Services, Department of Education) to develop a shared agenda for developmental screening. This will include completion of a systems mapping exercise, alignment of state plans for training, funding, and communication, and identification of shared metrics.

In addition, linkages will be made to efforts under the Virginia Mental Health Access Program. Expand (1) use of ASQ / other developmental screening tools within primary care settings and (2) family navigation.

Map interagency child mental health activities and supports (0-5 and school entry), to include current workforce, identification of community-based organizations poised to serve as strategic partners, and identification of 2-3 strategic needs.

Budget Update

Title V funding, to date, has been used primarily for planning purposes. Two stakeholder meetings were held (September 2018 and April 2019). The purpose of the meetings was to support Title V efforts to work with partners to develop statewide and regional strategies to increase universal developmental screening by aligning critical stakeholders around a common vision informed by their current practice and experience.

Regional strategies include developing a hub and spoke model. Smart Beginnings coalitions submitted letters of interest outlining their goals and objectives in building out their hubs. Six sites were selected to develop action plans in their regions to improve screening and referrals.

IV. Child Health Program

In FY20, the Title V Director will onboard a 0.5 FTE position to support an emerging Child Health Program, with an initial focus on advancing strong systems of care for all children and strengthening child and adolescent mental health initiatives. The Title V needs assessment revealed a need for strengthened mental health coordination across all MCH populations, from screening to assessment to referral to ongoing treatment and/or ongoing community-based surveillance and support. The Title V team has been working to develop a more coordinated system of care for children that provides supports across this continuum.

The program capacity component of the needs assessment also demonstrated lack of a centralized child health program. While a number of programs across the Office of Family Health Services do serve children from birth to middle school entry, there remains a need for cross-program coordination and strategic planning. Beyond support systems and services for mental health, the qualitative needs assessment captured requests for broader, upstream supports for families with children (e.g. addressing food deserts, financial stress, access to and navigation of housing and transportation, and lack of community).

During the prior five-year grant cycle, the Title V program successfully supported launch of an Adolescent Health Program. The program began with existing federal grants for positive youth development and sexual education, and it is quickly growing into a comprehensive program. In the coming five-year grant cycle, the Title V program will seek to replicate this success by launching a coordinated Child Health Program.

Initial partners will include:

- The Division of Child and Family Health's Early Childhood Unit, which administers the Title V-funded state developmental screening initiative, as well as the HRSA-funded Virginia Mental Health Access Program for child/adolescent mental health program. These programs are led by Bethany Geldmaker, PhD, PNP (ECH Consultant).
- The Division of Child and Family Health's CYSHCN Program administers the Child Development Center Program, which provides assessment and referral for children suspected of behavioral and developmental conditions.
- The Division of Prevention and Health Promotion's Injury and Violence Prevention Program administers a range of child maltreatment, child safety seat distribution and education, and injury prevention programs.

External agencies, such as the Department of Conservation and Recreation, Department of Transportation, and Department of Agricultural and Consumer Services, will be engaged in identification of future upstream work.

Child Health Work Detailed in Other Sections

Note that following strategies are detailed in the Women's/Maternal application and are thus not repeated within the Perinatal/Infant application:

Priority: Oral Health

- ***Maintain and expand existing MCH-focused dental education programs to improve oral health for individuals across the lifespan, to include advising on oral health integration in primary care settings, education for home visitors, school-aged oral health education, and emerging needs of adolescents*** *(Domains: Women/Maternal, Child, Adolescent)*
- ***Sustain network of 5 regional Oral Health Alliances and distribute mini-grants for implementation of systems change and data-sharing initiatives to improve the oral health of all Virginians, with emphasis on pregnant women, and children and adolescents aged 1-17*** *(Domains: Women/Maternal,*

Child, Adolescent)

- ***Convene statewide groups focused on targeted oral health issues (e.g. Water Equity Taskforce, Early Dental Home workgroup, Future of Oral Health workgroup), facilitate collaboration and workplan development, and provide leadership and oversight to guide initiatives*** *(Domains: Women/Maternal, Child, Adolescent)*

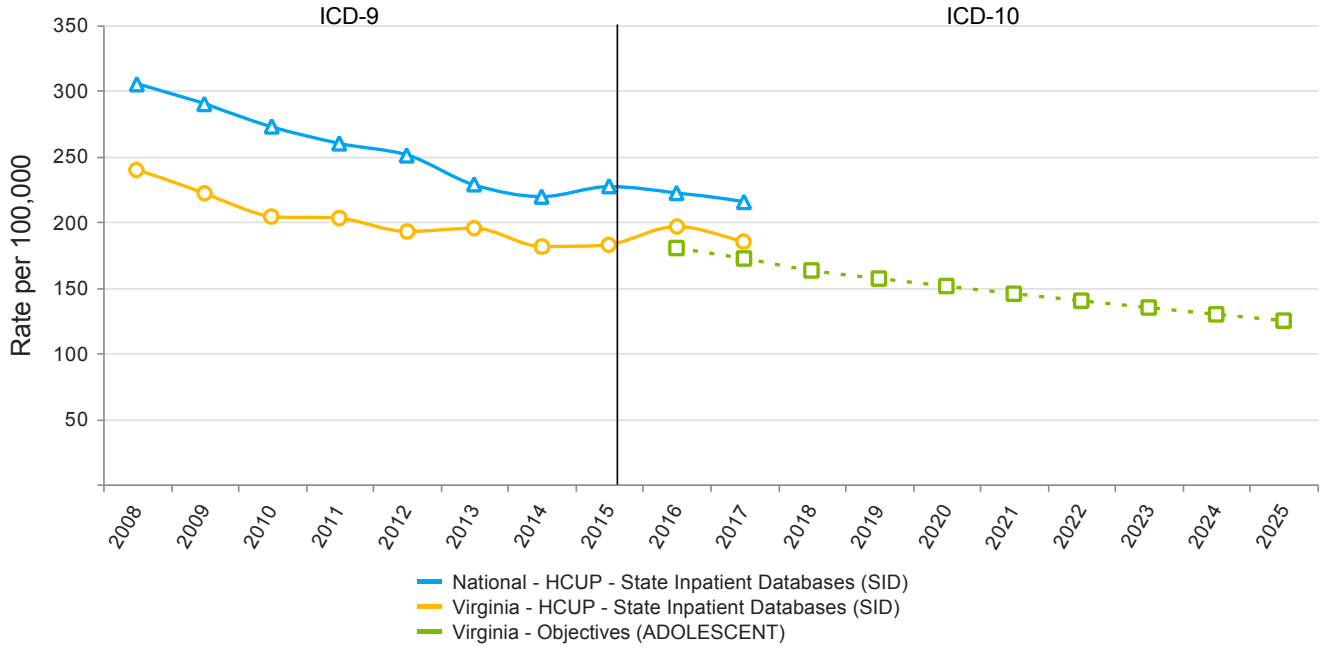
Adolescent Health

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-2017_2018	10.4 %	NPM 13.2
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	NVSS-2018	14.0	NPM 7.2
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2018	32.0	NPM 7.2
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2016_2018	9.9	NPM 7.2
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2016_2018	11.6	NPM 7.2
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-2017_2018	18.2 %	NPM 12
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	91.1 %	NPM 13.2

National Performance Measures

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



Note: ICD-10-CM beginning in 2016; previously ICD-9-CM with 2015 representing January - September

Federally Available Data				
Data Source: HCUP - State Inpatient Databases (SID)				
	2016	**2017**	**2018**	**2019**
Annual Objective	180	172	162.9	156.8
Annual Indicator	172.4	182.6	196.3	184.5
Numerator	1,826	1,451	2,087	1,964
Denominator	1,059,470	794,656	1,062,972	1,064,407
Data Source	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2014	2015	2016	2017

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	151.0	145.3	139.9	134.7	129.6	124.8

Evidence-Based or –Informed Strategy Measures

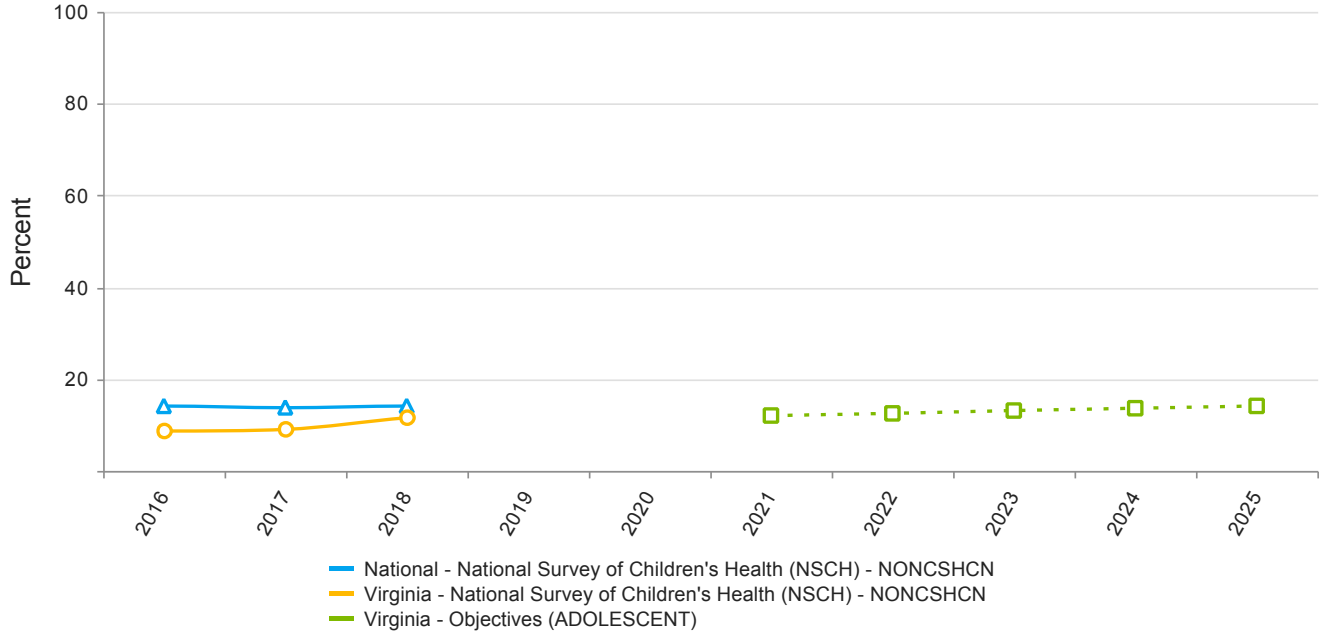
ESM 7.2.1 - Number of gatekeepers trained in the prevention of suicide among youth

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			10
Annual Indicator		102	195
Numerator			
Denominator			
Data Source		VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program
Data Source Year		2018	2019
Provisional or Final ?		Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	20.0	20.0	20.0	20.0	20.0	20.0

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
Indicators and Annual Objectives



NPM 12 - Adolescent Health - NONCSHCN

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - NONCSHCN	
	2019
Annual Objective	
Annual Indicator	11.6
Numerator	56,684
Denominator	489,697
Data Source	NSCH-NONCSHCN
Data Source Year	2017_2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	12.1	12.6	13.2	13.7	14.2

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	2018	2019
Annual Objective		25	100	250
Annual Indicator	0	0	0	0
Numerator				
Denominator				
Data Source	Division of Child and Family Health	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Provisional	Final

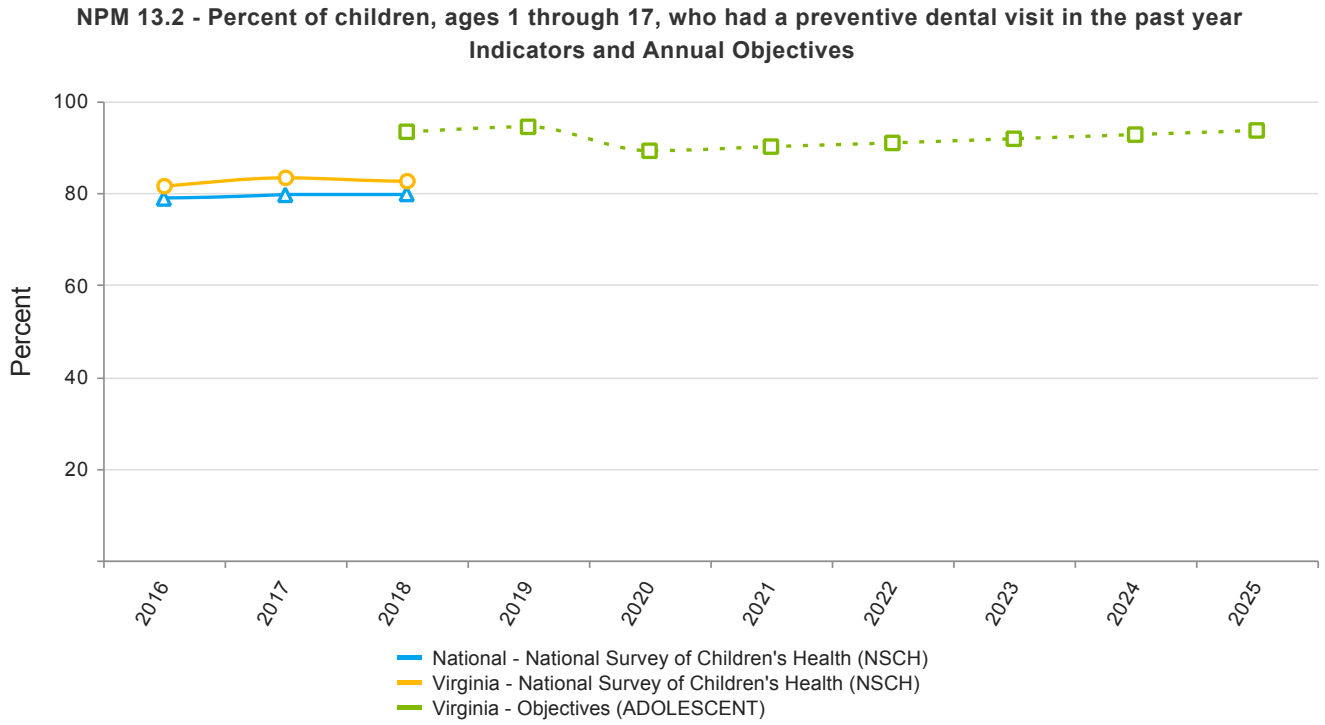
Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	400.0	425.0	450.0	475.0	500.0	525.0

ESM 12.2 - Percentage of Virginia schools reporting into the VDOE school health data system

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	75.0	77.0	79.0	81.0	83.0



NPM 13.2 - Adolescent Health

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH)				
	2016	**2017**	**2018**	**2019**
Annual Objective			93.2	94.3
Annual Indicator		81.4	83.1	82.4
Numerator		1,407,907	1,448,110	1,463,318
Denominator		1,729,004	1,741,839	1,775,616
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

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	2018	2019
Annual Objective			93.2	94.3
Annual Indicator	90.9	90.9	90.5	88.2
Numerator				
Denominator				
Data Source	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016	2016_2017	2017_2018
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	89.1	90.0	90.8	91.7	92.6	93.5

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			6
Annual Indicator		3	4
Numerator			
Denominator			
Data Source		VDH Oral Health Program documentation	VDH Oral Health Program documentation
Data Source Year		2018	2019
Provisional or Final ?		Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	6.0	6.0	6.0	6.0	7.0	7.0

State Performance Measures

SPM 4 - Pregnancy Intention: Mistimed or Unwanted pregnancy (wanted to become pregnant later or never)

Measure Status:	Active
State Provided Data	
	2019
Annual Objective	
Annual Indicator	25.3
Numerator	
Denominator	
Data Source	VA PRAMS
Data Source Year	2018
Provisional or Final ?	Final

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	23.8	23.3	22.8	22.3	21.8

State Action Plan Table

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

Priority Need

Mental Health: Promote mental health across MCH populations, to include reducing suicide and substance use.

NPM

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

Objectives

By June 30, 2025, 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 124.79.

Strategies

Empower communities to address mental health issues that impact young people.

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 2

Priority Need

Oral Health: Maintain and expand access to oral health services across MCH populations.

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, 2025, increase the percent of children (ages 12 through 17) who had a preventive dental visit in the past year from 88.2% (NSCH 2017-2018) to 93.5%.

Strategies

Maintain and expand existing MCH-focused dental education programs to improve oral health for individuals across the lifespan, to include advising on oral health integration in primary care settings, education for home visitors, school-aged oral health education, and emerging needs of adolescents.

Sustain network of 5 regional Oral Health Alliances and distribute mini-grants for implementation of systems change and data-sharing initiatives to improve the oral health of all Virginians.

Convene statewide groups focused on targeted oral health issues (e.g. Water Equity Taskforce, Early Dental Home workgroup, Future of Oral Health workgroup), facilitate collaboration and workplan development, and provide leadership and oversight to guide initiatives.

ESMs	Status
ESM 13.2.1 - Number of Regional Oral Health Collaborative Projects 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 3

Priority Need

Oral Health: Maintain and expand access to oral health services across MCH populations.

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, 2025, increase the percent of children, ages 1 through 17, who had a dental visit in the past year from .__% (PRAMS 20...) to ___%.

Strategies

Integrate targeted adolescent oral health messaging into existing MCH-focused dental education programs to improve oral health for individuals across the lifespan.

Sustain network of 5 regional Oral Health Alliances and distribute mini-grants for implementation of systems change and data-sharing initiatives to improve the oral health of all Virginians.

Convene statewide groups focused on targeted oral health issues (e.g. Water Equity Taskforce, Early Dental Home workgroup, Future of Oral Health workgroup), facilitate collaboration and workplan development, and provide leadership and oversight to guide initiatives.

ESMs	Status
ESM 13.2.1 - Number of Regional Oral Health Collaborative Projects 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 4

Priority Need

Strong Systems of Care for All Children: Strengthen the continuum supporting physical/socio-emotional development (i.e. screening, assessment, referral, follow-up, coordinated community-based care).

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, 2025, increase the proportion of adolescents, ages 12 through 17, in Virginia who are engaged in transition services to adult health care from 11.6% (NSCH 2017-2018) to 14.2%.

Strategies

Maintain data capacity for school health immunization data.

Expand and empower school nurse workforce.

ESMs	Status
ESM 12.1 - Number of providers in Virginia who have completed the transition training module.	Active
ESM 12.2 - Percentage of Virginia schools reporting into the VDOE school health data system	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

State Action Plan Table (Virginia) - Adolescent Health - Entry 5

Priority Need

Reproductive Justice & Support: Promote equitable access to choice-centered reproduction-related services, including sex education, family planning, fertility/grief support, and parenting support.

SPM

SPM 4 - Pregnancy Intention: Mistimed or Unwanted pregnancy (wanted to become pregnant later or never)

Objectives

Reduce the rate of mistimed pregnancies from 25.3% (PRAMS 2018) to 21.8% by 2025.

Strategies

Implement evidence-based comprehensive sexual education in areas of the state with disproportionately high rates of teen pregnancy and low access to sexual health information.

Advocate for policy change that requires sex education in Virginia to be medically accurate, comprehensive, inclusive and required.

Fund BrdsNBz, a free sexual health informational text line for teens operated by the American Sexual Health Association, statewide in Virginia.

Work with stakeholders to remove policy, financial, and training barriers to contraceptive access.

2016-2020: National Performance Measures

2016-2020: State Performance Measures

2016-2020: SPM 4 - Unintended Pregnancy: Proportion of females ages 15-44 using Tier 1 (most effective) contraceptive methods

Measure Status:			**Active**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective	2.6	33.3	34.1
Annual Indicator	35.5	31	65.1
Numerator			
Denominator			
Data Source	VA PRAMS	VA PRAMS	VA PRAMS
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Adolescent Health Domain
FY19 Annual Report

The FY19 workplan for the Adolescent Health Domain included the following performance measures:

1. Oral Health
2. Injury Hospitalization
3. Unintended Pregnancy

Strategies within the FY19 Adolescent Health workplan were implemented by the Division of Prevention and Health Promotion's Dental Health (DPH) and Injury and Violence Prevention (IVPP) Programs and the Division of Child and Family Health's Reproductive Health Unit. Summaries of activities completed during the reporting period are presented by performance measure below.

Oral Health

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

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

---

Objective

For the FY19 application, the objective was:

- 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 95.46%.

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year was 82.4%. Among adolescents 12-17 years old, 88.2% had a preventive dental visit, which did not meet the target set for reporting year 2019 of 94.3%.

Progress Updates

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 delivery of preventive dental services for MCH populations.

The Dental Health Program (DHP) 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).

The Dental Health Program (DHP) is described in more detail within the Women's/Maternal and Child Annual Reports.

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

This strategy is detailed within the Child Annual Report.

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.

This strategy is detailed within the Women's/Maternal Annual Report.

Evidence-Based Strategy Measures

The strategies proposed in the FY19 workplan aligned with the following ESM(s):

- 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)

These are detailed within the Women's/Maternal Annual Report.

Injury & Violence Prevention

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

FY19 Performance Measure: NPM 7.2 – Rate of hospitalization for nonfatal injury per 100,000 adolescents, ages 10 through 19

Objective

For the FY19 application, the proposed objective was:

- By June 30, 2020, decrease the rate of hospitalization for non-fatal injury per 100,000 children ages 10 to 19 from 182.6 to 150.95 (SID-Adolescent).

NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19 was 184.5 per 100,000, still above the target set for reporting year 2019 which was 156.8 per 100,000.

Related National Outcome Measures

The national outcome measures (NOMs) relevant to this NPM/SPM include:

- NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000
- NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

Significance of NOM 16.3: Suicide is the second leading cause of death for adolescents ages 15 through 19 years. In 2014, there were over 2,000 deaths due to suicide among adolescents ages 15 to 19 years, or 9.8 deaths per 100,000. Suicide and suicidal ideation is often indicative of mental health problems and stressful or traumatic life events. In 2015, 18 percent of high school students reported they had thought seriously about committing suicide in the past year. While females are more likely to report considering suicide, males are more likely to succeed in committing suicide. The suicide mortality rate for males is nearly three times that of females.

Related Healthy People 2020 Objectives:

- *Mental Health and Mental Disorders (MHMD) Objective 1: Reduce the suicide rate. (Baseline: 11.3 suicides per 100,000 in 2007, Target: 10.2 suicides per 100,000)*
- *Mental Health and Mental Disorders (MHMD) Objective 2: Reduce suicide attempts by adolescents. (Baseline: 1.9 suicide attempts per 100 occurred in 2009, Target: 1.7 suicide attempts per 100)*

The annual estimate for adolescent suicide in Virginia increased from 7.5 per 100,000 Adolescents ages 15 through 19 (2007-2009) to 9.9 per 100,000 Adolescents ages 15 through 19 (2015-2017), a 32% increase (Source: NVSS).

Suicide rate per 100,000 Adolescents ages 15 through 19

Year	Estimate
2007_2009	7.5
2008_2010	7.7
2009_2011	7.4
2010_2012	7.8
2011_2013	8.3
2012_2014	9
2013_2015	9.1
2014_2016	9.8
2015_2017	9.9

Year	Stratifier	Stratifier Subgroup	Estimate
2013_2017	Race/Ethnicity	Non-Hispanic White	11.9
	Race/Ethnicity	Non-Hispanic Black	5.1
	Race/Ethnicity	Hispanic	7.9
	Race/Ethnicity	Non-Hispanic Asian/Pacific Islander	6.3
	Sex	Female	4.7
	Sex	Male	14.4
	Urban-Rural Residence	Large Central Metro	9.1
	Urban-Rural Residence	Large Fringe Metro	11
	Urban-Rural Residence	Small/Medium Metro	6.2
	Urban-Rural Residence	Non-Metro	9.2

Progress Updates

The Virginia Department of Health, Division of Prevention and Health Promotion, Injury and Violence Prevention (IVP) Program is led by Lisa Wooten, MPH, BSN, RN (IVP Program Supervisor).

The IVP Program is described in more detail within the Child Annual Report.

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

The IVPP Youth Suicide Prevention Program employs a public health approach focusing on policy and systems change to implement statewide strategies targeting youth attending Virginia public schools and youth attending Virginia colleges. The program provides training and resources to reduce the risk for suicide for at risk youth by building capacity to respond to students in need of mental health services, and promote training for clinical staff and

students in distress following a suicide related crisis. The program supports the development of partnerships with community mental health organizations and provide best practice training in identifying and responding to students, faculty, staff and administration. Title V-funded and non-funded IVPP staff continue to lead these programs.

Evidence-Based Strategy Measures

The strategies proposed in the FY19 workplan aligned with the following ESM(s):

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

ESM 7.2.1: During FY19, IVPP leveraged MCH funds to contract with James Madison University (JMU) Campus Suicide Prevention Center to coordinate Applied Suicide Intervention Skills Trainings for 83 college faculty and staff statewide.

JMU coordinated 2 Recognizing and Responding to Suicide Risk and 2 Suicide to 2 Hope trainings:

- RRSR – August 6 & 7, 2019 – Fredericksburg – 38 participants
- RRSR – Sept 10 & 11, 2019 – Williamsburg – 17 participants
- Suicide 2 Hope – August 14, 2019 Fredericksburg – 28 participants
- Suicide 2 Hope – August 30, 2019 – Winchester – 29 participants

Participants included Counseling Graduate students, Nursing Students, Occupational Therapy Students, Suicide Prevention Program Coordinators, LCSW, LPC, Behavioral Health Care Managers and School Psychologists.

Reproductive Health

State Priority: Women's/Maternal Health: Support the physical and emotional wellbeing of women and their children.

FY19 Performance Measure: SPM 4: Unintended Pregnancy: Proportion of females ages 15-44 using Tier 1 (most effective) contraceptive methods

Objective

For the FY19 application, the objective was:

- 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%.

SPM 4 - Unintended Pregnancy: Proportion of females ages 15-44 using Tier 1 (most effective) contraceptive methods was 65.1%, exceeding the target set for reporting year 2019 which was 34.1%.

Progress Updates

The Adolescent Health Program is led by Madeline Kapur, MPH, MSW (Adolescent Health Coordinator). The Resource Mothers Program is led by Consuelo Staton, MEd. (State Resource Mothers Coordinator) and serves

pregnant and parenting teens. Both program managers report to the Reproductive Health Unit Supervisor, Emily Yeatts, MPH, MSW.

The goal of the Virginia Department of Health's Adolescent Health Program is to ensure that Virginia adolescents have access to the information and resources they need to optimize their health. The program has a number of current and upcoming initiatives that build toward this goal.

Top FY19 accomplishments included:

- One key initiative currently underway is the funding of positive youth development programs throughout the Commonwealth. The Reproductive Health Unit is using Title V State Sexual Risk Avoidance Education (SRAE) funds to support two evidence-based positive youth development programs: Teen Outreach Program (TOP) and Project AIM. Five sites throughout the state – four in western Virginia and one on the coast – receive these funds and use them to serve youth. The sites have served approximately 1,000 youth in regions of the Commonwealth that have disproportionately high teen pregnancy and birth rates, and continue to serve hundreds of youth each month. Both TOP and Project AIM have documented evidence of decreasing sexually risky behavior and delaying sexual initiation. Teens that participate in TOP, additionally, have fewer pregnancies, fewer suspensions and improved academics. Sites began implementation in October 2018; long-term, VDH anticipates seeing lower rates of teen pregnancy and teen birth in the areas that the SRAE program is serving.
- In October 2019, VDH's Adolescent Health Program launched BrdsNBz, a sexual health text line for teens that is owned and operated by the American Sexual Health Association (ASHA). Virginia teens can text anonymous sexual health and relationship questions and receive a response from an ASHA health educator within 24 hours. This will greatly increase the reach of the Adolescent Health Program, providing teens that VDH may not otherwise reach with vital sexual health information.
- In order to directly address unintended pregnancy rates across the Commonwealth, Title V funds continued to be used to provide administrative support to the Virginia LARC Initiative. The Virginia LARC Initiative is an innovative program designed to offer the most effective methods of contraception at no cost for low-income women of reproductive age, including adolescents.
- In addition to its pregnancy prevention programs, VDH's Reproductive Health Unit also continued to provide support to young parents. Resource Mothers is an adolescent health program for pregnant and parenting teens. As part of this program, community health workers offer home visiting services to teens until their child reaches the age of one. During these visits, community health workers provide educational and emotional support to the client and her family. Resource Mothers uses two evidence based programs: Growing Great Kids and AIM4TM (AIM for Teen Moms). Largely funded through federal TANF funds allocated by the Virginia General Assembly, Resource Mothers is offered at six local implementation sites, including five local health districts and one hospital system.
- Strategic planning yielded two new initiatives:
    - The Adolescent Health Program continued to explore opportunities to serve additional youth and increase youth engagement in existing programming. Some upcoming initiatives for the Adolescent Health Program include hiring Youth Advisors at VDH's Central Office and funding a comprehensive sexual education program. VDH's Youth Advisors, who will be between the ages of 18-22, will provide insight and expertise on VDH programs that impact adolescents and be responsible for building out a sustainable youth advisory structure in Virginia.
    - VDH will also begin funding two sites to implement the evidence-based, LGBTQ-inclusive comprehensive sexual education program, "Get Real." The curriculum addresses topics such as healthy relationships, communication skills, puberty, reproduction, sexual identity, abstinence, refusal skills and contraception. VDH plans to leverage Title V funds to support Virginia communities where the teen pregnancy rate is above the state average and where adolescents currently do not have

access to comprehensive sexual education.

Program Logos, Branding, and Communications:

The Adolescent Health program has a web page, which can be found here: http://www.vdh.virginia.gov/adolescent-health/. Between October 2018 and November 2019, the Adolescent Health Coordinator worked with the Office of Family Health Services' communications team to redesign the web page, making it easier to access, more digestible and relevant for youth. Some of the changes include more streamlined navigation, a "for teens" page, and a myriad of resources for youth, parents and other stakeholders.

In February 2019, Virginia's Title V State SRAE grant funded a social media campaign for Teen Dating Violence Awareness Month. VDH partnered with One Love to share the organization's "couplet" videos (https://www.joinonelove.org/act/couplets/). The campaign successfully reached the target population; 58,748 youth saw the videos, 20,212 youth watched the videos all the way through, and the videos had a "click through rate" (meaning users clicked on the video or link in caption) that was .38% higher than average.

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.

VDH worked to increase education about contraception among pregnant and parenting teens. During FFY19, all Resource Mothers staff were trained in AIM4TM, an evidence-based teen pregnancy prevention program that uses a positive youth development framework. By participating in AIM4TM, teen clients will have the opportunity to learn skills for advancing their education and professional careers, and also receive education about contraceptive methods. At the conclusion of the program, teens participate in a graduation ceremony, and at one of these ceremonies, a local community member who was a teen mother served as the keynote speaker. AIM4TM officially launched in January 2019, and 27 community health workers were trained during this reporting period.

State Performance Measure Update

Title V administrative support to the Virginia LARC Initiative, an innovative program designed to offer the most effective methods of contraception at no cost for low-income women. Below is a table illustrating the age range of patients during FFY19:

Total Count (N)	Missing	Percentile						
		0.05	0.10	0.25	0.50 Median	0.75	0.90	0.95
1,655	0 (0.0%)	18.00	19.00	21.00	26.00	31.00	37.00	40.00

The Virginia Title V State SRAE Program funds two Positive Youth Development programs, Teen Outreach Program and Project AIM, at five implementation sites throughout Virginia. The program trained 29 staff members and served 871 youth in FY19. The same five sites were funded in FY20, and the program continues to serve hundreds of youth per month throughout the Commonwealth.

The Virginia Resource Mothers Program (VRMP) offers mentorship and support to pregnant and parenting teens

across the Commonwealth. VRMP's goals include reducing infant mortality, increasing healthy birth outcomes, and preventing a subsequent teen pregnancy. In SFY 2019, VRMP enrolled 587 pregnant teens and was proud to welcome 285 infants born into the program.
VDH established a partnership with the Children's Hospital of Los Angeles (CHLA) to offer *Project AIM4TM (AIM for Teen Moms*), an evidence-based adolescent health program that is designed to prevent rapid repeat pregnancy among teen moms, increase consistent contraceptive use, and promote economic stability among young mothers. VDH launched this program during SFY19, and CHWs offered several iterations of AIM4TM to VRMP teen participants.

VDH also fulfilled its goal to replace its current curriculum with an evidence-based prenatal/perinatal curriculum. The *Growing Great Kids* (GGK) curriculum was selected as the new prenatal to age five curriculum for SFY 2020. GGK is a comprehensive and skills-focused home visiting curriculum that takes a strength-based approach to growing nurturing parent-child relationships and supporting healthy child development. VRMP staff received GGK curriculum training and is currently implementing the training modules during the program home visits.

Adolescent Health Domain
FY21 Application

The FY21 workplan for the Adolescent Health Domain includes the following performance measures:

1. Injury Hospitalization
2. Pregnancy Intention
3. Oral Health
4. Transition

Madeline (Maddie) Kapur, MSW, MPH (Adolescent Health Coordinator) currently serves as the Title V Adolescent Health Domain Lead.

Title V-funded efforts for adolescent health will be implemented by the Injury and Violence Prevention Program, Reproductive Health Unit, Dental Program, School Health Program. These entities and their proposed activities for the upcoming grant period are detailed below.

I. Injury & Violence Prevention Program

The Injury and Violence Prevention (IVP) Program is led by Lisa Wooten, MPH,
BSN, RN (Injury and Violence Prevention Program Supervisor). A detailed overview is provided within the Child Health Domain application.

Reduction of suicide deaths is a continuing priority across populations and particularly for adolescents. However, death statistics vastly underestimate the burden of intentional self-harm injuries in youth. Following publication of the *National Strategy for Suicide Prevention* in 2001, the Virginia Commission on Youth (a joint commission of the Virginia General Assembly) published the *Youth Suicide Prevention Plan*, and amended the *Code of Virginia* §32.1-73.7 to designate the Virginia Department of Health (VDH) as the lead agency for youth suicide prevention in the Commonwealth.

In 2003, the Joint Commission on Health Care directed Virginia's Secretary of Health and Human Resources to lead a cross-government effort to formulate a comprehensive plan for suicide prevention across the life span. This effort produced the *Suicide Prevention Across the Life Span Plan for the Commonwealth* (Senate Document 17, 2004). The plan recommended a series of important actions to be taken in leadership and infrastructure development, surveillance, public awareness, and intervention. Following publication of the 2004 plan, the Virginia Department of Behavioral Health and Developmental Services (DBHDS) was designated in the *Code of Virginia* as the lead agency for suicide prevention across the lifespan in Virginia (with VDH remaining the lead for youth suicide prevention).

Since its designation, VDH has continued to work collaboratively to employ evidence-based interventions in preventing youth suicide in Virginia with a variety of federal, state and local partners, including Virginia's Health Resources and Services Administration Maternal Child Block Grant Title V team.

Snapshot of Program Accomplishments

The IVP Program Youth Suicide Prevention Program employs a public health approach focusing on policy and systems change to implement statewide strategies targeting youth attending Virginia public schools and youth attending Virginia colleges. The program provides training and resources to reduce the risk for suicide for at risk youth by building capacity to respond to students in need of mental health services, and promote training for clinical staff and students in distress following a suicide related crisis. The program supports the development of partnerships with community mental health organizations and provide best practice training in identifying and responding to students, faculty, staff and administration. Title V-funded and non-funded IVPP staff continue to lead these programs.

Budget Update

IVPP leverages Title V funds, along with state revenue funds and other federal funds, to oversee the development, implementation, and evaluation of various statewide injury prevention programs. Efforts focused on capacity-building (particularly regarding staffing), sustaining and expanding service delivery, and policy.

Equity Considerations

Disparities are widespread across Virginia's landscape as it relates to suicide risk, inclusive of gender, race, sexual orientation, occupation, geographical (rural vs urban), maternal status, and military versus civilian status. According to the Centers for Disease Control and Prevention *Preventing Suicide: A Technical Package for Policy, Programs, and Practices*, the current evidence suggests that identifying people at risk of suicide and the continued provision of treatment and support for individuals can positively impact suicide and its associated risk factors (Direct language). It is crucial to build a community and safety net around youth at risk for suicide. Gatekeepers, or individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine, such as healthcare providers, counselors, faculty, coaches, ministers, youth workers, parents, or law enforcement, are in a unique position to connect with suicidal individuals and respond with necessary support for disparate and vulnerable populations.

Suicidal thoughts and behaviors vary by race and ethnicity among youth. Addressing burden through an equity lens is expected to improve the health of children and youth of color at risk for suicide.

Emerging Issues

Adverse childhood experiences (ACEs) are of increasing interest. Virginia's Behavioral Risk Factor Surveillance System (BRFSS), a population health survey on health behaviors of adults aged 18 years and older, reported that in 2018, 15.4% of participants responded 'yes' to four or more ACEs. Persons who experienced four or more ACEs also reflected higher rates of poor or fair health status (22.0%) and binge drinking (21.3%). Out of all BRFSS respondents who completed the survey in 2018, 32.5% experienced verbal abuse, 27.0% divorce, 26.1% household substance abuse, 16.9% household depression, 16.4% household physical abuse, 16.1% physical abuse, 12.8% sexual abuse, and 7.8% household incarceration (VDH Division of Population Health Data, 2020).

Consumer/Family Engagement & Partnership

Community engagement is critical to reducing risk of self-harm and suicide. The presence of increasing resources for treatment alone has not been shown to be a sole effective intervention without community engagement.

FY21 Action Plan Overview: Mental Health

State Priority: Mental Health
FY19 Performance Measure: NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 adolescents 10-19

Objective: By June 30, 2025, 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 124.79.

According to the Virginia MCH LiveStories, the percentage of high school youth who were bullied on school property decreased from 21.9% in 2013 to 15.7% in 2017 (Virginia Youth Survey). However, the percentage of middle school students who were bullied on school property remained stable at approximately 43%. Seven percent of high school youth reported electronically bullying someone, and the percentage increased with age with 10.3% of students 18 or older reporting electronic bullying. According to data from the Department of Behavioral Health and Developmental Services (DBHDS), the most common mental health diagnosis among adolescents is a mood disorder, followed by anxiety disorders, substance use disorders, behavioral disorders, and psychotic disorders. All categories of disorders increased in prevalence from 2016 to 2017.

According to the Virginia Youth Survey, the number of high school youth that felt sad or hopeless almost every day for two weeks in a row so that they stopped doing usual activities increased by 15.7% between 2011 and 2017. High school females were approximately twice as likely to report feeling sad and all suicide-related behaviors. According to the self-reported data from the Virginia Youth Survey a notable trend across all mental health and suicide-related behaviors is that once students begin reporting depression or suicidal thoughts, they were more likely to report the next stage of suicidal ideation or attempt. In 2017, among students who reported that they seriously considered attempting suicide: 82.0% reported having felt sad, empty, hopeless, angry, or anxious, 67.5% made a plan about how they would attempt suicide, 40.8% attempted suicide, 24.9% were physically hurt by someone they were dating or going out with in the past 12 months, 36.2% were bullied on school property, 29.2% were bullied electronically, and only 54.2% had at least one adult that they can talk to if they have a problem.

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

Activity	Expected Completion Date	Responsible Staff
Coordinate Applied Suicide Intervention Skills Trainings and Suicide 2 Hope trainings at campuses statewide	October 2020-September 2021	James Madison University; Suicide and Violence Prevention Coordinator=20%
Contract with American Association of Suicidology to coordinate 3 "Recognizing and Responding to Suicide Risk" trainings. Healthcare providers trained will be provided SEEK, ACES, and Intimate Partner Violence prevention resources.	October 2020-September 2021	2 Non-MCH funded positions

IVPP will continue its partnership with James Madison University and PRS to deliver gatekeeper and Suicide 2 Hope trainings statewide. Healthcare providers will continue to receive Recognizing and Responding to Suicide Risk trainings as gatekeepers in communities.

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

Activity	Expected Completion Date	Responsible Staff
Partner with the Title V Director to enhance a strategic plan for suicide prevention among middle school students	October 2020-September 2021	IVP Supervisor; 3 Non-MCH funded positions; Suicide and Violence Prevention Coordinator=20%; Contractor company
Partner jointly with Title V Director to complete a needs/asset assessment and evaluation specific to interagency adolescent mental health activities, to include key accomplishments, identification of community-based organizations poised to serve as strategic partners, and assessment of 3-5 strategic needs.	October 2020-September 2021	IVP Supervisor; 3 Non-MCH funded positions; Suicide and Violence Prevention Coordinator=20%; Contractor company

IVP Program will partner with the Title V team to complete a needs/asset assessment and evaluation specific to interagency adolescent mental health activities, to include key accomplishments, identification of community-based organizations poised to serve as strategic partners, and assessment of 3-5 strategic needs. This work will align with the Suicide Prevention Plan for the Commonwealth of Virginia as constructed by the IVP Program and the Virginia Department of Behavioral Health and Developmental Services.

II. Adolescent Health Program

The Adolescent Health Program is led by Madeline Kapur, MPH, MSW (Adolescent Health Coordinator). The Resource Mothers Program is led by Consuelo Staton, MEd. (State Resource Mothers Coordinator) and serves pregnant and parenting teens. Both program managers report to the Reproductive Health Unit Supervisor, Emily Yeatts, MPH, MSW.

The goal of the Virginia Department of Health's Adolescent Health Program is to ensure that Virginia adolescents have access to the information and resources they need to optimize their reproductive lives and health. The program has a number of current and upcoming initiatives that build toward this goal.

One key initiative currently underway is the funding of positive youth development programs throughout the Commonwealth. The Reproductive Health Unit is using Title V State SRAE funds to support two evidence-based positive youth development programs: Teen Outreach Program (TOP) and Project AIM. Five sites throughout the state – four in southwest Virginia and one on the coast – receive these funds and use them to serve youth. Both TOP and Project AIM have documented evidence of decreasing sexually risky behavior and delaying sexual initiation. Teens that participate in TOP, additionally, have fewer pregnancies, fewer suspensions and improved academics. Sites began implementation in October 2018; long-term, VDH anticipates seeing lower rates of teen pregnancy and teen birth in the areas that the SRAE program is serving. While COVID-19 impacted programming in FY20, Virginia SRAE sites were still able to begin programming with almost 1500 young people and complete programming with 500.

The Adolescent Health Program expanded its reach in FY20 by funding the comprehensive sexual education curriculum *Get Real. Get Real* is an evidence-based, LGBTQ-inclusive comprehensive sexual education curriculum for middle and high school youth developed by the Planned Parenthood League of Massachusetts. The curriculum addresses topics such as healthy relationships, communication skills, puberty, reproduction, sexual identity, abstinence, refusal skills and contraception. VDH funds three sub-recipients to implement *Get Real* in communities with some of the overall highest teen pregnancy rates as well as some of the highest racial and ethnic disparities in teen pregnancy rates in the state. Sub-recipients began receiving funding on July 1, 2020, and most have either just begun program implementation or are in the planning stages. By June 30, 2021, the three sub-recipients combined aim to serve 6,700 young people.

VDH partnered with the American Sexual Health Association to launch BrdsNBz, a free and anonymous sexual health text line, in September 2019. This service has greatly increased the reach of the Adolescent Health Program, providing teens that VDH may not otherwise reach with vital sexual health information, particularly during the COVID-19 pandemic. Usage of this service has steadily increased since its launch, and the Adolescent Health Program recently funded a mass postcard mailing to Virginia households in order to continue raising awareness about the service.

The Adolescent Health Program is currently in the process of hiring two Youth Advisors, young people who will provide their expertise on VDH's public health programs and initiatives. The Youth Advisors will split their time between providing input on existing programs and initiatives and developing and managing a statewide structure for infusing youth voice and leadership into public health programs in the state.

Virginia's current *Family Life Education* (sexual health education) standards fall woefully below what young people need. The recent Title V Needs Assessment demonstrated that young people want sex education that is comprehensive and LGBTQ+ inclusive, and Virginia is currently falling short. The Adolescent Health Program, in conjunction with the policy arm of the Office of Family Health Services and the Virginia Department of Education, aims to advocate to change the Code of Virginia to include a requirement that sex education be comprehensive, evidence-based, medically accurate, LGBTQ+ inclusive and required. Once the policy is amended, the Adolescent Health Program will work with the Virginia Department of Education to create standards that are consistent with public health best practices in sex education.

The results of the Title V Needs Assessment emphasize the need for additional interventions that address substance use, mental health, bullying and teen suicide. The Adolescent Health Coordinator, along with the new Youth Advisors, will work with the Department of Health Promotion and the Regional Tobacco Cessation Teams to develop an organized response to teen vaping in Virginia. The Adolescent Health Coordinator will also sit on the Title V Child/Adolescent Mental Health Workgroup, which will partner with the Virginia Department of Behavioral Health to address access to mental health services and the Virginia Department of Education to address bullying. In order to

increase community agency, the Adolescent Health Program will provide mini-grants to schools, community organizations or groups of youth that want to address one of these issues (substance use, mental health, bullying or teen suicide) in their communities. The Adolescent Health Program will provide suggestions and technical assistance, but communities will ultimately decide what interventions they think will be most effective.

Snapshot of Program Accomplishments

- The Adolescent Health program launched BrdsNBz, a free and anonymous sexual health text line for teens. Usage is steadily increasing, and service is safely providing valuable sexual health information to young people during the pandemic.
- The Adolescent Health Program began funding three sub-recipients to implement *Get Real,* a comprehensive and LGBTQ+ inclusive sex education curriculum, in areas of the state with the highest teen pregnancy rates and/or racial and ethnic disparities in teen pregnancy rates. Between the three sub-recipients, 6,700 young people will participate in year one of the program.
- VDH's Adolescent Health Program collaborated with the Office of Family Health Services, the Office of Epidemiology, the Office of Communications and 14 young leaders to develop a COVID-19 social media campaign for young people, which can be downloaded for viewing here.
- The Adolescent Health Program continued to leverage SRAE funds to support positive youth development programs throughout the Commonwealth. While COVID-19 interrupted programming this year, the SRAE still managed to begin programming with 1,500 young people and complete programming with 500.

Budget Update

Beginning in FY20, Title V monies began supporting two adolescent health initiatives discussed earlier in the application: *Get Real* and BrdsNBz. In FY21, Title V monies will be used to pay the part-time wage of Youth Advisors, fund the regional youth advisory structure, and provide mini-grants to communities in order to improve adolescent mental health.

Challenges & Barriers

The COVID-19 pandemic has presented challenges to both current and future Title V Adolescent Health initiatives. In-person programming for young people halted in March of 2020. The Youth Advisor hiring process was put on hold as VDH's human resources staff members had to focus on hiring thousands of contract tracers. In order to continue to provide information, resources and support to young people, the Adolescent Health program focused on further promoting the BrdsNBz sexual health text line, creating and disseminating a COVID-19 social media campaign for young people and adapting ongoing projects to fit the current environment. Currently, the program is working with sub-recipients to adapt programming to a virtual setting (some are still in the planning stages, while others have begun implementing virtually), and is currently hiring for the two Youth Advisor positions.

Consumer/Family Engagement & Partnership

The Adolescent Health Program is currently in the process of hiring two Youth Advisors at the Virginia Department of Health's Central Office. Youth Advisors will provide feedback on existing programs and develop and manage a statewide youth advisory structure. These efforts are detailed in the Cross-Cutting Domain application. In the meantime, the Adolescent Health Program elicits feedback from young people that participate in programs through post survey questions, and then will support sub-recipients in making programmatic changes based on youth feedback. Additionally, the Adolescent Health Program received feedback from 14 young leaders via survey on its

recent COVID-19 social media campaign for teens.

FY21 Action Plan Overview: Reproductive Justice & Support

State Priority: Reproductive Justice & Support
FY21 Performance Measure: SPM 4 – Pregnancy Intention: Mistimed pregnancy- wanted to become pregnant later or never

Objective: Reduce the rate of mistimed pregnancies from 25.3% (PRAMS 2018) to 21.8% by 2025.

Teen pregnancy rates declined remarkably in Virginia between 2012 (32.1 per 1,000 females age 15 to 19 years) and 2018 (19.1 per 1,000), but differences exist among race/ethnicity and regions within the state. Hispanic and non-Hispanic Black teens had the highest teen pregnancy rates in 2018 at 34.6 per 1,000 and 28.9 per 1,000 respectfully. The Eastern (24.0), Southwest (23.7), and Central (21.9) regions had rates higher than the state rate.

Strategy: Implement evidence-based comprehensive sexual education in areas of the state with disproportionately high rates of teen pregnancy and low access to sexual health information.
Domain: Adolescent

Activity	Expected Completion Date	Responsible Staff
Work with the program developer, Planned Parenthood League of Massachusetts, to schedule *Get Real* facilitator training with sub-recipients.	Ongoing	Maddie Kapur (Adolescent Health Coordinator)
Provide guidance, support and technical assistance to program sub-recipients to ensure successful implementation of *Get Real.*	Ongoing	Maddie
Collect fidelity logs, youth pre surveys and youth post surveys in order to ensure fidelity to the evidence-based curriculum and ensure program quality across sub-recipient, race, ethnicity, gender identity and sexual orientation. Review data with sub-recipients and support them in making any necessary programmatic changes.	Ongoing	Maddie & Nika Anwell (Special Projects Analyst, Division of Population Health Data).
Conduct Annual Site Reviews to further assess the quality of sub-recipient programs.	March – May, 2021	Maddie

In FY21, the Adolescent Health Program will begin a number of projects that further reproductive justice and amplify youth voice in Virginia.

For the first time in recent memory, VDH is funding a comprehensive sexual education program: *Get Real*. VDH selected Get Real based on its evidence base and because it is fully inclusive of LGBTQ sexuality and identity. The Get Real initiative promotes health equity by prioritizing the funding of agencies in communities with disproportionately high rates of teen pregnancy and/or racial and ethnic disparities in teen pregnancy.

About Get Real

Get Real is a comprehensive sexual education curriculum for middle and high school youth developed by the Planned Parenthood League of Massachusetts. The middle school program consists of nine lessons each in 6th, 7th and 8th grades. The high school program consists of eleven lessons that are designed to be taught in either 9th or 10th grade. The curriculum addresses topics such as healthy relationships, communication skills, puberty, reproduction, sexual identity, abstinence, refusal skills and contraception. The program also includes a focus on social and emotional learning as well as homework that promotes parental engagement.
Get Real is on The Department of Health and Human Service's list of evidence-based programs. Research published in 2014 showed that middle school girls and boys who received the curriculum were 15% and 16% less likely to engage in sex compared to their peers who did not receive *Get Real.* The family engagement component of the program had a long-term impact on middle school boys; boys who completed the *Get Real* take-home activities in the 6th grade were more likely to delay sex in the 8th grade. While there is currently no published research evaluating the effectiveness of the high school curriculum, the curriculum is evidence-informed based on widely evaluated best practices in comprehensive sexual education.

VDH leverages Title V funds to implement *Get Real* in communities across Virginia that have disproportionately high rates of teen pregnancy and/or stark racial and ethnic disparities in teen pregnancy. VDH currently funds program implementation across three sub-recipients: The Virginia League for Planned Parenthood, Eastern Virginia Medical School and Planned Parenthood South Atlantic. Between these three sub-recipients, VDH funds *Get Real* in some of the highest need areas of the state. While the 2018 overall teen pregnancy rate among 10-19 year olds in Virginia is 9.8 per 1,000, areas funded by this initiative, such as Roanoke, Richmond and Petersburg, have the highest overall teen pregnancy rates in the state (46 per 1,000, 35 per 1,000 and 82 per 1,000, respectively). Furthermore, these areas also have some of the highest racial and ethnic disparities in the state; for example, the teen pregnancy rate among Hispanic/Latinx teens in Richmond it is 81 per 1,000, and in Roanoke is 79 per 1,000.

Funding for these three agencies began on July 1, 2020. Sub-recipients are largely implementing the program virtually, and are either in the program planning stages or have just begun serving young people. Between the three sub-recipients, VDH anticipates serving 6,700 this year.

Strategy: Advocate for policy change that requires sex education in Virginia to be medically accurate, comprehensive, inclusive and required.
Domain: Adolescent

Activity	Expected Completion Date	Responsible Staff
Work with the Virginia Department of Education (VDOE)'s policy team to develop recommended changes to the Code of Virginia.	Ongoing	Maddie, Robin Buskey (VDH Policy Analyst), Emily Yeatts
Work with VDOE to submit new legislation up the chain of command.	Ongoing	Maddie, Robin, Emily
Meet with VDH employees, members of the Governor's Office and community members to discuss the importance of codifying comprehensive sex education in Virginia.	Ongoing	Maddie, Robin, Emily

Strategy: Fund BrdsNBz, a free sexual health informational text line for teens operated by the American Sexual Health Association, statewide in Virginia.
Domain: Adolescent

Activity	Expected Completion Date	Responsible Staff
Monitor user volume, interest in text line.	Ongoing	Maddie
Renew contract with ASHA	April 2021	Maddie
Send postcards promoting BrdsNBz to young people (ages 13-19) in areas of the Commonwealth with overall teen pregnancy rates that are 18 per 1,000 or above (at least twice the state average).	October 2020	Maddie
Partner with School Health Nurse Consultant to actively promote the service with VDH school nurses.	January 2021	Maddie, Joanna Pitts (School Health Nurse Consultant)

During FY20, VDH began funding a confidential sexual health text line for teens: BrdsNBz. While the Adolescent Health Program is growing, there are still many communities, populations and geographic areas that VDH does not reach or serve. Texting is a relatively low-cost intervention that provides access to sexual health information to young people in communities that VDH does not reach with its other sexual health programming.

About BrdsNBz

According to the BrdsNBz website, 9 out of 10 teens with a cell phone use text messaging. Teens are constantly using their phones; teen girls send an average of 40 texts per day, and older teen girls send an average of 50 texts per day. By meeting teens where they are, BrdsNBz provides a low-barrier, anonymous way for Virginia adolescents to get sexual health information. The BrdsNBz text line will help to prevent adolescent unintended pregnancy and increase effective contraceptive use by providing accurate and complete sexual health information to Virginia youth.

BrdsNBz usage is steadily increasing. After a slow winter, the number of messages the line received increased five-

fold between April and May, and ASHA has consistently received approximately 45 messages per month since then. VDH is working closely with ASHA to continue to advertise the text line to young people and increase awareness and usage.

FY21 Action Plan Overview: Mental Health

State Priority: Mental Health
FY21 Performance Measure: NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Objective: By June 30, 2025, 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 124.79.

Strategy: Empower communities to address mental health issues that impact young people.
Domain: Adolescent

Activity	Expected Completion Date	Responsible Staff
Adolescent Health Coordinator will sit on Child/Adolescent Mental Health Workgroup.	Ongoing	Maddie
Reach out to the Virginia Department of Education to support their work around bullying.	January 2021	Maddie, Joanna
Reach out to the Virginia Department of Behavioral Health Services to partner around increasing access to mental health services for Virginia adolescents.	January 2021	Maddie
Work with Child/Adolescent Mental Health Workgroup to develop catalog of interventions that address bullying, substance use, mental health and adolescent suicide prevention.	June 2021	Maddie
Release RFA for mini-grant that allows communities to choose from catalog or design their own intervention addressing bullying, substance use, mental health or adolescent suicide. RFA will be open to applicants such as community organizations, schools or groups of young people.	September 2021	Maddie

Virginia's Title V Needs Assessment clearly demonstrated the need for more support around adolescent mental health in Virginia. At the same time, VDH - particularly the Title V team - is making a concerted effort to put more power in the hands of Virginia communities. As a result, the Adolescent Health Program will focus primarily on empowering young people and communities with mini-grants that allow community members to implement the public health interventions that they think are needed to improve adolescent mental health in their schools and neighborhoods.

While these mini-grants will serve to empower young people and solve mental health issues on a community level, there are some barriers to adolescent mental health that are at the structural and policy level. Therefore, VDH staff will also convene with other VDH staff, staff at the Virginia Department of Education and the Department of Behavioral Health Services and community stakeholders in order to determine what policies or statewide structures can be improved in order to positively impact adolescent mental health.

III. Dental Health Program

The Division of Prevention and Health Promotion's Dental Health Program is led by Tonya McRae Adiches, RDH (Dental Health Programs Manager).

JoAnn Wells, BSHS, RDH, serves as the Maternal, Infant, and Adolescent Oral Health Consultant.

The Dental Health Program is detailed within the Women's Health application.

FY21 Action Plan Overview: Oral Health

State Priority: Oral Health
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, 2025, increase the percent of children (ages 12 through 17) who had a preventive dental visit in the past year from 88.2% (NSCH 2017-2018) to 93.5%.

According to the National Survey of Children's Health (2017-2018) 88.2% of adolescents 12-17 years in Virginia had a preventive dental visit. Overall, 82.4% of children, ages 1 through 17, had a preventive dental visit in Virginia.

IV. School Health Program

The VDH School Health Nurse Consultant (Joanna Pitts, BSN, RN, NCSN, CNOR) partners and collaborates closely with the Virginia Department of Education (DOE) School Nurse Consultant to serve elementary to high school aged children enrolled in public, private and parochial schools in the Commonwealth. The program aims to provide technical assistance and professional development training opportunities to school systems, particularly to school-based medical professionals, and families, and also to develop and update certain guidelines relevant to mandated services noted in the Code of Virginia.

Snapshot of Program Accomplishments

- VDH filled the vacant School Health Nurse Consultant position in May 2020.
- Since that time, Ms. Pitts has been immersed in the COVID-19 agency response and providing technical assistance to school nurses across the state. In collaboration with her counterpart at DOE, they hold weekly Zoom meetings, averaging over 250 participants, and maintain two Padlet sites as a resource for school nurses: COVID 19 Resources for VA School Nurses and Back to School, Information for School Nurses.
- The following programmatic documents have been reviewed and updated and set to be released late

2020/early 2021:

- The 1999 School Health Guidelines. These guidelines will be available in print and digitally on VDH's school health website.
- The Commonwealth of Virginia School Entrance Health Form. This form will also be available in Spanish for the first time.
- Guidelines for Managing Asthma in Schools. Although VDH provided much consultation, the Virginia DOE houses this document.

- Ms. Pitts also serves on ImmunizeVA workgroups, Virginia's statewide coalition aiming to improve vaccination coverage across the Commonwealth. She also created guidelines for Medical Reserve Corp volunteers, enabling them to assist in vaccination clinics occurring in school settings this past summer. At least five large immunization clinics occurred between June – August 2020.

FY21 Application Overview: Strong Systems of Care for All Children

State Priority: Strong Systems of Care for All Children
FY21 Performance Measure: NPM 12 - Percent of adolescents, ages 12 through 17, who received services necessary to make transitions to adult health care

Objective: By June 30, 2025, increase the proportion of adolescents, ages 12 through 17, in Virginia who are engaged in transition services to adult health care from 11.6% (NSCH 2017-2018) to 14.2%.

According to the National Survey of Children's Health (2017-2018) only 11.6% of adolescents age 12-17 years received services necessary to make transitions to adult health care.

Strategy: Maintain data capacity for school health immunization data.
Domain: Adolescent

Activity	Expected Completion Date	Responsible Staff
Continue to collect data on medical home and dental home on school entrance forms	Ongoing	Joanna, Meagan, DOE
Continue MOU with DOE to analyze school health data collected by DOE	Ongoing	Joanna, Meagan, DOE
Increase percentage of schools reporting to DOE to 100%	Sept 2021	DOE, Joanna
Explore and develop plan for expanding data fields in VIIS to include race and ethnicity	Sept 2021	Joanna, VIIS staff

School nurses recognize the importance of each student having a medical home and healthcare transition services, as supported by the American Academy of Pediatrics, American Academy of Family Physicians and American College of Physicians. In the ongoing provision for technical assistance and training opportunities, the VDH School Health Program promotes medical home and transition professional development opportunities related to medical home and transition for Virginia school-based medical professionals.

Critical to understanding the scope of medical home, transition services, select chronic health conditions, school health personnel staffing, and student clinic visits and disposition is the school health uniform data set survey. The VDH School Health Nurse Consultant works collaboratively with the VDOE School Nurse Consultant who administers the uniform data set survey. VDH maintains an agreement with DOE to analyze school health data that is collected from school systems across the Commonwealth. Currently, 75% of schools are reporting into this system. Those that are not are attributing this to lack of school nurses in the school system. There are efforts, legislatively, to mandate all school systems to report data into current system.

There is no race/ethnicity data collected relevant to immunizations available, so it is difficult to ascertain if and where disparities may lie within the state. The VDH School Health Nurse Consultant will continue to partner with DOE and work with the VDH Division of Immunization, Immunize VA, and MCH Epidemiologist to plan for the expansion of this data collection.

Evidenced-based/Informed Strategy Measure: Percentage of Virginia schools reporting into the VDOE school health data system

Strategy: Expand and empower school nurse workforce.
Domain: Adolescent

Activity	Expected Completion Date	Responsible Staff
Promote and support policy to mandate a school nurse in every school facility in the Commonwealth	Sept 2021	VDH, DOE
Promote national school nurse certification by providing technical and financial support to 5 School nurses practicing in Virginia.	Sept 2021	Joanna

The pandemic further strengthened the need for a school nurse to be in every school building in order to implement public health strategies, assess impact and to provide education and training to school personnel, students and families. It became very apparent early that the school nurse needed to be a vital member of school teams planning for re-opening during the COVID-19 pandemic. VDH and DOE will collaborate with the Virginia Association of School Nurses (VASN) on these policy initiatives and to promote educational opportunities and technical assistance.

Consumer/Family Engagement & Partnership

The VDH School Health Nurse Consultant collaborated with Jeannine Uzel, Director of Public Health Nursing, VDH Division of Immunization, local health departments, area schools, and with the Virginia DOE to increase access to vaccines, particularly for our underserved population. The team developed guidance and parental notification methods for area school divisions. Efforts were focused on reaching out to the student population that required additional immunizations prior to the start of the new school year. The resources we provided have been successfully used by area schools to advertise and perform drive thru immunization clinics for their school families.

The VDH School Health Nurse Consultant encouraged school nurses to participate in community contact tracing efforts. Currently, area school nurses have completed contact training courses and are currently working with their local health departments, serving as contact tracers, with the goal of reducing the impact of COVID-19 in their school

community.

Emerging Issues

COVID-19 will continue to challenge the school health system: physically, mentally and socially. Both the VDH and DOE school health nurse consultants will continue to provide technical assistance and support in the coming year.

With the pandemic, immunization rates have decreased across the board and in every age group. Initially, the CDC recommended prioritizing vaccines for children under 24 months of age. This guidance resulted in a decline in the administration of vaccines for children older than 24 months and adults. As of May 31, 2020 vaccines entered in the Virginia Immunization Information System (VIIS) were 23% lower compared to previous years, but in June, vaccine orders increased in Virginia. Getting these rates to pre-pandemic levels will be challenging and will require intense outreach and education strategies to be in place.

Adolescent Health Work Detailed in Other Sections

Note that following strategies are detailed in the Women's/Maternal application and are thus not repeated:

Reproductive Justice & Support

- ***Work with stakeholders to remove policy, financial, and training barriers to contraceptive access*** *(Reproductive Health Unit; Domain: Women's/Maternal, Adolescent)*
- ***Explore opportunities for providing support to families seeking fertility services and families experiencing miscarriage*** *(Reproductive Health Unit; Domain: Women's/Maternal)*

Priority: Oral Health

- ***Maintain and expand existing MCH-focused dental education programs to improve oral health for individuals across the lifespan, to include advising on oral health integration in primary care settings, education for home visitors, school-aged oral health education, and emerging needs of adolescents*** *(Domains: Women/Maternal, Child, Adolescent)*
- ***Sustain network of 5 regional Oral Health Alliances and distribute mini-grants for implementation of systems change and data-sharing initiatives to improve the oral health of all Virginians, with emphasis on pregnant women, and children and adolescents aged 1-17*** *(Domains: Women/Maternal, Child, Adolescent)*
- ***Convene statewide groups focused on targeted oral health issues (e.g. Water Equity Taskforce, Early Dental Home workgroup, Future of Oral Health workgroup), facilitate collaboration and workplan development, and provide leadership and oversight to guide initiatives*** *(Domains: Women/Maternal, Child, Adolescent)*

Children with Special Health Care Needs

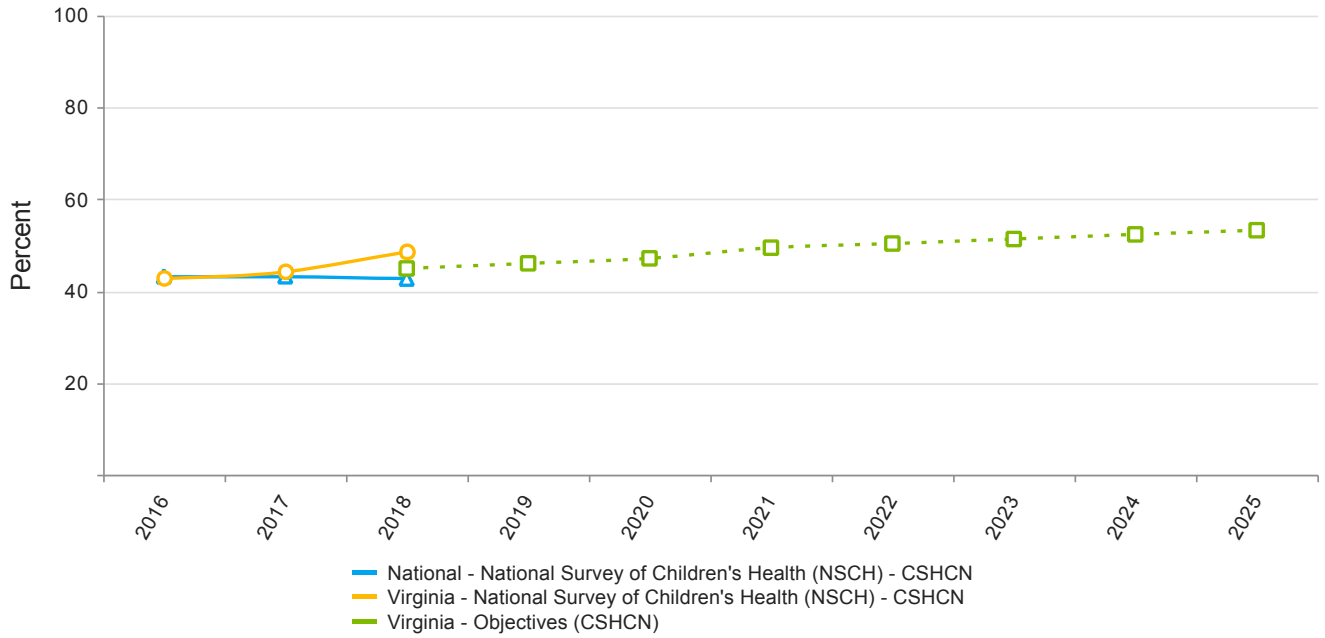
Linked National Outcome Measures

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-2017_2018	18.2 %	NPM 11 NPM 12 NPM 15
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2017_2018	49.7 %	NPM 11 NPM 15
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	91.1 %	NPM 11 NPM 15
NOM 22.1 - Percent of children, ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)	NIS-2018	77.8 %	NPM 15
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2018_2019	69.6 %	NPM 15
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2018	67.2 %	NPM 15
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2018	90.3 %	NPM 15
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2018	79.7 %	NPM 15
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year	NSCH-2017_2018	2.2 %	NPM 11 NPM 15

National Performance Measures

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

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**	**2018**	**2019**
Annual Objective			44.9	46
Annual Indicator		42.7	44.2	48.4
Numerator		167,058	172,978	188,625
Denominator		391,428	391,467	389,683
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

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						
	2020	2021	2022	2023	2024	2025
Annual Objective	47.1	49.4	50.3	51.3	52.3	53.2

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	2018	2019
Annual Objective		25	100	250
Annual Indicator	0	0	0	0
Numerator				
Denominator				
Data Source	Division of Child and Family Health	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

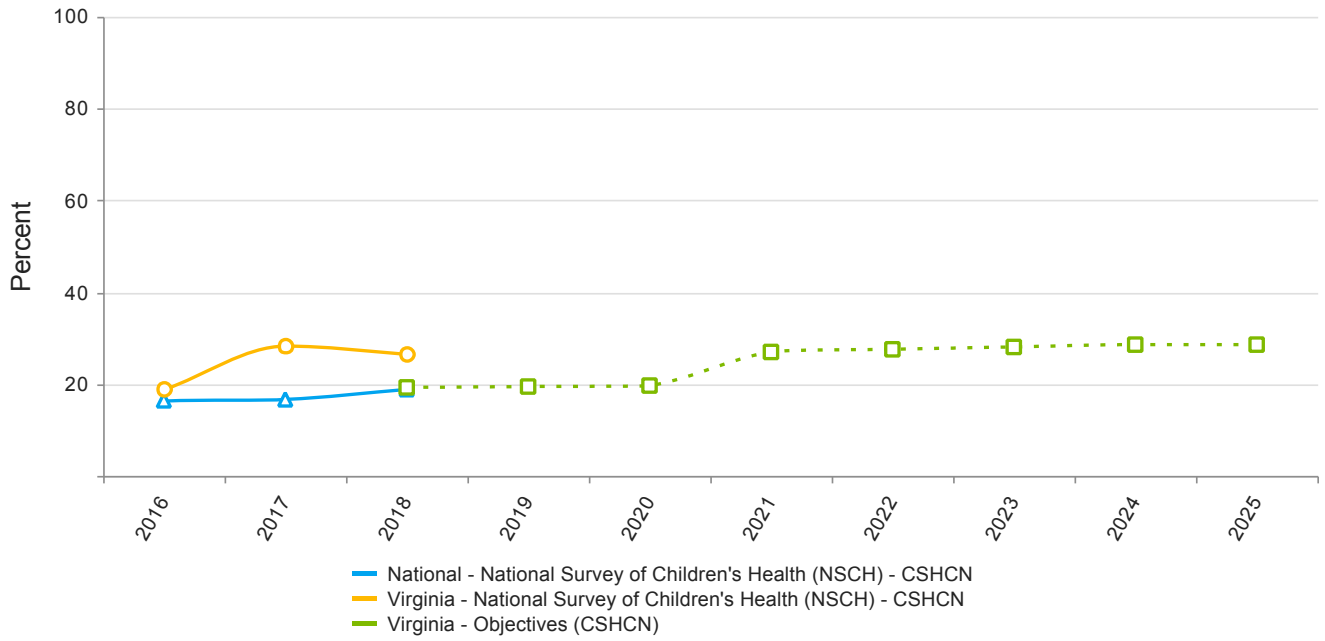
Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	400.0	425.0	450.0	475.0	500.0	500.0

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**	**2018**	**2019**
Annual Objective		90	91.5	93
Annual Indicator	89.2	98.9	96.8	99
Numerator	4,061	4,391	4,239	4,788
Denominator	4,555	4,439	4,377	4,835
Data Source	Office of Family Health Services, VDH	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	94.5	96.0	97.5	98.0	99.5	99.5

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
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**	**2018**	**2019**
Annual Objective			19.3	19.5
Annual Indicator		18.8	28.1	26.5
Numerator		31,194	48,657	47,355
Denominator		166,277	172,958	179,018
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

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						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	19.7	27.0	27.6	28.1	28.6	28.6

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	2018	2019
Annual Objective		25	100	250
Annual Indicator	0	0	0	0
Numerator				
Denominator				
Data Source	Division of Child and Family Health	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Provisional	Final

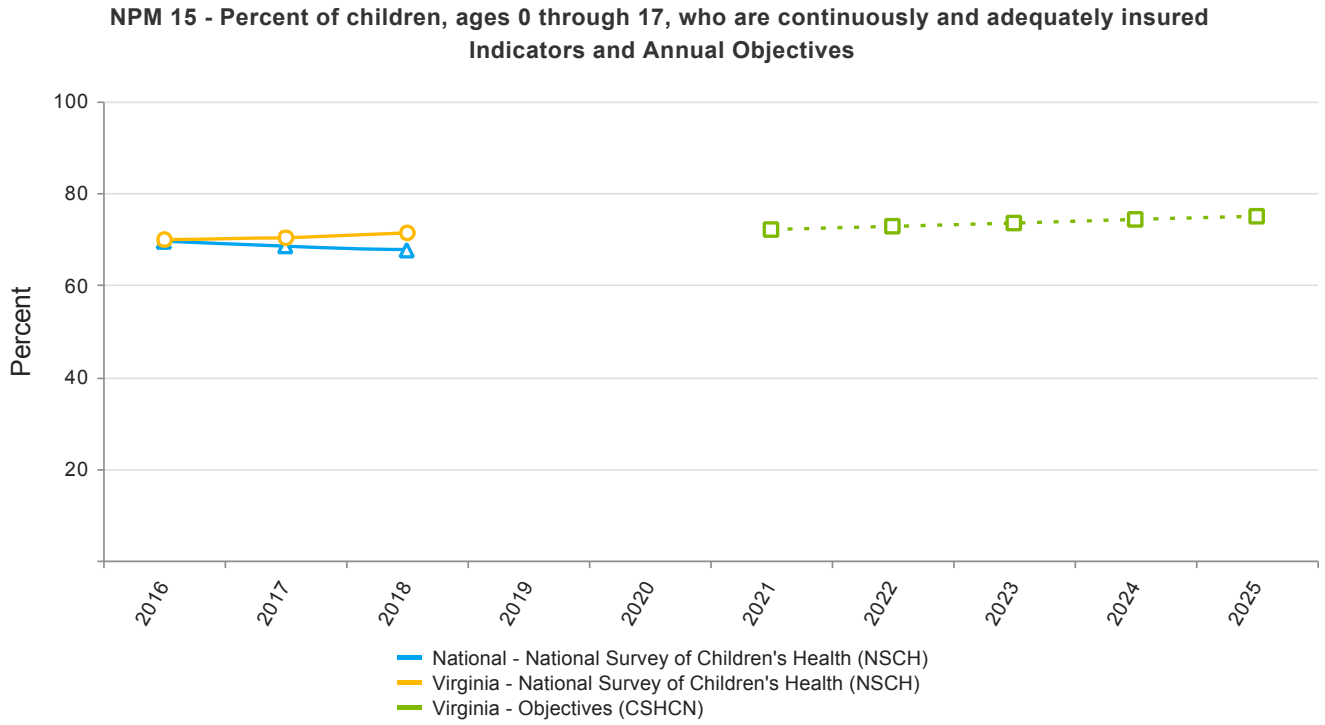
Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	400.0	425.0	450.0	475.0	500.0	525.0

ESM 12.2 - Percentage of Virginia schools reporting into the VDOE school health data system

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	75.0	77.0	79.0	81.0	83.0



NPM 15 - Children with Special Health Care Needs

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2019
Annual Objective	
Annual Indicator	71.2
Numerator	1,323,014
Denominator	1,857,510
Data Source	NSCH
Data Source Year	2017_2018

State Provided Data	
	2019
Annual Objective	
Annual Indicator	71.3
Numerator	
Denominator	
Data Source	NSCH
Data Source Year	2017_2018
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	72.0	72.7	73.4	74.2	74.9

Evidence-Based or –Informed Strategy Measures

ESM 15.1 - Number of Managed Care Organizations (MCO) and Care Connection for Children (CCC) Care Coordinators that attend statewide meeting

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	40.0	40.0	40.0	40.0	40.0

ESM 15.2 - Number of Managed Care Organization (MCO) and Care Connection for Children (CCC) regions that commit to partnering with each other to reduce barriers

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	3.0	3.0	4.0	5.0	6.0

State Action Plan Table

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

Priority Need

Strong Systems of Care for All Children: Strengthen the continuum supporting physical/socio-emotional development (i.e. screening, assessment, referral, follow-up, coordinated community-based care).

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, 2025, increase the percentage of children with special health care needs having a medical home from 48.4% (NSCH 2017-2018) to 53.2%.

Strategies

As a component of the Virginia Medical Neighborhood project, launch two sets of training modules for health care providers and families on (1) a comprehensive care approach to provide a medical home for children (including those with special health care needs) and (2) healthcare transition.

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

Through the CYSHCN network, facilitate access to comprehensive medical and support services that are collaborative, family-centered, culturally-competent, fiscally-responsible, community-based, coordinated and outcome-oriented to CYSCHN and their families (CYSHCN National Standard: Easy to Use Services and Supports / Care Coordination).

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

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

Strong Systems of Care for All Children: Strengthen the continuum supporting physical/socio-emotional development (i.e. screening, assessment, referral, follow-up, coordinated community-based care).

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, 2025, increase the proportion of adolescents with special health care needs in Virginia who are engaged in transition services to adult health care from 26.5% (NSCH 2017-2018) to 29.2%.

Strategies

As a component of the Virginia Medical Neighborhood project, launch two sets of training modules for health care providers and families on (1) a comprehensive care approach to provide a medical home for children (including those with special health care needs) and (2) healthcare transition.

Assure youth with special health care needs receive the services necessary to make transitions to all aspects of adult life (including adult health care, work, and independence) through referrals to adult providers, utilizing transition tools when appropriate (CYSHCN National Standard: Transition to Adulthood).

Engage youth and families in program development and outreach for medical home and transition (Standard: Got Transition's Six Core Elements of Health Care Transition – Transition Completion & Youth and Family Engagement).

ESMs	Status
ESM 12.1 - Number of providers in Virginia who have completed the transition training module.	Active
ESM 12.2 - Percentage of Virginia schools reporting into the VDOE school health data system	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

State Action Plan Table (Virginia) - Children with Special Health Care Needs - Entry 3

Priority Need

Finances as a Root Cause: Increase the financial agency and well-being of MCH populations.

NPM

NPM 15 - Percent of children, ages 0 through 17, who are continuously and adequately insured

Objectives

By June 30, 2025, increase the proportion of children with special health care needs in Virginia who are continuously and adequately insured from 71.3% (NSCH 2017-2018) to 74.9%.

Strategies

Assure families of children with special health care needs will have adequate private or public insurance or both to pay for the services they need (CYSHCN National Standard: Insurance & Financing).

ESMs	Status
ESM 15.1 - Number of Managed Care Organizations (MCO) and Care Connection for Children (CCC) Care Coordinators that attend statewide meeting	Active
ESM 15.2 - Number of Managed Care Organization (MCO) and Care Connection for Children (CCC) regions that commit to partnering with each other to reduce barriers	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 22.1 - Percent of children, ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

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

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

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

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

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 4

Priority Need

Strong Systems of Care for All Children: Strengthen the continuum supporting physical/socio-emotional development (i.e. screening, assessment, referral, follow-up, coordinated community-based care).

SPM

SPM 5 - Cross-Cutting (Family Leadership): Percentage of VDH CYSHCN programs (i.e. Care Connection for Children, Child Development Centers, Bleeding Disorders Program, Sickle Cell Program) actively incorporating family engagement annually

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).

2016-2020: National Performance Measures

Children with Special Health Care Needs (CSHCN) Domain
FY19 Annual Report

The FY19 workplan for the CSHCN Domain included the following performance measures:

1. Medical Home
2. Transition

Strategies within the FY19 CYSHCN workplan were implemented by the Division of Child and Family Health's CYSHCN Program. Activities completed during the reporting period are detailed below.

Children with Special Health Care Needs Program

State Priorities:
- Medical Home - Promote the importance of having a medical home among providers and families.
- Transition - Promote independence and transition of young adults with and without special healthcare needs

FY19 Performance Measures:
- NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home
- 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

For the FY19 application, the proposed objectives were:

- 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%.

ESM 11.2 – The percentage of CYSHCN served by the VA CYSHCN Program who report having a medical home was 99%, exceeding the target set for report year 2019 of 93%.

NPM 11 - Percent of children with special health care needs, ages 0 through 17, who have a medical home was 48.4%, exceeding the target set for reporting year 2019 which was 46%.

- 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 18.8% (NSCH 2016) to 19.7%.

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 was 26.5%, exceeding the target set for reporting year

2019 of 19.5%.

Related National Outcome Measures

The national outcome measures (NOMs) relevant to these NPMs include:

- NOM 19 - Percent of children in excellent or very good health
- NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM 19: The most recent National Survey of Children's Health Data, shows that 90% and 91.1% of children in the US and Virginia respectively, report being in excellent or very good health.

NOM 17.2: The most recent National Survey of Children's Health Data, shows that only 13.9% and 18.2% of children with special health care needs in the US and Virginia respectively, receive care in a well-functioning system. While Virginia is doing better than the nation and the region (16.3%) overall, the state still has a very steep hill to climb regarding improvements.

Progress Updates

Marcus Allen, MPH (CSHCN Director) currently serves as the Title V CSHCN Domain Lead. Shamaree Cromartie, MPH (Blood Disorders Coordinator) oversees the sickle cell and bleeding disorders programs.

Title V 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.

Title V federal and match funds constitute the majority of the program budget, and thus, the Title V Director and CSHCN Director work closely on budget and program development and management. To maximize federal funding and facilitate linkages to care, most CYSHCN services are provided in partnership with major health care systems and universities. An ongoing priority is development of a fiscal sustainability plan to leverage and expand existing partnerships with health systems and the state Medicaid agency.

Core CSHCN services are outlined in §§ 32.1-12 and 32.1-77 of the Administrative Code of Virginia (12VAC5-191-40), available at: https://law.lis.virginia.gov/admincode/title12/agency5/chapter191/. It closely mirrors MCHB vision for this population.

Mission: The CSHCN Program promotes the optimal health and development of individuals living in the Commonwealth with special health care needs by working in partnership with families, service providers, and communities.

Scope:

- Direct health care services
- Enabling services
- Population-based services

- Assessment of community health status and available resources
- Policy development to support and encourage better health.

The Program administers the following networks and services:

- Care Connection for Children.
- Child Development Services.
- Virginia Bleeding Disorders Program.
- Genetics and Newborn Screening Services.
    - Virginia Newborn Screening System.
    - Virginia Congenital Anomalies Reporting and Education System.
- Virginia Sickle Cell Awareness Program.
- Pediatric Comprehensive Sickle Cell Clinic Network.

Note that, due to the size and complexity of the Virginia Newborn Screening System, it has its own manager and functions as a sister program to the CSHCN Program. Both programs fall under the Division of Child and Family Health, along with the broader Title V MCH Program.

The target population to receive services from the networks and programs within the Program are the following:

- Residents of the Commonwealth.
- Individuals between the ages of birth and their twenty-first birthday except that the Virginia Bleeding Disorders Program and the Virginia Sickle Cell Awareness Program serve individuals of all ages.
- Individuals diagnosed as having, or are at increased risk for having, 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.

Each network and program within the CSHCN Program has its own specific eligibility criteria.

The Title V national performance measures, as required by the federal Government Performance and Results Act (GPRA-Pub. L. 103-62), are used to establish the program goals.

Program Overview

As defined above in the code, the core CSHCN programs include the Care Connection for Children, Sickle Cell, and Bleeding Disorders programs. The Child Development Center program is included, but it provides assessments of any child suspected of having a developmental and/or behavioral condition (i.e. serves children with and without special health needs). In FY19, the CSHCN program served about 7498 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 FY19, the CCC program served 2,995 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 FY19, the CDC program served 3,204 families, resulting in 5,855 diagnoses and 6,764 referrals for additional services.

Virginia Bleeding Disorders Program (VBDP)

The Virginia Bleeding Disorders Program is a legislatively enacted program established by the Commonwealth of Virginia through the Virginia Department of Health, Office of Family Health Services for the care and treatment of persons with hemophilia and other inherited bleeding disorders. Virginia recognizes that the ongoing medical costs of treating such bleeding disorders often exceed the financial capacity of families, despite the existence of various types of medical and hospital insurance. In order to address the need, the Virginia Bleeding Disorders Program provides a "safety net" for persons with inherited bleeding disorders. The safety net includes:

- Coordinated, family oriented, multidisciplinary services for persons with congenital bleeding disorders;
- A Pool of funds to assist with the purchase of factor and/or supplies and;
- Insurance case management and premium assistance to help keep eligible clients insured.

In FY19, the VBDP served 384 people.

Pediatric Comprehensive Sickle Cell Program

The Pediatric Comprehensive Sickle Cell Clinic Network is a statewide group of clinics, located in major medical centers, that provide comprehensive medical and support services that are collaborative, family centered, culturally competent, community based and outcome oriented for newborns identified from newborn screening, children, and youth living with sickle cell disease.

In FY19, the clinics served 915 families.

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 ensure early parent education,

encourage confirmatory testing, and early entry into care for newborns and their families identified with sickle cell disease and other hemoglobinopathies.

Program Logos, Branding, and Communications:

The Title V and CYSHCN Directors worked with UVA to create a domain name for a suite of Title V-funded educational modules (some modules were already in existence), along with logos intended to brand the work. The domain name is *Promoting Healthy Communities* and the web address or URL to the site is https://promotinghealthycommunities.org/.

The site includes the newly created medical home and transition training for providers and families along with Newborn Screening, Breastfeeding, and Early Hearing Detection and Intervention education. Below are the logos specific to medical home and transition.

Specific to medical home and transition education, VDH has spent more than 2 years working with UVA to create training modules for providers and families to promote the importance of a patient centered medical home and transition from pediatric to adult healthcare. The modules were launched on October 24, 2019.

Title V covers the cost of the modules so they are complimentary for anyone who wishes to take them (Continuing Medical Education Credits are offered), even if they don't live in the state.

The Care Connection for Children logo has been with the program for more than a decade and was developed under previous leadership.

The current Blood Disorders Program Coordinator developed the Virginia Sickle Cell Awareness program logo in 2017. She collaborated with the OFHS communication team and received feedback/input from medical center and community based partners. During the first year of the new logo, there was an unprecedented demand for educational materials from the community – so much so that the program was unable to keep up initially with literature requests. In addition, the Sickle Cell Data Collection (SCDC) logo was developed by the Centers for

Disease Control and Prevention team and is included on all program materials.

Top FY19 Accomplishments

- The CYSHCN Director served on the AAP, Patient Centered Medical Home Advisory Group;
- The CYSHCN Director is currently serving as Region III Director on the AMCHP Board of Directors and served on the planning committee for the 2019 MCH Technical Assistance Meeting;
- The CSHCN and Title V Directors, along with the Director of the Blue Ridge CCC, met with and provided a presentation on the state CCC program at the request of Virginia's Medicaid Agency (DMAS).. More than 280 Medicaid Managed Care, care coordinators attended this presentation. A link to the medical home and transition training modules was shared with attendees;
- The CSHCN and Title V Directors, along with staff from each of the regional CDCs, held a meeting with Medicaid at their Central Office. The purpose of this meeting was to troubleshoot barriers that the program is facing regarding reimbursement for services and other related topics that are hindering service delivery for children with developmental and behavioral conditions.
- The Blood Disorders Program Coordinator in the CYSHCN Unit received a grant from the Centers for Disease Control to improve Sickle Cell Disease Surveillance. The grant is for one year and the goal is to create the infrastructure needed to collect population-based, comprehensive health information about people living with sickle cell disease. Once collected, staff will be able to use the information to inform policy and to improve outcomes for this population. Partners on this project include Virginia Commonwealth University, the Department of General Services-Division of Consolidated Laboratory Services, and Virginia Health Information;
- The Sickle Cell program worked with state leadership to request funding to create the infrastructure for an Adult Comprehensive Sickle Cell Network. If funded, the program will work to set up contracts with regional centers across the state to complement the existing pediatric centers;
- The CYSHCN Unit worked with the Title V Director to provide seed money to the CDC center at Virginia Commonwealth University to help them hire a psychologist to serve children with suspected developmental and behavioral conditions. The center expects to be able to maintain the position long term;
- CYSHCN staff continue to work closely with the Virginia Department of Education to realign the services that it provides for children with special health care needs as part of a partnership with CYSHCN programs;
- The Title V team was accepted by AMCHP to present at the national conference in March of 2020. The presentation will center on effective ways to do a customer service survey with families who receive Title V funded services;
- CYSHCN team members worked closely with VDH epidemiology staff to recruit partners to participate in the

MCH needs assessment for 2020;

- CYSHCN staff are working with the AAP to explore efforts to help pediatricians to understand the National Children's Health Survey. The goal is to make them aware of some of the key measures that we are focused on nationally (greater understanding can sometimes lead to greater participation when it comes to moving the needle on better outcomes for children).

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

VDH has spent more than 2 years working with UVA to create training modules for providers and families to promote the importance of a patient centered medical home and transition from pediatric to adult healthcare. The agency is pleased to report that this effort has been successful and the modules went live online on October 24, 2019. The Virginia Title V program covers the cost of the modules so they are complimentary for anyone who wishes to take them (Continuing Medical Education Credits are offered), even if they don't live in the state.

ESM 11.1 - Number of providers in Virginia who have completed the medical home training module
ESM 12.1 - Number of providers in Virginia who have completed the transition training module.

- It is important to note that the modules were released in the fall of 2019 and VDH/UVA are working on a plan to promote them fully. The modules went live online on October 24, 2019 with an official public launch date of the modules on November 24, 2019. As of January 27, 2020, Medical Home provider completed = 10 and Medical Home provider in progress = 11.

Details within the MCH Workforce Development section of the Application.

Strategy 2: Assure children with special health care needs receive coordinated, ongoing, comprehensive care within a medical home (CYSHCN National Standard: Medical Home).

The CCC program worked 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 obtain services.

The CCC program conducts a parent survey periodically (in partnership with Virginia Commonwealth University) to measure parent satisfaction with services. The most recent survey was completed in 2018 and 97.5% of parents surveyed stated that their child had a primary care provider. VDH uses the term "primary care provider" rather than medical home in the survey because it is a term that is more easily understood by the general public. In addition to

encouraging clients to have a medical home, the CCC program provides a service that is supportive of the child's medical home and specialty care. The figure below was taken from the parent survey and demonstrates some of the supportive services that are provided. In the survey, respondents were asked, "Since Care Connections for Children has been assisting you, has it been easier to do these things?" The results were compared to data gathered in 2013 and the chart displays the percentage of clients who answered "yes" (does not apply and not sure answers were dropped).

Has Been Easier – "Yes"	2013	2018
Get answers to questions about child's health and health care services	88%	95.0%
Get basic or primary medical care	82%	94.6%
Get medical care from a specialist	84%	94.3%
Coordinate services among different providers	79%	93.0%
Get information about resources in my community	79%	91.5%
Get equipment or medical supplies	82%	90.9%
Understand your health insurance benefits or help with denials by health plan	71%	90.2%
Get educational services for child	77%	89.5%
Get prescription medication for your child	82%	89.4%
Get or keep health insurance for my child	73%	88.2%
Get dental care	66%	82.0%
Get support for self (help from other parents, respite)	68%	82.0%
Prepare child for adulthood (if child is 14 years or older)	65%	80.7%
Pay medical costs	65%	78.3%

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 99%. This high percentage is likely because centers often need referrals for services in order to get reimbursed and they seek medical records from those providers before they complete their assessment. Therefore, many of the families served will need to have a medical home for a referral (if one is lacking). When a child is identified as not having a provider, center staff work closely with the family to connect them to one.

The four pediatric comprehensive sickle cell clinics reported that 98% of their patients had a medical home (primary care provider). Each clinic site coordinated care and ensured patients had a PCP in different ways (as described below):

- One clinic site verified the PCP at each visit. Families were educated on the importance of having well visits with their PCP, which encouraged the continuity of care for conditions not related to sickle cell disease. The clinic also worked in partnership with the PCP to arrange the initial visit at the sickle cell clinic and to start penicillin by two months of age.
- Another clinic site sent the clinic notes and letters to the primary pediatrician after each sickle cell clinic visit.
- The third clinic site assisted the families of newborns in finding a PCP in their community with appropriate knowledge and experience with sickle cell disease. Identified PCPs were provided with the NIH "Evidence-Based Management of Sickle Cell Disease; Expert Panel Report from 2014." Coordination of care with the PCP was maintained via telephone calls and/or written summaries detailing the plan of care and current health status of the patient following the comprehensive clinic evaluation.

- The fourth clinic site maintained contact with the PCP to ensure providers made timely referrals to the clinic to confirm the diagnosis of sickle cell disease and other hemoglobinopathies, facilitate entry of infants into care, and ensure patients remained in care.

At the end of FY19, 70% of Virginia Bleeding Disorder clients over 21 years reported having a PCP; 95% of clients under 21 reported having a PCP. VCU initiated a Medical Home Quality Improvement project. Implementation started April 2019. The VCU Program Manager served on the Region III PCP QI project.

Program-Specific Transition Activities

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 Daughters CCC program developed the tool and they update it regularly with consultation from the other CCC centers across our state who are contracted with the CSHCN program. The tool is based on the work of *Got Transition.*

In 2018, VDH partnered with VCU to survey parents of children who receive services from a CCC center. Transition related data was very positive, especially when compared to the data from the last time the survey was conducted. In the 2018 survey, 80.7% of parents surveyed stated that the CCC program has made it easier for them to prepare their child for adulthood. This is up from 2013 when 65% of parents stated the program made it easier to prepare their child.

During the fall of 2019, the CCC program held a statewide conference for CCC staff. At the conference, Dr. Patience White (a renown expert in transition) served as a keynote speaker. She shared specific data about Virginia and facilitated a discussion about transition and its importance when it comes to health outcomes for people with special healthcare needs.

The CDC program provided assessments and diagnoses of very young children suspected of having developmental and behavioral conditions such as ADHD and autism. 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).

Each pediatric sickle cell clinic identified at least one adult provider that will accept sickle cell patients and used the American Society of Hematology Sickle Cell Disease Transition Readiness Assessment to assess patients' readiness for transition. In FY19, 27 patients had their first adult provider clinic appointment. Due to geographical location and resources, each clinic handles transition differently, as described below:

- One clinic has a designated Transition Coordinator that provided transition and social work services to patients 15-21 years of age. The Transition Coordinator conducted ongoing assessments for each patient and family to gauge their strengths/needs. Counseling and connection to community resources were provided to help families in need identified through assessments. Cognitive Behavior Therapy is used to address issues that may be affecting patients' ability to cope with their illness. All transition aged patients and their parents were provided data to create their individualized health care transition plan, which is documented in their charts. Data was collected via the Transition Coordinator Assessment during clinic appointments. Each team member worked with the patient to ensure the plan was comprehensive and appropriate to address the unique needs of that patient. All transition-aged patients were educated about the phases of transition during clinic appointments, ER visits, and hospital admissions. New educational

materials were distributed as they were available and documented in patients charts. All new patient appointments for adult providers were made by the patient with the assistance of the Transition Coordinator. The transition coordinator attended, when possible, and documented the patient's participation in the first appointment. Patients called the transition coordinator when there was a problem or concern with the adult provider and adult physicians often consulted the transition coordinator with client issues. When possible, the transition coordinator saw the patient while they were admitted (as a courtesy to the physicians). A transition retreat-cookout was held that provided community based resources from Generation S and No Excuses mentoring group.

- Another clinic used the American Society of Hematology survey to help assess learning needs of patients. The Clinical Nurse Educator attempted to meet with the majority of transition age patients to assess knowledge and explain the reason for transition and what to know when transition is complete. When answers were unknown, the Nurse Educator went into detail about each question until she believed the patient understood the information provided. The education consultant attempted to meet with the majority of patients going to college/university to ensure that they connected to the disability office and were receiving proper assistance.
- The third clinic site distributed a transition notebook at the comprehensive clinic appointment closest to the patient's 15th birthday, which begins the process of creating a personal health care management organizer. Once the notebook is received, each patient participated in a four-part curriculum. Part One focused on knowledge of medical history/genetics, medication management, and self-care. Part Two covered educational/vocational options. Part Three covered health benefits/insurance, and Part Four covered social support, coping, self-esteem and resource identification. Patients also received a copy of *Hope and Destiny Jr.* and a lunch lecture was held during one of the sickle cell clinics that focused on transition.
- The fourth clinic site entered patients in the transition program upon starting the ninth grade. Each patient received a transition notebook that contained a transition curriculum that served as a guide in the development of an individualized health care plan. This plan addressed issues in the following domains: medical, social, educational/vocational and psychological. In addition to the intervention that occurred in clinic, two weekend overnight retreats with transition age patients were planned

The bleeding disorder centers had 12 patients transition from pediatric to adult care in SFY19. The Program Manager held quarterly calls to discuss the patients that would be transitioning to adult care. Some of the other efforts that the centers took were:

- One center began to notice a trend of no-shows for their transition age group and had to make decisions to keep some patients longer.
- One center prepared a business proposal to start an adult hematology program. Meetings throughout the year focused on establishing comprehensive care and transition policies and hiring of staff. The center posted the Nurse Practitioner and Social Worker Positions

Overall Systems Outcomes for CYSHCN

The Title V Director, CSHCN Director, and Blood Disorders Coordinator worked to update and align the state's Title V CSHCN action plan with the Standards for Systems of Care for Children and Youth with Special Health Care Needs.

Family Professional Partnerships: Families of CYSHCN will partner in decision making at all levels and will be satisfied 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.

Another one of our core programs, the Child Development Centers (CDCs) also actively engage families. The CDCs provide assessments of children suspected of having developmental and/or behavior conditions. Families are an active part of the assessments that are done and they receive documentation regarding diagnoses. In addition, center staff members refer them to clinical and non-clinical resources for assistance and share the results of their assessments with other providers serving the family.

The comprehensive pediatric sickle cell clinics continued to offer genetic counseling to aide in future reproductive health decision making. Examples of other family related activities included:

- One clinic encouraged families to utilize computers available in the Family Education Room to learn more about sickle cell disease and new treatment options. The social workers at this clinic also held monthly support groups and started an ambassador program to enhance connections among the families, strengthen support networks, and facilitate peer-to-peer support.
- Another clinic held an annual sickle cell family education day. The clinic collaborated with a local non-profit organization to host a day of sickle cell education, camp activities, and opportunities for families to support each other by sharing life experiences caring for a child with sickle cell disease.
- A third clinic held an educational program for parents of newly diagnosed patients, called “First Steps.” The program provided basic information about sickle cell disease and a forum for families to discuss the challenges of caring for an infant with sickle cell disease.

Examples of family related activities for the VBDP:

- All of the CYSHCN programs have an Education Consultant assigned to the program. The Education Consultant works with the families to do parent interviews, formal assessments, school visits and school plans of care.
- Families were educated on home therapy management in order for patients to infuse at home.
- One center had a lunch lecture to introduce transition-aged patients to the new adult clinic and the providers, while providing an overview of the transition process.
- The centers had educational sessions during clinic for families on various topics that included collaborating with their local hemophilia foundation and resources available to them
- Caregiver support groups were held

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 continued 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 98% were insured. VBDP staff conducted health insurance assessments, intensive insurance case management when clients have significant changes in their insurance, and referrals for compassionate use programs. Ninety-six percent of the clients had adequate private or public insurance. One of the VBDP’s most important partners in this process is Patient Services Incorporated (PSI). PSI provided insurance case management and premium assistance to help eligible families maintain insurance coverage. The program on average served 20 patients. The FY18 estimated cost avoidance for the program is

$4,832,075.70.
Based on the data reported from the centers, 96% of sickle cell patients served had adequate private or public insurance.

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. Due to intensive insurance case management and compassionate use programs improving efficiencies in processing applications, our POF utilization has steadily decreased over the years.

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 available, 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.

VBDP staff conducted health insurance assessments, intensive insurance case management when clients have significant changes in their insurance, and referrals for compassionate use programs. Ninety-six percent of the clients had adequate private or public insurance. Effective January 1, 2019, Virginia expanded eligibility for health coverage for adults between the ages of 19 and 64. Letters and phone outreach to all uninsured or patients potentially eligible for Medicaid expansion that were part of the VBDP. One of the VBDP's most important partners in this process is Patient Services Incorporated (PSI). PSI provided insurance case management and premium assistance to help eligible families maintain insurance coverage. The program typically can assist at least 20 patients. Due to Medicaid expansion, the program is providing premium assistance to 5 patients. The program on average served 20 patients. The FY18 estimated cost avoidance for the program is $ $4,832,075.70.

In addition to the above, staff created a list of activities that align with our strategy. Please see below for progress made on those activities:

- Through CCCs, conduct medical insurance benefits evaluation and coordination, to include identifying potential Medicaid-eligible families, providing assistance with applying, and providing ongoing education and support to access covered services- The CCCs continue to complete this task for the people they serve and the task continues to be part of each center's work plan;
- Through all CYSHCN centers, identify potential Medicaid-eligible families and refer to DMAS- The CYSHCN program continues to work very closely with families to refer as needed to Medicaid if it appears that the family may be eligible. Each program has staff such as nurses and social workers who are very familiar with Medicaid. The program continues to maintain this expertise;
- Work towards strengthening relationship with DMAS/MCOs and health systems by exploring opportunities for shared financing to sustain and expand services- This year CYSHCN VDH staff and CDC program staff worked very closely with DMAS to deal with reimbursement issues that pose a real threat to the vitality of the CDC program. There have been issues with reimbursement that have created budget concerns. DMAS responded and the one center with the biggest issues regarding reimbursement has started to see a major improvement. The partnership with DMAS has been very valuable and they are attentive to the needs of the children that the CDC program serves. Staff continue to work very closely with them and think that this partnership serves as a good example of two state agencies working together to serve children and families;
- Administer a Care Connection for Children pool of funds for payment of direct medical care services for

uninsured and underinsured clients- Virginia Title V continues to fund this program that provides life preserving medications such as insulin and durable medical equipment to low in come clients who are at or below 300% of the FPL and not eligible for Medicaid. It remains the payer of last resort and staff spend a lot of their time trying to find other resources that exist for families in need;

- Administer a bleeding disorders pool of funds for payment of direct medical care services for the uninsured and underinsured clients- This fund is still ongoing for the purchase of factor for people with bleeding disorders. However, the expansion of Medicaid in Virginia has greatly reduced the need for the agency to purchase the medication;
- Manage an insurance case management contract (PSI) to help assure people with bleeding disorders have ongoing access to adequate insurance- The CYSHCN program continues to fund this service. The budget has been reduced because the need has decreased due to Medicaid expansion.

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 VDH partners with readily refers these children to 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.

The Hemophilia Treatment Centers (HTC) worked to increase access to unidentified or underserved populations through community or program efforts. Examples included:

- Worked with NC HTC social worker about resources for southwest Virginia family
- One center started an outreach clinic to reach an underserved area. The clinic is held every other month
- Social worker worked with local health department to coordinate dental work for patients
- Discussions were held with a HTC in NC regarding transitioning of several patients they had been caring for, as they can no longer accept VA Medicaid.
- Worked with uninsured local Mennonite community to provide factor and care to families

The sickle cell clinics provided the following to help families access services easily:

- A "Day Hospital" ensured continuity of care. Patients presenting to the ER with pain or fever during normal clinic business hours are triaged and sent to the clinic, if appropriate. Home health is arranged, when feasible, to avoid admissions.
- All newborns confirmed to have a hemoglobinopathy are referred to the VDH's Care Connection for Children program to provide case management services.
- Spanish-speaking patients are identified prior to visit and interpreter services are coordinated. Phone interpretation is used with other languages.

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.

In addition to the above, staff created a list of activities that align with our strategy. Please see below for progress made on those activities:

- Conduct subrecipient monitoring to ensure CCCs meet required service levels for providing care coordination services- The CYSHCN director visited select centers during the year to observe operations and to ask questions about any needs that partners have. In addition, staff review invoices to assure that expenses are in line with the budget and that they are allowable. The unit also prints a data report at the end of each fiscal year to monitor service levels;
- Maintain infrastructure for centralized data system (CCC-SUN) for use by statewide CCC staff to track and document case management and care coordination services, insurance type, pool of funds, and I&Rs- CCC-SUN continues to be used and the VDH Office of Information Management maintains the database to include assuring that it is secure and functioning as intended;
- Offer and manage a pool of funds program for the uninsured and underinsured to cover medications, durable medical equipement, and insurance specialty copays- This program continues to offer support to families who qualify. Medicaid expansion in Virginia appears to be saving the program money.
- Collaborate with CCC Directors to assure all care coordinators are CCMs- The program continues to encourage staff who are not certified to become CCMs as funding allows;
- Convene quarterly CCC directors meetings- The CCC program has set dates for quarterly meeting for the current fiscal year. The major topic of interest will be long term sustainability of the program;
- Submit RAP for contractor to conduct an updated CCC Parent Survey and a CCC return on investment evaluation (pending management approval)- The CCC parent survey was completed in 2018, results were published and they were shared with staff. CYSHCN staff and partners will hold a workshop at the 2020 AMCHP conference regarding the implementation of such a survey for family input. Staff did not have the capacity to manage a return on investment evaluation.

Early and Continuous Screening & Referral -- Assure children are screened early and continuously for special health care needs

During the fiscal year staff continued the following activities that align with this strategy:

- All newborn screening results will be delivered to parents and providers in a timely fashion and arrangements made for necessary follow-up and referral to services (e.g. CCCs, Sickle Cell centers)- The CYSHCN program Blood Disorders Coordinator continues to manage entry into care for children who test positive on the newborn screen for sickle cell disease. She notifies the physician on record and refers children to the Pediatric Comprehensive Sickle Cell Network for care. This work is critical to help prevent serious illness and/or death in children with sickle cell disease;
- Track and document entry into care based on referrals made to specialty providers as a result of diagnosis of hemoglobinopathies- The blood disorders coordinator continues to carry out this task;
- Through the CDCs, provide interdisciplinary evaluations that may include pediatric medical examination, nurse evaluation, psychosocial history, pyschological assessment, and educational evaluation- The CDCs continue to provide this service for families in 5 regions of the state;
- Through CDCs, conduct treatment planning that may include the evaluation team developing a written report that integrates their findings, establishes diagnoses, and formulated recommendations for each client- The CDCs continue to carry out this task. Once diagnosed, short term care coordination occurs to connect

families to needed services

Children with Special Health Care Needs (CSHCN) Domain
FY21 Application

The FY21 work plan for the CSHCN Domain includes the following performance measures:

1. Adequate and Continuous Insurance
2. Medical Home
3. Transition

Marcus Allen, MPH (CSHCN Director) currently serves as the Title V CSHCN Domain Lead. Shamaree Cromartie, MPH (Blood Disorders Coordinator) oversees the sickle cell and bleeding disorders programs.

For the FY21 Application, the Title V Director, CSHCN Director, and Blood Disorders Coordinator worked to align the state CSHCN action plan with the Standards for Systems of Care for Children and Youth with Special Health Care Needs.

Children with Special Health Care Needs 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 40% 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.

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 limited pool of funds (payor of last resort) for uninsured or underinsured families with no other means for obtaining life-preserving medications and/or durable medical equipment.

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.

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 a coordinated, family-centered, culturally competent, and multidisciplinary system of care for clients of all ages with inherited bleeding disorders. 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.

FY21 Application Overview: Strong Systems of Care for All Children

---

State Priority: Strong Systems of Care for All Children
FY21 Performance Measure: NPM 11 - Percent of children with and without special health care needs having a medical home

Objective: By June 30, 2025, increase the percentage of children with special health care needs having a medical home from 48.4% (NSCH 2017-2018) to 53.2%.

According to the National Survey of Children's Health (2017-2018) 48.4% of children with special health care needs in Virginia had a medical home. There were 99.0% of CYSHCN served by the VA CYSHCN Program report having a medical home.

Strategy: As a component of the Virginia Medical Neighborhood project, launch two sets of training modules for health care providers and families on (1) a comprehensive care approach to provide a medical home for children (including those with special health care needs) and (2) healthcare transition.
Domain: CSHCN

Activity	Expected Completion Date	Responsible Staff
Renew contract with UVA	7/1/21	Marcus Allen (CSHCN Director)
Hold quarterly meetings with UVA to encourage promotion of the resource and discuss any updates that need to happen	Quarterly	Marcus Allen with Jennifer MacDonald
Continue to communicate with partners to promote the modules	Ongoing	Marcus and UVA
Follow up with Florida Title V regarding their desire to partner with VDH on the modules and make a final decision on partnership	6/30/21	Marcus, UVA, Florida Title V/CYSHCN
Gather any evaluation data or feedback from UVA about the modules	by 6/30/21	VDH & UVA
Tracking of people who complete the modules	by 6/30/21	VDH & UVA

The transition and medical home modules were launched in the fall of 2019 after more than two years of development work. VDH plans to continue to meet with UVA Quarterly. At the meetings we will discuss any program updates that need to be made and continued promotion of this resource in the Commonwealth.

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

Activity	Expected Completion Date	Responsible Staff
Partner with family-identified medical home to coordinate care for CYSHCN served through CCCs, CDCs, SCPs, and Bleeding disorders programs	Ongoing	Marcus, Shamaree
Partner with family-identified medical home to coordinate entry into specialty care for newborns with a positive hemoglobinopathy screening.	Ongoing	Shamaree
All CYSHCN programs will continue to promote medical home and help families find one if needed	Ongoing	Marcus, Shamaree
All programs will help to promote the medical home module to families once they have been created and they will be asked to promote the modules within their health systems as a whole.	Ongoing	Marcus, Shamaree, center partners
Partner with state and National AAP to promote fact sheet for pediatricians on the National Survey of Children's Health. Virginia will be the first state to pilot this. The document focuses on medical home	by 6/30/21	Marcus & State/National AAP
CDC program will continue to work with the Virginia Department of Medical Assistance Services (DMAS) and MCOs on any reimbursement issues related to services it provides on behalf of VDH	Ongoing	Marcus, DMAS, MCOs, CDCs

As a unit, the CYSHCN team will continue to require that all of its programs include work plan language regarding promoting the importance of a medical home to all families served. These requirements will continue to go beyond promotion and require that centers connect families to a medical home, if they don't have one. 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 the child with special needs to get services.

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 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 work with state Medicaid and managed care organizations to address any reimbursement issues that may arise as has occurred in previous years. The VBDP and Pediatric Comprehensive Sickle Cell Centers will continue to partner with medical homes to coordinate care in partnership with families.

Strategy: Through the CYSHCN network, facilitate access to comprehensive medical and support services that are collaborative, family-centered, culturally-competent, fiscally-responsible, community-based, coordinated and outcome-oriented to CYSCHN and their families (CYSHCN National Standard: Easy to Use Services and Supports / Care Coordination).

Domain: CSHCN

Activity	Expected Completion Date	Responsible Staff
Conduct subrecipient monitoring to ensure partners meet required service levels for providing care coordination and other similar services.	Ongoing	Marcus and Shamaree
Maintain infrastructure for centralized data system (CCC-SUN) for use by statewide CCC staff to track and document case management and care coordination services, insurance type, pool of funds, and I&Rs.	Ongoing	Marcus
Collaborate with CCC Directors to encourage staff to become and maintain certifications as case managers	Ongoing	Marcus
Convene center director/consultant meetings to provide technical assistance and troubleshoot issues. Staff will make annual site visits (when possible and after COVID) and/or offer technical assistance via phone or email.	Ongoing	Marcus and Shamaree
CDC program will continue to provide assessments of children throughout the state of Virginia suspected of having developmental and/or behavioral conditions. Once diagnosed, the results will be shared with the medical home (with permission from the family) and children will be referred for services.	Ongoing	Marcus, CDC centers
CYSHCN program will continue to promote telehealth and support the CDC centers as they provide services remotely. Regular calls will be held statewide with centers to encourage teamwork in working to overcome barriers to telehealth and to deal with any other program struggles.	Ongoing	CDC Centers
Sickle cell centers will continue to offer satellite clinics as capacity allows, as well as telehealth services. These off site clinics in two regions of Virginia and telehealth services during the pandemic improve access to care for families.	Ongoing	Shamaree, Sickle cell centers
Southwest Virginia CCC will continue to support onsite telehealth services for families in partnership with UVA.	Ongoing	SWVA CCC staff and UVA

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 VDH partners with readily refer children to specialties within their own health system and services are generally offered on the same campus. This same benefit exists for CYSHCN served through the CCC, CDC, and bleeding disorder programs.

Two of the SCP sites implement satellite clinics in areas with geographic need for services in order to improve family access of care. They also address issues of family support, health insurance, and identify transportation barriers for patients getting to appointments and provide assistance in obtaining bus tickets, Medicaid cabs, gas vouchers, etc. The centers refer patients to the appropriate community-based organizations, such as the Sickle Cell Association program, Catholic Charities, food banks and other community resources. The centers encourage staff and patients to participate in events such as Camp Young Blood, sickle cell walks, holiday parties and a sickle cell ball. Activities may be limited in the upcoming FY due to COVID-19, but the centers will adjust to still make sure that the patients and families have the needed resources. The VBDP program manager works with the Virginia Hemophilia Foundation on education to families regarding ED/EMS, dental services, and education regarding schools. VBDP helps families fill out applications for children to participate in a summer camp. In addition, families continue 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.

COVID-19 has made CYSHCN program work very challenging at times. Many of the CCC program care coordinators work from home and this will likely continue into FFY 2021. The staff have adapted well as much of their work is remote (in general). One of the biggest strengths during this time has been the trusting relationship that care coordinators have with their clients. They often have been a comforting ear for parents who needed someone to listen to them even if the care coordinator may not be able to provide them with a solution to their problem. Center program directors meet more frequently with the CYSHCN Director so that he can offer any needed technical assistance.

Some CDC program centers shuttered operations for quite some time but most will be operating in FFY 2021. The CYSHCN Director works with one of the center program leads to hold monthly virtual meetings. These meetings have been useful in helping centers work through challenging issues with reimbursement and telemedicine. Several centers have increased telemedicine utilization during the pandemic and its use will continue into FFY21.

State Priority: Strong Systems of Care for All Children
FY21 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, 2025, increase the proportion of adolescents with special health care needs in Virginia who are engaged in transition services to adult health care from 26.5% (NSCH 2017-2018) to 29.2%.

According to the National Survey of Children's Health (2017-2018) 26.5% of adolescents with special health care needs in Virginia were engaged in transition services to adult health care.

Strategy: As a component of the Virginia Medical Neighborhood project, launch two sets of training

modules for health care providers and families on (1) a comprehensive care approach to provide a medical home for children (including those with special health care needs) and (2) healthcare transition.
Domain: CSHCN

This strategy is detailed under the Medical Home performance measure.

Strategy: Assure youth with special health care needs receive the services necessary to make transitions to all aspects of adult life (including adult health care, work, and independence) through referrals to adult providers, utilizing transition tools when appropriate (CYSHCN National Standard: Transition to Adulthood).
Domain: CSHCN

Activity	Expected Completion Date	Responsible Staff
Through CCCs, facilitate transition from child to adult-oriented health care systems (e.g. transition planning tools, educational plans).	Ongoing	Marcus
Partner with the Comprehensive Sickle Cell Centers to ensure that all transition-age patients complete the American Society of Hematology transition readiness assessment tool or a similar tool/process.	Ongoing	Shamaree
Partner with funded hemophilia treatment centers to ensure the transition process from pediatric to adult treatment centers (e.g. biannual transition calls between regional hemophilia treatment centers and the state's only comprehensive adult treatment center; development of transition plan of care).	Ongoing	Shamaree
Encourage all CYSHCN programs to promote the transition and medical home community/family modules and provider modules	Ongoing	Marcus, Shamaree, UVA development team

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. All CYSHCN programs will be expected to support VDH in promoting the online transition modules 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. For FY 21, one of the bleeding disorders' centers will start an adult program. The opening of another adult clinic will help with accessibility.

Strategy: Engage youth and families in program development and outreach for medical home and transition (Standard: Got Transition's Six Core Elements of Health Care Transition – Transition

***Completion & Youth and Family Engagement**).*
Domain: CSHCN

Activity	Expected Completion Date	Responsible Staff
Address youth/family engagement component of HCT assessment by ensuring onboarded youth advisors receive training about the 6 Core Elements.	After staff hired	Maddie (support from Marcus and Carla)
Engage youth advisors and parents (including engaging Family Delegate, VDH youth advisors, KASA, Family-to-Family, Virginia Board for People with Disabilities, etc.) in program development.	End of FY 2021	Maddie, Marcus, Carla, Shamaree
Task youth advisors with engaging state and community partners (e.g. go out and build partnerships with KASA, etc.)	Ongoing	Maddie (support from Marcus and Carla)
Address transition completion component of HCT assessment by developing and implementing HCT feedback survey for all CYSHCN programs.	Ongoing	Marcus, Carla, Meagan, Maddie, Shamaree
Following module launch event, brainstorm with Medical Neighborhood team on promoting medical neighborhood concept (including medical home and transition policy, tracking and monitoring, readiness, planning, and transfer of care).	Ongoing	Marcus, UVA, Carla, Shamaree
Engage partners (e.g. Family Delegate, KASA), youth advisors, and families in encouraging others to complete modules.	Ongoing	Marcus, Maddie, Carla

During FY21 the CYSHCN Program and Adolescent Health Program will partner to increase family/youth engagement. Program efforts will focus on transition and are designed to improve outcomes for the adolescent and CYSHCN populations. Staff will engage the state's Family MCH Delegate, organizations like Kids As Self Advocates (KASA), the Virginia Board for People with Disabilities, and others to explore strategies targeted at youth. The ultimate goal is to encourage young people to promote transition improvement strategies amongst their peers.

Activities were informed by results of Virginia's Got Transition self-assessment conducted in May 2017. The Adolescent Health Domain Team Lead and the CSHCN Domain Team, which includes the Family MCH Delegate, jointly prioritized activities.

FY21 Application Overview: Community, Youth, and Family Leadership

---

State Priority: Community, Youth, and Family Leadership

FY21 Performance Measure: Family Leadership - Percentage of VDH CYSHCN programs (i.e. Care Connection for Children, Child Development Centers, Bleeding Disorders Program, Sickle Cell Program) actively incorporating family engagement annually.

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: 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).
Domain: CSHCN

Activity	Expected Completion Date	Responsible Staff
Maintain paid parent coordinators and/or promote family involvement at CCC centers to provide support and resources to families served.	Ongoing	Marcus
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).	Ongoing	Marcus, Shamaree
Solicit, document, and respond to family feedback on satisfaction with services (e.g. bleeding disorders family satisfaction survey every other year, CCC parent survey every 5 years).	Ongoing	Shamaree, Marcus
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).	Ongoing	Shamaree
CYSHCN programs will continue to partner with the VA Department of Education (DOE) to support families utilizing the expertise of educational consultants.	Ongoing	All Programs

The regional Care Connection for Children centers (CCC) will continue to be encouraged to employ parent coordinators as staff. Maintaining such staff has been difficult but care coordinators will continue to actively engage families in order to offer resources and support. Most of the parent coordinators who are employed have a child with a special health care need so they understand the unique challenges families face. In addition to providing general

support to families, parent coordinators in various regions across the Commonwealth work to: maintain center resource lists; create newsletters; lead educational activities and trainings; and work closely with families on overcoming barriers to care.

Another one of our core programs, the Child Development Centers (CDCs) also actively engage families. The CDCs provide assessments of children suspected of having developmental and/or behavior conditions. Families are an active part of the assessments that are done and they receive documentation regarding diagnoses. In addition, center staff members refer them to clinical and non-clinical resources for assistance and share the results of their assessments with other providers serving the family.

The Virginia Bleeding Disorders Program (VBDP) and the Sickle Cell Program (SCP) will continue to have a number of programs/events to support families in decision making at all levels. The VBDP educates families on home therapy management for those who infuse at home. The SCP centers offer genetic counseling to aide in future reproductive decision making. The regional centers provide events for families, including social gatherings and overnight camps with educational and group activities focusing on transition and self-advocacy. The program will continue to provide basic information about SCD and a forum for families to discuss the challenges for caring for an infant with SCD. Social workers will continue to send out pertinent information for families as topics arise pertaining to medical advances in SCD. Families with newborns diagnosed with SCD will be given a copy of *Hope and Destiny: A Patient's and Parent's Guide to Sickle Cell Anemia* and patients entering the transition phase will be given a copy of *Hope and Destiny Jr* (as funding allows).

FY21 Application Overview: Finances as a Root Cause

State Priority: Finances as a Root Cause
FY21 Performance Measure: NPM 15 - Percent of children, ages 0 through 17, who are continuously and adequately insured

Objective: By June 30, 2025, increase the proportion of children with special health care needs in Virginia who are continuously and adequately insured from 71.3% (NSCH 2017-2018) to 74.9%.

Strategy: Assure families of children with special health care needs will have adequate private or public insurance or both to pay for the services they need (CYSHCN National Standard: Insurance & Financing).
Domain: CSHCN

Activity	Expected Completion Date	Responsible Staff
Through CYSHCN programs, conduct medical insurance benefits evaluation and coordination, to include identifying potential Medicaid-eligible families, providing assistance with applying, and providing ongoing education and support to access covered services.	Ongoing	Marcus, Shamaree
Work towards strengthening relationship with DMAS/MCOs and health systems by exploring opportunities for shared financing to sustain and expand services.	Ongoing	Marcus

Administer a Care Connection for Children pool of funds for payment of direct medical care services for the uninsured and underinsured clients.	Ongoing	Marcus
Administer a bleeding disorders pool of funds for payment of direct medical care services for the uninsured and underinsured clients.	Ongoing	Shamaree
Manage an insurance case management contract (PSI) to help assure people with bleeding disorders have ongoing access to insurance.	Ongoing	Shamaree
Continue to encourage social work support at the VBDP and SCP centers across the state	Ongoing	Shamaree
Plan and hold a statewide meeting of MCO care coordinators and VDH CCC care coordinators regarding collaborating to reduce barriers families face in understanding Medicaid benefits and accessing care, medications, and therapies. At the meeting, the VDH Title V Director will share the results of the agency needs assessment. She will also help facilitate a discussion with the CYSHCN director regarding efforts that can be made to address concerns about transportation, health equity, recreational opportunities, and transportation needs.	By September 2021	Marcus, Carla, DMAS staff (Virginia Medicaid agency)
The Virginia Bleeding Disorders program will conduct a needs assessment in partnership with Virginia Commonwealth University (VCU) to evaluate the extent to which the program serves its target population and is maximizing the funding based on changes in healthcare and treatment options.	By June 2021	Shamaree and VCU
The CYSHCN director will work with CCC and CDC partners to update each work plan template. A specific focus will be on outreach to underserved and minority populations with a health equity lens.	By June 2021	Marcus, CCC/CDC
VDH will explore a regional meeting in the SWVA area to discuss issues related to developmental/behavioral follow-up services. The proposed meeting would focus on potential solutions to the problem	By September 2021	Marcus, SWVA CDC

The CYSHCN programs will continue to help families struggling with insurance issues by connecting them to public

and private options as needed. The CCC program reports that about 93% of CYSCHN served are insured and the CDC program reports that 98% are insured. As for the VBDP, 99% of patients have 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 will continue to provide insurance case management and premium assistance to help eligible families maintain insurance coverage. Based on the data reported from the centers, 98% of sickle cell patients have private or public insurance. Each center has social work support to help families address insurance needs and as with all VDH CYSHCN programs, families are encouraged to apply for Medicaid if it appears they are eligible.

The expansion of Medicaid continues to be popular in Virginia and has been received well. Program partners continue to support families as they seek to access insurance options. This is critical for all programs but it makes the most difference for young adults transitioning and for people of all ages who have hemophilia. Since implementation of Medicaid expansion, the CYSHCN program has already had a number of clients with hemophilia transition to Medicaid.

VDH will continue 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 continues 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 -- continues to be available, 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.

The qualitative portion of the VDH Title V/MCH needs assessment identified that health insurance for health care services for CYSHCN is both an asset and a frustration for families. As documented in the needs assessment report, one of the most significant accomplishments has been the expansion of Medicaid coverage. This has led to more parents being insured as indicated by a subject matter expert interviewed for the qualitative part of our needs assessment. In other words, healthy insured parents can lead to healthy insured children. However, Virginia still has significant work to do. The qualitative part of our needs assessment also demonstrated that parents struggle to understand their insurance and what it provides. Examples of barriers mentioned included: filling out required paperwork; understanding information about insurance/confusion; being able to access certain medications; language issues; not having insurance at all; and MCO/benefit changes mid-year that at times may disrupt services provided. This is further supported by data from the National Survey of Children's Health that shows that more than 25% of parents state that their insurance is not adequate or they had gaps in insurance.

Due to the information received from our needs assessment, Virginia wants to work to continue to make improvements regarding insurance by choosing to devote some focus on NPM 15: Percent of children, ages 0 through 17, who are continuously and adequately insured. National Survey of Children's Health (2017-2018) data showed:

- 71.3% of CYSHCN are continuously and adequately insured.
- 73.8% of CYSHCN have insurance coverage that is usually/always adequate to meet his/her needs.
- Regarding mental or behavioral health needs, 42.4% of CYSHCN have insurance that **always** offers benefits or covers services, while 31.6% of parents responded **usually** and 26.0% responded **never**.

Our strategy is to continue to strengthen the relationship that our care coordinators have with Medicaid care

coordinators. The VDH CYSHCN Unit meets with Medicaid regularly and both organizations agree that a more formal relationship is desired. We want to have a statewide meeting between both groups before the end of FFY 21. One of the key results of the meeting that we want to achieve is regular regional meetings between the Care Connection for Children care coordinators and the MCO care coordinators. The purpose of this is for them to work together to support families who are encountering barriers to care and struggling to understand their insurance.

Evidenced-based/Informed Strategy Measures for this objective are the number of MCO and CCC care coordinators who attend meeting and the number of MCO/CCC regions who commit to partnering with each other to reduce barriers.

Budget Update

The CYSHCN CCC program budgetary needs have outpaced MCH funding. This is due to the fact that program care coordinators across the state tend to stay in their positions long term and they receive regular merit/cost of living increases. VDH has been in talks with Medicaid and several MCOs but the process of seeking reimbursement for services is difficult. During FFY21, the CYSHCN program plans to continue this discussion and the CYSHCN program director will continue to bring up the topic at statewide CCC director's meetings to encourage increased health system financial support.

Consumer/Family Engagement & Partnership

The CYSHCN Program works very closely with the MCH Family Advocate for Virginia and will continue to do so. Staff attend and participate in quarterly Department of Education Family Engagement Network meetings (led by the state family delegate and DOE staff) and utilize the delegate to support the continued development of the transition and medical home modules. In addition, the CCC program will continue to employ parent coordinators and all programs will continue to enthusiastically engage families to care for children with special needs. Last, the CYSHCN program will partner with the MCH Adolescent Health Program leadership to support youth advisors as they engage their peers on the importance of transition to adult medical care and life.

Emerging Issues

The death of Mr. George Floyd and the resulting appropriate social unrest has encouraged the CYSHCN program to do more to address health equity and disparities. During FFY21, we will revise the CCC and CDC work plans. Each plan will require stronger and more deliberate outreach to underserved minority populations. In addition, during the planned care coordination meeting between the Medicaid MCO care coordinators and the CCC care coordinators we will add a discussion regarding the importance of health equity to the agenda. The goal will be to explore increased efforts that can be made to support minority and other underserved populations.

Developmental and behavioral health services in Southwest Virginia continue to be a major struggle. VDH funds a Child Development Clinic in the region but care after diagnosis is lacking. Families often have to travel for more than two hours to receive care. During FFY21 the CYSHCN Program Director plans to work closely with the center in the region to hold a regional meeting about the issue. The goal will be to bring partners such as Carilion Health System and the University of Virginia together to explore options for improving services locally either through telemedicine or via regional clinics.

Sickle cell disease continues to be a neglected health condition. VDH received a grant in FY 20 to create the infrastructure for a population based sickle cell surveillance system. VDH has applied for additional funding through the Centers for Disease Control and Prevention to continue the work to create the surveillance system and begin to collect and analyze data that can be used to improve health policies and outcomes for the sickle cell population.

Prior to COVID-19, funding was approved to establish the Virginia Sickle Cell Patient Assistance Program. The program would provide health insurance premium assistance and cost sharing assistance to patients diagnosed with Sickle Cell Disease who do not qualify for Medicaid. The funding was originally cut from the FY 21 budget, but is currently back in the Special Session budget. If approved, VDH will set up and administer the program.

Other Programmatic Activities

Coordination with Virginia Department of Education (DOE)**:** The Virginia Administrative code states that DOE will collaborate with the four CYSHCN programs to provide consultation for families, educators, and school administrators. CYSHCN program staff partner with school systems and the educational consultants to ensure students receive services consistent with their level of need. The Educational Consultants make school visits, communicate with teachers, counselors, and school nurses to activate home schooling and assist with 504 plans and IEPs. In addition, they conduct educational assessments of children who have been identified as having issues performing in school.

DOE continues to work on aligning services statewide for children served. The agency has been working on this for more than a year and their goal is to have uniform policies to assist in data collection, educational consultant supervision and evaluation, and aligning practices across the Commonwealth.

Sickle Cell Study: The Blood Disorders Program Coordinator will continue plans to work with a general pediatric fellow and doctor on a research study that will explore improving communication around sickle cell trait information/counseling after newborn screening (funded by the Academic Pediatric Association Research in Academic Pediatrics Initiative on Diversity, RAPID). The study objective is to identify the educational and healthcare needs and preferences of parents whose children have been identified as having SCT. The study is currently finishing up interviews with families and data analysis will begin soon. Abstracts will be submitted to various conferences and publications.

SEEK Partnership: The CYSHCN Program continues to partner with the Division of Prevention and Health Promotion to promote the "SEEK" model. SEEK stands for "Safe Environment for Every Kid." The program utilizes a brief evidence-based questionnaire to screen for prevalent psychosocial problems such as parental depression and substance abuse. It also screens for the risk factors for child maltreatment. The model is designed to be used in a clinical setting with the goal to identify issues and to connect families to support and resources as needed. Children's Hospital of the King's Daughters and Carilion Health System have embraced this model.

Virginia Bleeding Disorders Needs Assessment:
The VBDP program reported that the recent Medicaid expansion in Virginia has decreased the need for insurance case management services and pool of funds services for people living with hemophilia and other bleeding disorders. This is significant because factor and premium payment is very expensive. With the decreased need for insurance case management services and pool of funds, the program will conduct an extensive year long needs assessment to determine if the program and population has other unmet needs.

Adult Comprehensive Sickle Cell Clinic Network:

During the most recent session of the Virginia General Assembly, the Code of Virginia was amended to add adult sickle cell comprehensive care (priority of the Governor) and approved funding to support the infrastructure for an adult sickle cell network. VDH is currently in the process of writing regulations that mirror the pediatric regulations. It is anticipated that a network of adult centers will be functional by the end of FFY 21. After the change in regulations are approved, requests for proposals will be solicited. The proposed funding will support at least four centers across the Commonwealth of Virginia to improve transfer of care from pediatric to adult care and provide infrastructure funding. Individuals and caregivers of individuals living with sickle cell disease will be a part of the stakeholders group to provide input.

Cross-Cutting/Systems Building

State Performance Measures

SPM 1 - Cross-Cutting (Early and Continuous Screening): Percent of infants who are diagnosed with a newborn screening disorder that are referred to care coordination services in the CYSHCN program

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	100
Numerator	
Denominator	
Data Source	VDH Newborn Screening Program, VDH EHDI
Data Source Year	2018
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	100.0	100.0	100.0	100.0	100.0

SPM 2 - Cross-Cutting (Youth Leadership): Develop and sustain the Virginia Department of Health Youth Advisor Program

Measure Status:	Active

State Provided Data		
	2018	2019
Annual Objective		
Annual Indicator		Yes
Numerator		
Denominator		
Data Source		VDH Adolescent Health Program
Data Source Year		2019
Provisional or Final ?		Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

SPM 3 - MCH Workforce Development (Racial Equity): Develop and implement MCH workforce development policies addressing racial equity for all Title V program staff and subrecipient staff

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	Yes	Yes	Yes	Yes	Yes

State Action Plan Table

State Action Plan Table (Virginia) - Cross-Cutting/Systems Building - Entry 1

Priority Need

Community, Family, & Youth Leadership: Provide dedicated space, technical assistance, and financial resources to advance community leadership in state and local maternal and child health initiatives.

SPM

SPM 2 - Cross-Cutting (Youth Leadership): Develop and sustain the Virginia Department of Health Youth Advisor Program

Objectives

By June 30, 2021, increase equity in VDH's public health initiatives by incorporating youth voice into the development, planning and management of public health initiatives that impact young people.

Strategies

Hire two part-time Youth Advisors to provide expertise, guidance and feedback on current and future public health initiatives.

Fund regional system that incorporates numerous and diverse youth voices into public health in Virginia.

State Action Plan Table (Virginia) - Cross-Cutting/Systems Building - Entry 2

Priority Need

Racism: Explore and eliminate drivers of structural and institutional racism within OFHS programs, policies, and practices to improve maternal and child health.

SPM

SPM 3 - MCH Workforce Development (Racial Equity): Develop and implement MCH workforce development policies addressing racial equity for all Title V program staff and subrecipient staff

Objectives

By September 31, 2021, develop and implement MCH workforce development policies addressing racial equity for all Title V program staff and subrecipient staff.

Strategies

Incorporate racial equity training into individual staff training plans and minimum strategic planning requirements into subrecipient agreements.

Provide support to Central Office, LHD, and interagency staff on planning and implementing MCH programs with attention to racial equity and upstream factors.

Support 35 local health districts in developing and maintaining equity-focused, data-driven workplans aligned with findings from the 2020 MCH Needs Assessment and local Community Health Assessments, to include (1) MCH equity considerations, (2) coordination with community-based organizations, (3) upstream/cross-sector strategic planning, and (4) coordination with broader systems of care for children.

Pilot racial equity training with statewide partners.

State Action Plan Table (Virginia) - Cross-Cutting/Systems Building - Entry 3

Priority Need

MCH Data Capacity: Maintain and expand state MCH data capacity, to include ongoing needs assessment activities, program evaluation, and modernized data visualization and integration.

SPM

SPM 1 - Cross-Cutting (Early and Continuous Screening): Percent of infants who are diagnosed with a newborn screening disorder that are referred to care coordination services in the CYSHCN program

Objectives

By June 30, 2020, increase the percentage of infants with confirmed newborn screening disorder that are referred to care coordination services, from 57% (2017) to 60%.

Strategies

Maintain the VaCARES Registry and expand capacity to document and track referrals of infants from the Newborn Screening Program to CYSHCN programs.

Partner with internal agency teams to identify needs, gaps and future direction of the current birth defects surveillance system.

Coordinate and partner with external stakeholders to increase the percentage of birthing facilities that report CCHD information into the current IS from 65% (2020 baseline) to 75% by September 2021.

Partner with NYMAC (New York - Mid-Atlantic Regional Genetics Network) to assess and respond to state needs related to genetic services.

State Action Plan Table (Virginia) - Cross-Cutting/Systems Building - Entry 4

Priority Need

Community, Family, & Youth Leadership: Provide dedicated space, technical assistance, and financial resources to advance community leadership in state and local maternal and child health initiatives.

SPM

SPM 1 - Cross-Cutting (Early and Continuous Screening): Percent of infants who are diagnosed with a newborn screening disorder that are referred to care coordination services in the CYSHCN program

Objectives

By June 30, 2020, increase the percentage of infants with confirmed newborn screening disorder that are referred to care coordination services, from 57% (2017) to 60%.

Strategies

Maintain and expand family engagement on state NBS Advisory Committee.

Sustain Early Hearing Detection & Intervention Program, to include support for paid 1-3-6 Family Educators.

State Action Plan Table (Virginia) - Cross-Cutting/Systems Building - Entry 5

Priority Need

Maternal and Infant Mortality Disparity: Eliminate the racial disparity in maternal and infant mortality rates by 2025.

SPM

SPM 3 - MCH Workforce Development (Racial Equity): Develop and implement MCH workforce development policies addressing racial equity for all Title V program staff and subrecipient staff

Objectives

Eliminate the racial disparity in maternal and infant mortality rates by 2025.

Strategies

Explore opportunities to develop and pilot racial equity curricula at Virginia colleges and universities providing medical, nursing, dental, and other clinical health professional training.

Develop and mobilize strong interagency, multisector, and community partnerships to address disparities in maternal and infant mortality rates.

Sustain state maternal mortality and child fatality review programs

Work with stakeholders to increase access to doula services among women of color.

Maintain Title V representation on the Virginia Neonatal Perinatal Collaborative's Steering and Executive Committees, and develop a shared visioning and planning document specific to the VDH-VNPC relationship

Launch CDC Project LOCATe by June 2022

Launch health disparities dashboard by June 2022

Launch VNPC stillbirths dashboard by June 2022

Increase capacity of youth-serving agencies to implement AIM4TM, an evidence-based pregnancy prevention program designed for parenting teens

Assure Resource Mothers staff are trained in the Growing Great Kids curriculum, a skills-driven program designed to promote healthy child development and strengthening protective factors for families in a home visiting setting

Support training, support, and evaluation for home visiting programs, to include MIECHV, Healthy Start, and Early Impact Virginia

2016-2020: State Performance Measures

2016-2020: SPM 6 - Cross-cutting (Family Engagement): Implement and develop report on survey of families served by the VDH Care Connection for Children (CCC) programs

Measure Status:		**Active**	
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			0
Annual Indicator		Yes	Yes
Numerator			
Denominator			
Data Source		VDH CYSHCN Program	VDH CYSHCN Program
Data Source Year		2018	2019
Provisional or Final ?		Final	Final

2016-2020: SPM 7 - Cross-Cutting (Early and Continual Screening): Percent of infants with confirmed newborn screening disorders who are enrolled in supportive services no later than 6 months of age

Measure Status:	**Active**

Baseline data was not available/provided.

Cross-Cutting / Systems Domain
FY19 Annual Report

The FY19 workplan for the Cross-Cutting / Life Course Domain included the following performance measures:

1. Family Engagement

Strategies within the FY19 Cross-Cutting Domain workplan were implemented by the CSHCN Program, with support from the Title V Director and MCH Epidemiogist.

State Priority: Family Engagement – Foster a culture of family/youth engagement and leadership.

FY19 Performance Measure: Cross-Cutting (Family Engagement) – Implement and develop report on survey of families served by the VDH Care Connection for Children (CCC) programs

---

Objective

For the FY19 application, the proposed objective was:

- 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.

Progress Updates

The Title V Director, CSHCN Director, and Blood Disorders Coordinator worked to align the full state CSHCN action plan with the Standards for Systems of Care for Children and Youth with Special Health Care Needs.

In addition, the Title V Director set forth a vision for a more robust state plan for family and youth leadership and worked with the Adolescent Health Coordinator and the State Family Delegate to develop strategic plans.

Details are provided within the FY21 Application.

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).

This work was successfully completed and is detailed within the CSHCN Annual Report.

Cross-Cutting/Systems Building Domain
FY21 Application

The FY21 workplan for the Cross-Cutting/Systems Domain includes the following performance measures:

1. Youth Leadership
2. Early and Continuous Screening (Newborn Screening)
3. MCH Workforce Development: Racial Equity

Funded efforts will be implemented by the following entities:

- Adolescent Health Program
- Newborn Screening Program
- State, Local, and Subrecipient Programs

I. Adolescent Health Program

FY21 Application Overview: Community, Family, & Youth Leadership

State Priority: Community, Family, & Youth Leadership
FY20 Performance Measure: Youth Leadership – Develop and sustain the Virginia Department of Health Youth Advisor Program

Objective: By June 30, 2021, increase equity in VDH's public health initiatives by incorporating youth voice into the development, planning and management of public health initiatives that impact young people.

Strategy: Hire two part-time Youth Advisors to provide expertise, guidance and feedback on current and future public health initiatives.
Domain: Cross-Cutting/Systems

Activity	Expected Completion Date	Responsible Staff
Hire Youth Advisors (screening, interviews and offers).	August – September 2020	Maddie Kapur (Adolescent Health Coordinator)
Onboard Youth Advisors	October 2020	Maddie
Support Youth Advisors in developing a system where VDH programs can solicit Youth Program Advisors' expertise on initiatives that impact young people.	October 2020	Maddie
Support Youth Advisors in evaluating requests for input and managing workload.	October 2020 – September 2021	Maddie
Interview Youth Advisors to gauge how empowered they feel as VDH employees.	Ongoing	Objective
Conduct Positive Youth Development Trainings for VDH staff that will be working with Youth Advisors	Ongoing	Maddie
Support ongoing work of Youth Advisors and sustainably incorporate youth voice into VDH's public health initiatives.	Ongoing	Maddie

Strategy: Fund regional system that incorporates numerous and diverse youth voices into public health in Virginia.
Domain: Cross-Cutting/Systems

Activity	Expected Completion Date	Responsible Staff
Youth Advisors begin working at Central Office	October 2020	Maddie
Support Youth Advisors in developing a system to incorporate diverse youth voice in and empower young people to lead public health programming.	October 2020 – January 2021	Maddie
Support Youth Advisors in launching system that empowers young people in public health in Virginia.	January 2021	Maddie
Support Youth Advisors in managing system and planning for sustainability.	January – September, 2021	Maddie

Before now, the Adolescent Health Program has not had a structured way to include youth and family input in VDH's programs. Youth Advisors in Central Office will have the opportunity to give input on a variety of public health initiatives that affect young people, thereby increasing family voice and equity in Title V programs. Additionally, Youth Advisors will develop a structure for Regional Youth Advisory Councils, who will not only influence Title V initiatives but will also plan and implement public health interventions in their communities. This youth advisory structure allows for

timely direct input from youth on VDH programs and equitable geographical representation on the regional youth advisory councils.

About the Emerging Youth Advisor and Youth Advisory Council Program

One of the emerging priorities of VDH's Title V Program is increasing family and youth engagement in Title V-funded initiatives. As a result, VDH's Adolescent Health Program must establish a structure that consistently brings youth voice into adolescent health programs. The Adolescent Health Program proposes two separate initiatives: Youth Advisors in Central Office and a to-be-determined structure, which the Youth Advisors will develop with Title V staff support, that organizes youth across Virginia to provide leadership and input on VDH public health initiatives.

The Adolescent Health Program is in the process of hiring two paid part-time Youth Advisors to serve as youth culture experts and consultants. These Youth Advisors are wage employees in VDH's Central Office in Richmond, providing expertise, support, guidance and feedback to improve and effectively engage youth and young adults in VDH's programs. Applicants must be between the ages of 18-22. With the guidance of the Adolescent Health Coordinator, Youth Advisors will provide feedback on current and future adolescent health initiatives and develop and manage the Regional Youth Advisory Program.

Long-term, VDH will fund a statewide system that allows youth leaders in every region to both provide input on existing public health initiatives and lead public health interventions in their own communities. VDH's Youth Advisors, who are currently being hired, will be instrumental in the planning, development and management of this program. Title V staff will empower and support Youth Advisors in executing their vision for this system, whatever that vision may be. For this reason, VDH Title V staff does not yet have additional details on this regional system.

Youth Advisors will be brought on board at the beginning of FY21. They will spend FY21 providing input on existing VDH programs and developing and managing a sustainable regional youth advisory structure in Virginia.

II. Newborn Screening Program

The Code of Virginia mandates that all Virginia infants are screened for thirty-three disorders tested through dried blood spot (DBS) screening, Critical Congenital Heart Disease (CCHD) and hearing loss within 24-48 hours of birth and/or before discharge from the hospital. The Virginia Newborn Screening program consists of DBS newborn screening, the Early Hearing Detection and Intervention (EHDI) and CCHD follow-up teams. The DBS and EHDI teams track and follow-up on all out-of-range results, facilitates access to specialty services for further testing and confirmation of diagnosis, and infants that are diagnosed with a newborn screening disorder are referred to Care Connection for Children Centers (CCC) for care coordination services. EHDI also refers diagnosed infants to Early Intervention (EI) and maintains contracts with multiple institutions to assure family-to-family support and a hearing aid loan bank. The DBS program also maintains contracts with four regional medical centers to assure diagnosis and treatment of infants who screen positive for a dried blood spot genetic disorder. The CCHD team primarily confirms diagnosis reported from hospital facilities, refers diagnosed infants to CCC programs and performs QA/QI by analyzing CCHD data to assure that reporting is consistent, accurate and complete.

Per the Code of Virginia, all infants born in Virginia are to be screened for thirty-one errors of metabolism, critical congenital heart disease (CCHD) and hearing loss. Virginia's newborn screening (NBS) programs, as well as its birth defects surveillance program, are housed under the Division of Child and Family Health (DCFH) and currently managed by Jennifer Macdonald, Director, Division of Child and Family Health until a Program Manager can be

hired . Each program has a team that utilizes specific, evidence-based approaches to education, tracking of screening results, follow-up, facilitating access to diagnostic and specialty services and referring to supportive services, post diagnosis.

The VDH Newborn Dried Blood Spot Screening (NBS DBS) Follow-Up Program and the Department of General Services (DGS) Division of Consolidated Laboratory Services (DCLS) work in close collaboration to maintain the operations of Virginia's NBS-DBS program. This program is solely funded through fee-for-service enterprise funding. Fees are collected by DCLS from birthing hospitals and certain medical providers who perform the collection of DBS specimens. The current fee is $138/infant as of October 1, 2019. Fees are evaluated periodically and typically increased when new disorders are added to the panel in order to cover the cost of supplies, equipment, staffing and management of obtaining confirmatory diagnostic services, etc. VDH receives approximately $1.7 million annually from the enterprise fund via DCLS to conduct follow-up activities. The funding supports the DBS team who are VDH employees and co-locate at VDH and DCLS. The team consists of a program supervisor, 4.5 public health nurses and two administrative staff who follow over 15,000 infants who have abnormal or critical screen results. Funding also supports contractual genetic services for four regional medical centers to assist in the follow-up of infants who screen abnormal for metabolic disorders. These centers provide healthcare provider consultation, diagnostic work-up of infants and treatment services once diagnosed. Approximately 150 infants in the Commonwealth are diagnosed with a core NBS DBS disorder every year and then referred to CYSHCN care coordination programs for further support.

Snapshot of Program Accomplishments

- Although challenging, the Virginia NBS-DBS program has successfully continued seven days a week screening, follow-up and referral operations in the midst of the COVID pandemic. The CCHD program has also continued to confirm and refer reported cases of CCHD during this time.
- The NBS-DBS program released a new follow-up system in REDCap that has modernized the process in which follow-up is communicated and documented between the program and its medical specialists. Its implementation has increased timeliness of reporting results and decreased the percentage of lost-to-follow up infants. Comprehensive programmatic policy and procedures were developed and approved this year as well.
- The Birth Defects Surveillance Program successfully completed its Zika Birth Defects Surveillance project funded through the CDC. A Program Coordinator was hired in August 2020, a position which is the first of its kind in the agency, and is now on course to evaluate and grow the program. After a hiatus of programmatic activities due to lack of funding and staffing resources, the CCHD newborn screening program has reached a critical milestone and is up-to-date on performing case confirmations, and is now able to focus on quality assurance and improvement activities.
- The Virginia EHDI program collaborated with the OFHS Communications Team on a variety of media, including its logo.

FY21 Application Overview: MCH Data Capacity

State Priority: MCH Data Capacity
FY20 Performance Measure: SPM 1 - Cross-Cutting (Early and Continuous Screening): Percent of infants who are diagnosed with a newborn screening disorder that are referred to care coordination services in the CYSHCN program.

Objective: By June 30, 2020, increase the percentage of infants with confirmed newborn screening disorder that are referred to care coordination services, from 57% (2017) to 60%.

Strategy: Maintain the VaCARES Registry and expand capacity to document and track referrals of infants from the Newborn Screening Program to CYSHCN programs.
Domain: Cross-Cutting / Systems

Activity	Expected Completion Date	Responsible Staff
Improve documentation to track number of infants referred and who accepted services to CYSHCN programs	Jan 2021	NBS-DBS, BD, CYSHCN staff
Develop and finalize policy and procedures for BD and CCHD referrals into CYSHCN programs	Jan 2021	BD, CYSHCN staff
Maintain VaCARES registry	Ongoing	Birth Defect Surveillance Staff, OIM
Develop or explore development of system to track long-term healthcare utilization	Sept 2021	DBS-NBS program staff
ID shared metrics with DMAS around healthcare utilization for selected NBS disorders.	Sept 2021	DBS-NBS staff

In FY20, state newborn screening information will continue to be delivered to providers and parents in a timely fashion and arrangements made for necessary follow-up services are documented. If indicated the need for repeat screening and follow-up will be communicated to the providers by hospital or state program.

Strategy: Partner with internal agency teams to identify needs, gaps and future direction of the current birth defects surveillance system.
Domain: Cross-Cutting / Systems

Activity	Expected Completion Date	Responsible Staff
Complete comprehensive evaluation of VDH's birth defects program and VaCARES	March 2021	Birth Defects Surveillance Program Coordinator
3 year work plan completed	Sept 2021	Birth Defects Surveillance Program Coordinator

A comprehensive evaluation of the agency's birth defects surveillance program and a short-term work plan will be completed by September 2021.

Strategy: Coordinate and partner with external stakeholders to increase the percentage of birthing facilities that report CCHD information into the current IS from 65% (2020 baseline) to 75% by September 2021.
Domain: Cross-Cutting / Systems

Activity	Expected Completion Date	Responsible Staff
ID birthing facilities not reporting into reporting system	January 2021	CCHD Coordinator
Create outreach and education plan	Mar 2021	CCHD Coordinator, NBS Unit Educator
Educational site visits to targeted birthing facilities	Mar 2021 – Sept 2021	CCHD Coordinator, NBS Unit Educator

Historically, Virginia's birth defect surveillance program has been a passive one, but in the wake of the congenital Zika virus outbreak in 2016, a renewed interest and need for this important public health activity has arisen. In July 2019, VDH completed the Zika Birth Defects surveillance project, funded and coordinated through the Centers for Disease Control (CDC). This project included implementation of the Zika Pregnancy Registry (ZPR), following infants enrolled in the ZPR for 24 months, and case confirmation of all Zika related birth defects reported into the Virginia Congenital Anomalies Reporting and Education System (VaCARES) in 2016 and 2017. During this project, Virginia was one of two states to participate in the March of Dimes survey of women who participated in the ZPR to gain insight into their perceptions of health care, information and social supports. Findings are soon to be published. This was a great educational experience for VDH and with the implementation of certain information system enhancements, VDH will be well equipped to respond and expand documentation to emerging infections or conditions, such as Neonatal Abstinence Syndrome (NAS).

Title V funding has historically only funded the maintenance of the reporting system, VaCARES, and additional funding now supports critical staff positions to maintain, evaluate, plan and grow the program. Title V funding is supporting a Birth Defects Program Coordinator, who was hired in July 2020, and contracted position to maintain the CCHD NBS program.

CCHD NBS is considered a point-of-care test done at the bedside before discharge of the infant. If an infant fails its CCHD screening, immediate action is routinely taken before the infant's discharge and well before it is reported to VDH. For that reason the Virginia CCHD NBS program centers its activities on confirmation of diagnosis, quality assurance and referral to services, which is more in alignment with current birth defect surveillance activities and thus moved to that team in 2019. Historically, these activities were absorbed by DBS NBS staff and the program's reporting system, VaCARES, maintenance are funded by Title V. In aligning with the birth defects surveillance program, Title V now funds a contractor to continue CCHD NBS activities. This increased staff resource has created the ability to expand CCHD-NBS activities beyond case confirmation and referral, but to include quality assurance, technical assistance, and educational outreach.

Strategy: Partner with NYMAC (New York - Mid-Atlantic Regional Genetics Network) to assess and respond to state needs related to genetic services.
Domain: Cross-Cutting / Systems

Activity	Expected Completion Date	Responsible Staff
NBS Manager and Title V Family Representative to serve as state co-leads for NYMAC Project	Sept 2021	Christen, Dana
Facilitate connections to Title V partners as appropriate	Sept 2021	Carla, Christen, Marcus, Dana

NYMAC is currently establishing state to work on issues that prevent families from having access to genetic services. There is strong interest in having Title V involved in all of our state teams. The vision is for NYMAC to put together a state needs assessment summary that will be provided to the state team. Then, a team of 10-15 stakeholders (families, genetics providers, Medicaid rep, state genetics organizations, primary care, etc) will identify a key barrier to accessing genetic services and select a project that we will fund to address that problem. This will consist of monthly team calls.

The NBS Manager and Title V state representative will serve as team co-leads. The Title V and CSHCN Directors will serve on the state team.

FY21 Application Overview: Community, Family, & Youth Leadership

State Priority: Community, Family, & Youth Leadership
FY20 Performance Measure: SPM 1 - Cross-Cutting (Early and Continous Screening): Percent of infants who are diagnosed with a newborn screening disorder that are referred to care coordination services in the CYSHCN program.

Objective: By June 30, 2020, increase the percentage of infants with confirmed newborn screening disorder that are referred to care coordination services, from 57% (2017) to 60%.

Strategy: Maintain and expand family engagement on state NBS Advisory Committee.
Domain: Cross-Cutting / Systems

Activity	Expected Completion Date	Responsible Staff
Maintain family representation on NBS Advisory Committee	Ongoing	DBS-NBS staff
Increase family representation by adding parent representative who experienced NBS-DBS process, but not affected with a diagnosed NBS disorder	Sept 2021	DBS-NBS staff

The voting membership of the Virginia Newborn Screening Advisory Committee consists of multiple stakeholders representing all aspects of the newborn screening system, including affected family and parent representatives. This body meets bi-annually to provide consultation to the program and when needed, workgroups are convened to review disorders requested to be on the Virginia DBS NBS panel. Starting January 1, 2019, the program implemented screening for two new disorders, Pompe and Mucopolysaccharidosis Type I (MPS I), and expanded its operations to seven days/week. Currently, the regulatory review and program planning is underway to implement screening capability for two additional disorders, Spinal Muscular Atrophy (SMA) and X-linked

adrenoleukodystrophy (X-ALD). The program has recently received funding from CureSMA and the Assoication of Public Health Laboratories (APHL) to assist in the implementation of SMA screening.

Consumer/Family Engagement & Partnership

On a daily basis, the follow-up nurses engage independently with parents who call with questions and concerns, but full consumer and family engagement in the NBS-DBS program is in evolution. The Newborn Screening Advisory Committee by-laws stipulate that two family advocates shall compose two of the twenty committee members. Currently, there are two family members whose children have been affected newborn screening disorders. When by-laws are up for review in Fall 2020, it will be requested that a consumer advocate be added that has not been affected by a diagnosed newborn screening disorder, but understands that their infant received a newborn screening. This member provide prospective and inform educational initiatives that focus on general public education and informing families of results, whether positive or negative.

The program is currently adding to the body of knowledge and collaborating with Children's National Medical Center (CNMC) on a study with the goal to learn more about the experiences of parents after they receive their child's newborn screening result. The study is being led by a study team at CNMC and it is anticipated that 1,500 people from multiple states will take part.

The NBS-DBS Program Coordinator also participates on the Genetics Alliance Family Training and Education Workgroup and informs educational initiatives. The VDHNBS-DBS program has also entered into an agreement to become a "Community Outreach Partner" for their Newborn Screening Family Education Program. Genetic Alliance's Expecting Health program is building a network to support the dissemination of *Navigate Newborn Screening*, a free online newborn screening educational module for families to learn vital knowledge and skills to participate in the newborn screening system.

The Birth Defect Surveillance Program has been very limited in scope and the evaluation planned for this year will inform how family and community participation can be incorporated into programmatic activities.

Strategy: Sustain Early Hearing Detection & Intervention Program, to include support for paid 1-3-6 Family Educators.
Domain: Cross-Cutting / Systems

Activity	Expected Completion Date	Responsible Staff
Educate EI providers about the 1-3-6 EHDI guidelines and VISITS reporting through site visits	Ongoing	Virginia EHDI Program
Signed data sharing agreement in place with Department of Behavioral Health and Developmental Services (DBHDS)	Ongoing	Jen
Maintain current EI automatic referral system in the EHDI-IS and evaluate EI reporting enhancements made in FYs 18 &19.	Ongoing	Virginia EHDI Program, DHPD, OIM
Empower families impacted by a diagnosis of hearing loss to understand EI resources available to them through information sharing via established family support groups, regional learning communities and 1-3-6 family educators.	Ongoing	Virginia EHDI Program, VCU CFI, Hands & Voices, Virginia AAP
Publish and distribute the Virginia Shared Plan of Care (SPoC) for families, audiologists, PCPs and EI specialists.	Ongoing	Virginia EHDI Program

The Virginia Early Hearing Detection and Intervention (EHDI) Program provides technical assistance and follow-up for hearing loss newborn screening services. The Virginia EHDI Program budget totals approximately $750,000 and is funded through a variety of federal grantors: HRSA EHDI, CDC EHDI and HRSA Title V.

The funding supports the VDH EHDI team which consists of a program supervisor, two full-time follow-up specialists, 2 wage staff and fifty percent of an epidemiologist to support programmatic data needs. Funding also supports contractual services with VDH Office of Information Management for IS support, Virginia Commonwealth University's (VCU) Center for Family Involvement (CFI) and the University of Virginia's (UVA) Hearing Aid Loan Bank (HALB). Program activities focus on meeting the overall goal of developing and maintaining a comprehensive and well-coordinated system of care that promotes early diagnosis and early entry into supportive family services.

A long standing goal of the program has been to increase family and health care provider engagement and leadership within the EHDI system. A major component of the HRSA EHDI grant was to increase family engagement throughout the 1-3-6 process. The Virginia EHDI Advisory Committee's voting membership is now made of up of 25% parents and the co-chair is a parent of a child who is deaf/hard of hearing. The Virginia EHDI program has also coordinated and hosted may initiatives and events to engage families and healthcare providers together. Along with outreach to many conferences and support group events, these include funding for regional 1-3-6 family educators and the implementation of six regional learning communities, which eventually transfer to parent lead communities, and the funding and hosting of a trauma informed care conference and the nationally recognized The Care Project retreat (http://www.thecareproject.com/retreats/). Out of the EHDI Learning Communities came a Shared Plan of Care (SpoC) specifically for families and their primary professional support systems. Guides/checklists have been created for families, providers, audiologists and Early Interventionists to assist them in their specific key roles and functions as it pertains to the navigation of services to a newly diagnosed infant in their first year of life.

The program is additionally working on the requirement of HB2026 which was passed in the 2019 Virginia General Assembly and directs the Board of Health to amend regulations governing newborn screening to include congenital cytomegalovirus (cCMV) in newborns who fail their newborn hearing screening. A total of $198,000 was included in the state general fund budget for FY20 to initiate the cCMV program at the state level. First year funds will be utilized

to hire a wage staff resource and make enhancements to the EHDI-IS. Funding in subsequent state fiscal years will only support staff resources. As of this application submission date, a statewide workgroup has drafted regulations and the Virginia EHDI Advisory Committee approved them and sent them to the Commissioner of Health to initiate the regulatory process on behalf of the Board of Health. It is predicted that Virginia will go live with screening and follow-up activities in early 2020.

Another major focus of the Virginia EHDI Program is assuring infants diagnosed with any type of hearing loss are entered into the Early Intervention system in a timely manner and based on 1-3-6 national EHDI guidelines. The Virginia Department of Behavioral Health and Developmental Services (DBHDS) is the leady agency for Part C in Virginia. Historical analysis of EHDI data reflects that mothers reporting less than a high school education or GED, mothers less than 20 years of age, African Americans and families in the Blue Ridge and Southwest regions of the state are less likely to enroll in EI services. Since an automated referral system was added to the EHDI-IS, the system has proven to ensure that all diagnosed children are referred to EI on a timely basis, but reporting of enrollment has declined due to factors such as FERPA requirements that DBHDS adheres to, lack of knowledge of reporting capabilities, and lack of knowledge and socioeconomic factors of families. The Virginia EHDI Program continues to partner with multiple stakeholders and spearhead efforts to educate and promote appropriate resources for families affected by a diagnosis of hearing loss, including VCU CFI 1-3-6 Family Educators, the Virginia chapter of Hands and Voices, and six regional Learning Communities. A collaborative effort with DBHDS will improve data sharing, ensure compliance with national guidelines and improve the quality of enrollment information reported to VDH.

VDH contracts with VCU CFI to implement the 1-3-6 Family Educators Program and assist in the start up and maintenance of six regional learning communities throughout the Commonwealth.

Emerging Issues

The Virginia NBS-DBS has incorporated second-tier molecular testing in the screening algorithms for at least four disorders: Cystic Fibrosis (CF), Severe Combined Immunodeficiency (SCID), Pompe disease and Mucopolysaccharoidosis Type I (MPS-I). Molecular testing has enabled national newborn screening programs to better inform physicians and diagnose disorders, but this ability also has crossed the lines of programmatic goals of screening versus diagnosis. The Virginia NBS-DBS program will continue to weigh implementation strategies and costs that may incorporate molecular testing as part of a potential disorder's algorithm. Currently, the Newborn Screening Advisory Committee, as a result of a legislative mandate, is taking up Krabbe disorder as a potential addition to Virginia's newborn screening panel and is weighing the molecular options available. Krabbe disease is also not on the Secretary of Health and Human Services' Recommended Uniform Screening Panel (RUSP) and poses a few challenges that include lack of national data, and since it is not on the RUSP, ethically, a lack of screening uniformity across the nation.

The Virginia NBS-DBS does not conduct long term tracking/follow-up of children diagnosed with certain disorders, but understands this is a needed arm of current programming. With the addition of two lysosomal disorders in 2019, the increased NBS fee covered such a position, but with the current environment of COVID, the human resources process has thwarted efforts. The program will continue to work with the agency to meet this goal .

The Birth Defect Surveillance Program will most likely face challenges when rapid surveillance of birth defects, as a result of emerging infections and disorders, is required. An example of this may be future activities of Neonatal Abstinence Syndrome (NAS) monitoring. It will be challenging to assess stakeholder organizational obstacles in the wake of COVID, its impact on reporting into Virginia's current system, and reengaging them into the process.

FY21 Application Overview: Racism

State Priority: Racism
FY21 Performance Measure: MCH Workforce Development – Racial Equity

Objective: By September 31, 2021, develop and implement MCH workforce development policies addressing racial equity for all Title V program staff and subrecipient staff.

Strategy: Incorporate racial equity training into individual staff training plans and minimum strategic planning requirements into subrecipient agreements.
Domain: Cross-Cutting

Activity	Expected Completion Date	Responsible Staff
Continue to provide training and guidance to Title V staff on planning and implementing public health programs with a racial equity lens during monthly All-Team meetings and regularly scheduled 1:1 meetings.	Ongoing	Carla
Develop and disseminate guidance for supervisors of Title V-funded staff on incorporating a minimum of 3 annual racial equity training activities and at least 1 annual training activity related to MCH competencies into individual staff training plans.	January 2021	Carla
Develop and disseminate language regarding required racial equity training for inclusion in all contracts and subrecipient agreements.	January 2021	Carla
Track compliance annually.	Ongoing	Carla, Title V team

Strategy: Provide support to Central Office, LHD, and interagency staff on planning and implementing MCH programs with attention to racial equity and upstream factors.
Domain: Cross-Cutting

Activity	Expected Completion Date	Responsible Staff
Continue to provide training and guidance to Central Office Title V staff during monthly All-Team meetings and regularly scheduled 1:1 meetings.	Ongoing	Carla
Lead development of team training plan on racial equity and social justice for Central Office and LHD staff.	Ongoing	Carla
Explore opportunities to partner on development of an interagency "working brown bag" series on policies at the intersection of MCH racial equity and social justice (e.g. redlining and disparate birth outcomes, climate change and asthma).	June 2021	Carla, Black Infant Health Coordinator

Title V funds are allocated to 35 local health districts (LHDs) to address locally-identified priorities; each LHD must maintain a workplan and report annually on successes, challenges, and emerging needs. The Title V Director provides technical assistance to LHDs through site visits and webinars.

LHD priorities for the previous five-year grant cycle included: (1) access to maternal/prenatal care, (2) substance use, including tobacco and opioid use among pregnant women, (3) safe sleep, and (4) increased coordination with family support and community-based organizations. Each LHD was required to select at least one of these four priorities.

For the 2021-2025 grant cycle, workplans will focus on the health of pregnant women and children 0-17, with emphasis on the following 4 topics:

1. MCH initiatives that center equity,
2. Coordination with community-based organizations,
3. Place-based, upstream/cross-sector strategic planning (e.g. housing, transportation),
4. Coordinated systems of care for children.

FY21 Application Overview: Racism

State Priority: Upstream/Cross-Sector Strategic Planning
FY21 Performance Measure: MCH Workforce Development – Racial Equity

Objective: By September 31, 2021, develop and implement MCH workforce development policies addressing racial equity for all Title V program staff and subrecipient staff.

Strategy: Support 35 local health districts in developing and maintaining equity-focused, data-driven workplans aligned with findings from the 2020 MCH Needs Assessment and local Community Health Assessments, to include (1) MCH equity considerations, (2) coordination with community-based organizations, (3) upstream/cross-sector strategic planning, and (4) coordination with broader systems of care for children.

Domain: Cross-Cutting/Systems

Activity	Expected Completion Date	Responsible Staff
Provide team-based technical assistance to Title V-funded local health district staff on MCH strategic planning.	September 2021	Title V Director and Team

Title V LHD funding will continue to balance addressing local emerging issues within specific populations with sustained commitment to a core set of statewide MCH priorities and services. Beginning September 2020, a team-based will be implemented to deliver technical assistance (TA) and workforce development for LHD staff. Led by the Title V Director, this team of subject matter experts will be available to deliver technical assistance through cross-team TA and site visits. Districts will receive coaching on developing workplans, selecting local performance measures, and building capacity for grant-writing and outcome reporting.

Each LHD is charged with conducting a community health assessment (CHA) every 5 years. This process includes identifying local priorities for MCH populations. Local CHAs, combined with the results of the 2021-2025 Title V needs assessment, will drive strategies and activities within each district. The first six months of the new grant cycle will be dedicated to intensive 1:1 strategic planning with each district.

Strategy: Pilot racial equity training with statewide partners.
Domain: Cross-Cutting

Activity	Expected Completion Date	Responsible Staff
Coordinate with facilitators to create meaningful and customized racial equity trainings	September 2020	Virginia Health Catalyst
Create marketing materials, including a flyer and social media messaging, to promote trainings	September 2020	VCH
Utilize an online registration system, manage registrants, and send event confirmations	October 2020	VCH
Conduct online racial equity trainings throughout the remainder of 2020	December 2020	VHC
Create a summary report sharing how many attendees were trained and evaluate the trainings	January 2021	VHC

VDH will contract with VHC to partner with Dialectix Consulting and Virginia Center for Inclusive Communities to provide twelve free racial equity trainings to partners across Virginia. VHC will coordinate with facilitators to create meaningful, customized trainings to address real-world issues related to health equity. Marketing materials including flyers and social media messaging will be developed and shared to promote the trainings to partners and other

organizations state-wide. An online registration system will be created and utilized to manage participant registration and send event confirmations and reminders. The trainings will be provided throughout the remainder of the year and will include a training evaluation. Evaluation and training results will be detailed in the form of a summary report. These trainings will be virtual to allow partners from across Virginia to participate. The trainings will be offered in three bundles, and each bundle will be offered twice (six total bundles offered). To ensure the most people can attend, participants will only be able to sign up for one course bundle. Each bundle will focus on a different topic area.

Course Bundle One: Understanding Racial Equity

Exploring Racial Equity in Health Care: In an increasingly multicultural society, it is critical for healthcare providers to work across lines of difference to support its most vulnerable populations. These individuals' interactions and experiences are often shaped by biases around race. This workshop will provide participants with an opportunity to reflect on their own race and consider its impact in workplace and community dynamics. Attendees will walk away with practical tips and approaches to bias-free decision-making in the workplace and while providing healthcare to underserved communities.

Course Bundle Two: Addressing Racism Daily

Unconscious Bias: Understanding the latest research on how our brain wiring relies on mental shortcuts, and how these unconscious impulses impact our behaviors in ways that perpetuate disparities and inequity. Focuses on knowledge, tools, and strategies for interrupting individual bias, as well as dialogue about how to implement anti-bias strategies organization-wide.

How to be an Ally: How do you effectively work on a social justice issue that doesn't impact you directly? There is a unique challenge for allies in navigating the conundrums involved in allyship, for example, when do you speak up for others, and when do you step back to allow others a voice? This workshop offers a path forward for allies, focusing on providing a developmental path, tools, and skills to be more effective in the fraught role of an ally.

Conflict Resolution: This workshop focuses particularly on microagressions, and the challenging task of navigating conversations of unintended slights and othering. Participants will learn how to spot and interrupt microagressions effectively, with an eye towards creating greater inclusion within the organization, protecting people from the impact of harmful statements, and nonjudgmentally educating offenders and others.

Course Bundle Three: Implementing Change in the Workplace

Action Plan Development: Participants will work through the Action Planning process and consider how they would like individuals and institutions to address bias and what it takes to stand up to it—in the moment and the long term. By the end of the program, participants will receive resources to develop and implement a 1-3 year action plan for diversity, equity, and inclusion at their organizations.

Action Plan Implementation: Participants will share their experiences and lessons learned from the process of implementing their Action Plans, discuss any issues or challenges they have and receive feedback from the facilitator(s) and partner organizations. Facilitators will also share how to assess the success of their Plans and how to sustain them long-term, and will celebrate participant successes.

Other Programmatic Activities

Activity	Expected Completion Date	Responsible Staff
• Define components of 'resiliency'	Nov 30, 2020	Dana Yarbrough, Title V Director
• Meet with F2FHIC cultural brokers to confirm 'translation' of resiliency concepts into their home country norms, customs and idioms	Jan 5, 2021	Dana Yarbrough,
• Identify at least 2 Title V staff to work with the F2FHIC staff to develop the training/mentoring project and to select at least two languages (e.g., English and Korean)	March 1, 2021	Dana Yarbrough, Title V Director
• Pilot the training/project with 5 diverse families and document what works/doesn't work	April 15, 2021	Dana Yarbrough, F2FHIC cultural brokers
• Work with Title V programs to identify at least 30 diverse families to participate in the training/mentoring project	June 15, 2021	Dana Yarbrough, CYSHCN Director, CCC and CDC Program Directors
• Conduct evaluation of the resiliency project	June 30, 2021	Dana Yarbrough and F2FHIC Evaluation Specialist

Families calling the F2FHIC and Title V programs are reporting higher anxiety and stress from changes in routines, finances and health as a result of COVID-19 stay at home, virtual schooling and social distancing orders. Being able to cope with life's struggles, or being resilient and able to bounce back from difficult situations, is an important skill that positively impact healthy choices.

The F2FHIC proposes to develop a 4 week skill building session for culturally & linguistically diverse families (at least two underserved communities) that focuses on identifying individual leadership behaviors, finding fresh approaches to old problems, and reinforcing trusting, collaborative relationships with community agencies, planning teams and/or health care professionals. Over the 4 weeks, families will participate in virtual group sessions, complete self-assessments, develop an individualized resiliency plan, and receive support from a coach/mentor.

Budget Update

Personnel

Salary	FTE
Principal Investigator , Dana Yarbrough	0.20
Cultural Broker, Af American Community	0.20
Cultural Broker, Refugee Community	0.10
Project Evaluator, Seb Prohn	0.05

Other

Stipends for Family Participants (30 x $500)

Equity Considerations

To transform the way diverse families perceive themselves and the systems in which they and their CYSHCN interact, we must make deliberate efforts to understand the different and complex ways in which structural racism has affected families in the past and continues to affect them today. Resilience and racial equity will be deliberately embedded into every facet of

the training/mentoring project.

III.F. Public Input

Solicitation of public input is an ongoing process, as summarized below.

Virginia's MCH Needs Assessment is conducted every five years to identify pressing health concerns and shifts in program/workforce capacity. This needs assessment, paired with continuous input received from families, programmatic partners, and other stakeholders, informs the state's Title V MCH Action Plan.

Ongoing Stakeholder Input

Title V staff have the opportunity to partner with a large body of stakeholders through various coalitions, advisory boards, and special projects. Informal stakeholder feedback is regularly requested as part of day-to-day program operations to ensure the state's Title V MCH Action Plan remains relevant to current needs of MCH populations. This feedback is taken into account during program planning and is reflected in annual updates to the state action plan.

Annual Formal Public Comment: Virtual 'Town Hall' and Virginia Register of Regulations

Annually, VDH makes the Title V Application/Report available for formal public comment via Virginia's "Town Hall" virtual platform.

The site is a source of information about proposed changes to state regulations and includes a calendar of key meetings and board minutes. The site also facilitates solicitation of public input through online comment forums and an email notification service.

The "Town Hall" platform is maintained by the Virginia Department of Planning & Budget and is available at: https://townhall.virginia.gov/index.cfm.

An announcement of the availability of the Title V Application/Report for public comment is also published within the "General Notices" section of the Virginia Register of Regulations.

Formal public comments are typically solicited after the state's annual federal grant review and before the federal deadline for edits to the state's Title V submission.

Historically, few formal public comments have been received. No formal comments on last year's FY20 Application / FY18 Annual Report were logged.

Annual Public Input Survey

An annual public input survey is distributed to supplement responses to formal public comment solicitations. The survey was first piloted in 2017 (for the FY18 Application / FY16 Annual Report). It generated over 80 responses, greatly exceeding prior responses to public calls for input.

The survey is administered as follows:

- The draft application/report are posted on the VDH Title V website with a link to the survey. The public is asked to review the draft and then complete the survey.
- To recruit respondents, the survey details are emailed directly from program staff to a wide range of state and local partners. The state family representative (Dana Yarbrough) is also emails survey details directly to

families.

- Respondents have the opportunity to (1) rate whether the state priorities align with their perceived priorities for each MCH population, (2) rate the appropriateness and fit of the selected strategies, and (3) provide feedback on any important details, topics, or strategies they feel are missing.
- Respondents can also opt-in to receive program surveys and information about MCH needs assessment activities by providing their contact information. Once the survey closes, responses are compiled and presented back to staff during Title V monthly meetings.

Survey respondents represent individuals identifying as parents, youth/adolescents, state agency employees, community service providers, researchers/academia, and health care providers. Last year's FY20 Application / FY18 Annual Report saw a dip in responses for public input. Among responses, participants did agree that the following were important issues/priorities for Virginia's MCH populations:

- Woman/Maternal Mental Health (e.g. postpartum depression, emotional wellness)
- Infant Mortality (e.g. racial and ethnic disparities)
- Unintended Pregnancy (e.g. preventive care visit, family planning, sexual and reproductive health education)
- Child/Adolescent mental health and socioemotional development
- Family-centered care and connection to necessary services

Direct Submission of Comments or Inquiries

A copy of the current application and contact information for the Title V Director are made publically available on the VDH Title V website to facilitate submission of any additional public comments or inquiries throughout the year.

III.G. Technical Assistance

Virginia was selected to receive technical assistance (TA) from the National MCH Workforce Development Center in Chapel Hill, North Carolina, as part of the 2015-2016 state cohort. Virginia's project, the *Medical Neighborhood,* continues to grow, and the VDH Title V team continues to reach out to the MCH Workforce Development Center for ongoing assistance and resources as necessary. Progress on the medical home and training modules, the first project of the medical neighborhood team, is detailed within the CSHCN annual report.

In 2018, Virginia was also selected to receive TA from the MCH Workforce Development Center on development of a statewide developmental screening initiative, to include implementation science expertise and support for stakeholder engagement on visioning and in-depth systems mapping. The team continues to work closely with the Center to develop of a state plan to strengthen the screening-assessment-referral continuum, which will begin with formation of 6 regional hubs. Progress on the Virginia Developmental Screening Initiative is detailed within the Child Annual Report.

The largest emerging issues related to MCH populations are (1) health equity and (2) long-term impacts of COVID-19.

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 existing racial disparities. In 2019, Governor Ralph Northam mandated for all state agencies to work jointly to eliminate racial disparities in maternal mortality by 2025. Early efforts to fulfill these commitments have included data-driven discussions about factors driving disparities during team strategic planning meetings, and carried throughout the needs assessment process with intentional data disaggregation and qualitative focus on underserved, minority communities. With the addition of a priority need focused on racism, Virginia's MCH Program recognizes that the historical, structural, and community context in which these disparities exist are complex and require dedicated space, time, scholarship, and community engagement strategies.

COVID-19 Response

While the agency's response has been timely and robust, long-term implications of the pandemic on Virginia's families remain to be seen. Of particular interest are opportunities to (a) advance equitable development post-COVID-19, (b) explore telehealth models that have been naturally piloted during this time and evaluate them (i.e. continue to invest in core infrastructure and build the evidence base), and (c) draw clearer linkages to Title V as a partner on assuring MCH and CSHCN populations are considered as part of state emergency planning.Given the breadth of the pandemic's impacts on MCH populations, the state response to date is detailed below.

After cases of COVID-19 were first confirmed in the United States in early January 2020, the Virginia Department of Health (VDH) established its Incident Command (IC) structure and coordination with local, federal and private sector health partners. Response activities has since included frequent operational briefings with local health districts, participation in local, state and federal calls, frequent partner briefings and exercise of Pandemic flu plans.

Trigged by the first confirmed case in Virginia, significant community spread in the contiguous United States, and the World Health Organization (WHO) announcing a pandemic, on March 13, 2020 Governor Ralph Northam announced a state of emergency in Virginia. By the end of March, all public and private schools were ordered to provide services virtually and a mandatory stay-at-home order was in place for most citizens, excluding essential personnel.

VDH has stood up a public facing dashboard which is updated daily (COVID-19 Data). VDH generally receives data on cases several days after the person becomes sick. This means that the most recent dates will become more complete over time. Data are presented by onset date, as this provides a better glimpse of true disease timing. The 7-day moving average is presented to make the trend easier to interpret.

Virginia's data has clearly shown that COVID-19 has disproportionally affected certain populations within the Commonwealth. It is clear that COVID-19 is disproportionately affecting Virginia's Latino and Black populations. Although Latinos make up approximately 9% of Virginia's population, current data suggest that they account for 32% of cases, 30% of hospitalizations and 11% of deaths. The Black population makes up 20% of the Commonwealth's population and account for 26% of cases, 30% hospitalizations and 27% of all deaths. The Northern and Eastern regions of the state have been particularly hit hard. Of the pregnant women affected by COVID-19 in the Commonwealth, Latinas make up 54% of cases. As of this report, there have been no deaths reported in children 0-19, but disparities exist here as well, with Latino children representing 32% of all 0-19 cases.

The local health department system has been significantly impacted by COVID-related activities and day-to-day operations seemingly have come to a halt to contain this outbreak. Contact investigation services are primarily conducted by local health department staff and identify key variables for each case including Illness onset date, infectious period, contacts/exposure sites.

To complement and assist the local health departments, there is a large scale effort within VDH to hire contact tracers to contact and counsel all persons suspected to have had significant contact with a COVID+ patient. These contacts are interviewed, monitored, tested (as appropriate), isolated or quarantined (as appropriate), educated and provided and connected with wrap-around supporting services within 24. In August 2020, Virginia was one of the first states to implement an exposure notification app, COVIDWISE, to assist in contact tracing efforts. COVIDWISE is designed to notify users when they have been in contact with other users that have tested positive for COVID-19.

Testing capacity has steadily increased since the start of the pandemic and is performed by a mix of private and public laboratories within the state, including the Division of Consolidated Laboratory Services (DCLS), 16 university and hospital based labs, and over 20 commercial laboratories. The state continues to see more testing sites being stood-up, with approximately 190 accessible to the public at the time of this report. Multiple community testing sites have been implemented and continued to be planned for to serve the most vulnerable and underserved communities. VDH has received federal funding to support various public health activities through various funding streams. Funds have been dispersed to support child nutrition, Ryan White HIV/AIDS Part B programs, hospital preparedness, rural health preparedness and epidemiology and laboratory capacity.

During this time, the agency has shifted to a teleworking culture. Many of the MCH team's programmatic direct client services have shifted to telehealth and have been significantly impacted. The majority of the Title V-MCH team's work as it relates to the agency's response has been imbedded into the Community Mitigation arm of the VDH IC structure. Since the start of Virginia's outbreak, staff have provided consultation and direct services in data collection and analysis, child care, K-12 and Institutes of Higher Education (IHE) reopening strategies, program consultation to stakeholders, community based organizations (CBOs) and contractors, stabilizing nutrition programs, targeted public education, and updating public facing information on the agency Corona Virus webpage (https://www.vdh.virginia.gov/coronavirus/schools-workplaces-community-locations/). Specific examples include:

- The MCH Epidemiologist has collected data internally on pregnant women and outcomes to inform strategies.
- Coordinate and consult with the Virginia Department of Social Services (DSS) to create, monitor and publish phased guidance for the Commonwealth's child care providers.

- Coordinate and consult with the Virginia Department of Education (DOE) to create, monitor and publish phased guidance for the PK-12 re-openings.
- In collaboration with DOE, educate and prepare School Health Nurses for re-opening, mass vaccination clinics and increasing general immunization rates during this time for school age children.
- Participation on the Governor's COVID-19 Education Task Force to inform policy strategies for the executive branch and legislators in preparation for thespecial session of the General Assembly, occurring August – present, and the 2021 GA session in January – February 2021.
- Consult and inform targeted adolescent COVID prevention messaging.
- Assist in the receipt of the National Stockpile via direct services at the site and support services via teleworking.

Efforts from the team will continue in these realms and provide supportive services in the transition of services back to full capacity once the outbreak is stabilized.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Health-Medicaid MOU (current as of 9.15.2020).pdf

V. Supporting Documents

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

Supporting Document #01 - 2020 MCH Qualitative Assessement Report (final).pdf

Supporting Document #02 - 2020 MCH Quantitative Summary Presentation (final).pdf

Supporting Document #03 - 2020 School Health Guidelines.pdf

Supporting Document #04 - Attachment - State Title V Partnerships.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - FY21 Title V Organizational Chart.pdf

VII. Appendix

This page is intentionally left blank.

Form 2
MCH Budget/Expenditure Details

State: Virginia

	FY 21 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 12,287,553	
A. Preventive and Primary Care for Children	$ 3,795,675	(30.8%)
B. Children with Special Health Care Needs	$ 5,130,124	(41.7%)
C. Title V Administrative Costs	$ 1,227,859	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 10,153,658	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 9,215,665	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 1,618,704	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 2,086,819	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 12,921,188	
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)	$ 25,208,741	
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)	$ 0	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 25,208,741	

OTHER FEDERAL FUNDS	FY 21 Application Budgeted
No Other Federal Programs were provided by the State on Form 2 Line 9.	

	FY 19 Annual Report Budgeted		FY 19 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 12,128,653		$ 12,287,553	
A. Preventive and Primary Care for Children	$ 3,749,177	(30.9%)	$ 3,795,675	(30.8%)
B. Children with Special Health Care Needs	$ 5,293,471	(43.6%)	$ 5,130,124	(41.7%)
C. Title V Administrative Costs	$ 1,212,865	(10%)	$ 1,227,859	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 10,255,513		$ 10,153,658	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 9,097,551		$ 9,215,665	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 1,125,000		$ 1,618,704	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 1,427,400		$ 1,852,807	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 11,649,951		$ 12,687,176	
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		$ 24,974,729	
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)	$ 0		$ 0	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 40,693,062		$ 24,974,729	

OTHER FEDERAL FUNDS	FY 19 Annual Report Budgeted	FY 19 Annual Report Expended
No Other Federal Programs were provided by the State on Form 2 Line 9.		

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: Special enterprise funds from dried blood spot newborn screening program fees.	
2.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: FY19 self-reported revenue from the Child Development Center Program is as follows: JMU $214,823, VCU $292,998, Carilion $585,144, Lenowisco $46,842, CSG $713,000.	

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	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Pregnant Women	$ 964,653	$ 964,653
2. Infants < 1 year	$ 1,132,961	$ 1,132,961
3. Children 1 through 21 Years	$ 3,795,675	$ 3,795,675
4. CSHCN	$ 5,130,124	$ 5,130,124
5. All Others	$ 36,281	$ 36,281
Federal Total of Individuals Served	$ 11,059,694	$ 11,059,694

IB. Non-Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Pregnant Women	$ 581,409	$ 581,409
2. Infants < 1 year	$ 1,886,919	$ 1,886,919
3. Children 1 through 21 Years	$ 1,162,818	$ 1,162,818
4. CSHCN	$ 859,152	$ 859,152
5. All Others	$ 3,846,530	$ 3,846,530
Non-Federal Total of Individuals Served	$ 8,336,828	$ 8,336,828
Federal State MCH Block Grant Partnership Total	$ 19,396,522	$ 19,396,522

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	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Direct Services	$ 209,363	$ 209,363
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 38,233	$ 38,233
B. Preventive and Primary Care Services for Children	$ 41,527	$ 41,527
C. Services for CSHCN	$ 129,603	$ 129,603
2. Enabling Services	$ 6,268,902	$ 6,268,902
3. Public Health Services and Systems	$ 5,809,288	$ 5,809,288
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		$ 114,213
Physician/Office Services		$ 150
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 60,647
Laboratory Services		$ 28,533
Other		
Substance Use		$ 5,820
Direct Services Line 4 Expended Total		$ 209,363
Federal Total	$ 12,287,553	$ 12,287,553

IIB. Non-Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Direct Services	$ 63,082	$ 63,082
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 9,643	$ 9,643
B. Preventive and Primary Care Services for Children	$ 9,643	$ 9,643
C. Services for CSHCN	$ 43,796	$ 43,796
2. Enabling Services	$ 4,773,010	$ 4,773,010
3. Public Health Services and Systems	$ 4,379,574	$ 4,379,574
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		$ 43,796
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		$ 0
Laboratory Services		$ 4,881
Other		
Substance Use		$ 14,405
Direct Services Line 4 Expended Total		$ 63,082
Non-Federal Total	$ 9,215,666	$ 9,215,666

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: 99,091 **Data Source Year: 2018**

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	97,305 (98.2%)	5,213	459	416 (90.6%)

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 2019 reporting year: Data reported from most recent available data year 2018; compiled by the Virginia Newborn Screening and Birth Defects Surveillance Programs and Early Hearing Detection Intervention (EHDI); Division of Child and Family Health

Data Sources: Virginia Department of General Service StarLIMS (State Laboratory Newborn Screening Database), VACares (Birth Defects Registry)

*Critical Congenital Heart Disease: Regulations require only well-born infants (excludes NICU, specialty care, and prenatal diagnosis) and it is not expected to have 100% infants screened. The majority of infants diagnosed with CCHD in Virginia are found through prenatal anatomical ultrasounds; however, the newborn screening program still refers these cases to Care Connection for Children (CCC) of the VDH Children with Special Health Care Needs Program. For CCHD data, 29264 infants did not have record of screening reported, and 5354 infants were not screened due to prenatal diagnosis, parent refusal, NICU admission, or other reasons.

Glycogen Storage Disease Type II (Pompe) - screening began 2019
Mucopolysaccharidosis Type 1 (MPS I) - screening began 2019
X-Linked Adrenoleukodystrophy (X-ALD) - screening to start 2020

Field Level Notes for Form 4:

1.	**Field Name:**	**Core RUSP Conditions - Referred For Treatment**
	Fiscal Year:	**2019**
	Column Name:	**Core RUSP Conditions**

Field Note:
Note for FY19 report: The Virginia Newborn Screening Program (VNSP) has 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.

CCHD referrals: If an infant previously received a referral or is already enrolled in CCC, we would not re-refer. Similarly, if a CCHD diagnosis was confirmed for an infant that passed away or moved out of state, we would also not refer those cases to CCC.

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Virginia

Annual Report Year 2019

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		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	29,022	30.0	0.0	64.0	6.0	0.0
2. Infants < 1 Year of Age	48,893	30.0	0.0	64.0	6.0	0.0
3. Children 1 through 21 Years of Age	22,942	24.0	0.0	70.0	6.0	0.0
3a. Children with Special Health Care Needs	7,498	41.0	0.0	56.0	3.0	0.0
4. Others	35,854	8.0	0.0	82.0	10.0	0.0
Total	136,711					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	99,843	Yes	99,843	100	99,843	29,022
2. Infants < 1 Year of Age	99,106	Yes	99,106	100	99,106	48,893
3. Children 1 through 21 Years of Age	2,226,246	Yes	2,226,246	100	2,226,246	22,942
3a. Children with Special Health Care Needs	486,657	Yes	486,657	100	486,657	7,498
4. Others	6,192,178	Yes	6,192,178	49	3,034,167	35,854

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2019**
	Field Note: Data note for reporting year 2019: Resource mothers; WebVision – Report #081 from the Data Warehouse using the date range Oct 1, 2018 to Sep 30, 2019; Number reported includes pregnant and postpartum women receiving counseling/education services from LHDs - obtained from LHD mid-year reports	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2019**
	Field Note: Data note for reporting year 2019: Includes 50% of infants receiving a hearing screening test during calendar year 2018 (48608) (Virginia EHDI); Infants served through Resource Mothers (285)	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2019**
	Field Note: Data note for reporting year 2019: Reproductive health program Claims data/invoices; WebVision – Report #081 from the Data Warehouse using the date range Oct 1, 2018 to Sep 30, 2019; Adolescent health youth served by SRAE	
4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2019**
	Field Note: Data note for reporting year 2019: CCC-SUN, Individual Program Reports from partners (CCC, CDC, Sickle cell, and Bleeding Disorders programs under 21);	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2019**
	Field Note: Data note for reporting year 2019: Number of mothers of infants/toddlers diagnosed as deaf/hard of hearing referred for emotional, informational and systems navigational support. (Data from F2F); Reproductive Health Program claims data/invoices; WebVision – Report #081 from the Data Warehouse using the date range Oct 1, 2018 to Sep 30, 2019	
6.	**Field Name:**	**Total_TotalServed**
	Fiscal Year:	**2019**
	Field Note: Data note for reporting year 2019:	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2019**

Field Note:
Data note for reporting year 2019: Statewide Needs Assessment; Statewide efforts attributed to programs receiving Title V funding: Provide 100% of Mat/Inf salaries and funding for MMRT salaries, and partial salary and funding for Reproductive Health and Child Health/Home-visiting, partial salary and funding Resources Mothers (pregnant and parenting teens); MCH epi team partial salaries; Needs Assessment support; Pop Health Data Manager salary; Cancer epi partial salaries

2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2019**

Field Note:
Data note for reporting year 2019: Title V provides 100% salary support for Mat/Inf and EHDI program manager staff; provides support for VACARES

3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2019**

Field Note:
Data note for reporting year 2019: Statewide Needs Assessment; 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; participation in state child health planning and advisory boards including the Child Health Insurance Plan Advisory Committee (CHIPAC), Virginia Interagency Coordinating Council (VICC); development of school health guidelines for all public schools and in consultation for private/parochial schools

4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2019**

Field Note:
Data note for reporting year 2019: Statewide Needs Assessment; 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; development of school health guidelines for all public schools and in consultation for private/parochial schools (including recommendations for development of local programs and policies related to health care services for students with special health care needs)

5.	**Field Name:**	**Others**
	Fiscal Year:	**2019**

Field Note:
Data note for reporting year 2019: Statewide Needs Assessment; Title V provides funding to local health districts to carry out essential public health services in every community in Virginia (includes reproductive health education services that are available to women and men)

Data Alerts: None

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

State: Virginia

Annual Report Year 2019

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	100,226	55,314	21,316	14,382	184	4,096	869	0	4,065
Title V Served	9,101	3,594	946	2,691	17	174	2	0	1,677
Eligible for Title XIX	29,320	11,827	10,814	5,986	65	414	66	0	148
2. Total Infants in State	96,865	54,238	21,774	14,403	188	4,024	891	0	1,347
Title V Served	96,865	54,238	21,774	14,403	188	4,024	891	0	1,347
Eligible for Title XIX	29,320	11,827	10,814	5,986	65	414	66	0	148

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Virginia

A. State MCH Toll-Free Telephone Lines	2021 Application Year	2019 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 230-6977 x211	(800) 230-6977 x211
2. State MCH Toll-Free "Hotline" Name	Virginia Statewide Human Services I&R System (211)	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"		10,800

B. Other Appropriate Methods	2021 Application Year	2019 Annual Report Year
1. Other Toll-Free "Hotline" Names	American Sexual Health Association BrdsNBz Sexual Health Text Messaging System; Crisis Text Line	American Sexual Health Association BrdsNBz Sexual Health Text Messaging System; Crisis Text Line
2. Number of Calls on Other Toll-Free "Hotlines"		286
3. State Title V Program Website Address	http://www.vdh.virginia.gov/vdhlivewell/	http://www.vdh.virginia.gov/vdhlivewell/
4. Number of Hits to the State Title V Program Website		40,000
5. State Title V Social Media Websites	Facebook: VDHLiveWell ; Instagram: @vdhlivewell ; Pinterest: VDH LiveWell ; Youtube: VDH LiveWell	Facebook: VDHLiveWell ; Instagram: @vdhlivewell ; Twitter: @vdhlivewell ; Pinterest: VDH LiveWell ; Youtube: VDH LiveWell
6. Number of Hits to the State Title V Program Social Media Websites		839,136

Form Notes for Form 7:

BrdsNBz: a total of 286 questions were received and answered since October 2019. Those include initial questions and follow-up questions. This does not include "non-question" text messages.

Form 8
State MCH and CSHCN Directors Contact Information

State: Virginia

1. Title V Maternal and Child Health (MCH) Director	
Name	Carla Hegwood
Title	Director, Title V MCH Block Grant
Address 1	109 Governor Street
Address 2	
City/State/Zip	Richmond / VA / 23219
Telephone	(804) 864-7674
Extension	
Email	carla.hegwood@vdh.virginia.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Marcus C. Allen
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	Assistant Director, Strategic Initiatives / Director, Center for Family Involvement, VCU
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
State Priorities – Needs Assessment Year

State: Virginia

Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Upstream / Cross-Sector Strategic Planning: Eliminate health inequities arising from social, political, economic, and environmental conditions through strategic, nontraditional partnerships.	New
2.	Community, Family, & Youth Leadership: Provide dedicated space, technical assistance, and financial resources to advance community leadership in state and local maternal and child health initiatives.	Revised
3.	Mental Health: Promote mental health across MCH populations, to include reducing suicide and substance use.	New
4.	Finances as a Root Cause: Increase the financial agency and well-being of MCH populations.	New
5.	Racism: Explore and eliminate drivers of structural and institutional racism within OFHS programs, policies, and practices to improve maternal and child health.	New
6.	MCH Data Capacity: Maintain and expand state MCH data capacity, to include ongoing needs assessment activities, program evaluation, and modernized data visualization and integration.	New
7.	Reproductive Justice & Support: Promote equitable access to choice-centered reproduction-related services, including sex education, family planning, fertility/grief support, and parenting support.	Revised
8.	Strong Systems of Care for All Children: Strengthen the continuum supporting physical/socio-emotional development (i.e. screening, assessment, referral, follow-up, coordinated community-based care).	Revised
9.	Maternal and Infant Mortality Disparity: Eliminate the racial disparity in maternal and infant mortality rates by 2025.	New
10.	Oral Health: Maintain and expand access to oral health services across MCH populations.	Continued

Form Notes for Form 9:

None

Field Level Notes for Form 9:

Field Name:

Priority Need 8

Field Note:
This may include: developmental screening, EHDI, NBS, referrals to CSHCN and community supports, school health nursing, Early Intervention, Bright Futures/AAP, and all CYSHCN programs.

Field Name:

Priority Need 9

Field Note:
This may include: Black infant health strategies (breastfeeding, safe sleep, LISSDEP, home visiting support, NAS Project ECHO) + Black maternal health strategies (e.g. MCH PIP substance use project, $$ to community orgs, MMRT, normalizing health-seeking behaviors around prenatal care, doulas, $$ to VHHA, VNPC if partnering?, etc).

Form 10
National Outcome Measures (NOMs)

State: Virginia

Form Notes for Form 10 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
2018	78.6 %	0.1 %	73,790	93,921
2017	79.0 %	0.1 %	74,267	94,044
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% points or >1.2 times the estimate, 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
2017	61.0	2.6	566	92,793
2016	69.0	2.7	652	94,518
2015	68.6	3.1	488	71,125
2014	70.5	2.7	666	94,526
2013	67.1	2.7	625	93,167
2012	70.5	2.8	653	92,670
2011	69.7	2.8	645	92,553
2010	68.7	2.7	637	92,775
2009	67.5	2.7	632	93,687
2008	58.3	2.5	556	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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2018	17.1	1.8	87	509,297

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 3 - Notes:

None

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
2018	8.2 %	0.1 %	8,175	99,788
2017	8.4 %	0.1 %	8,393	100,344
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% points or >1.2 times the estimate, 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
2018	9.4 %	0.1 %	9,401	99,797
2017	9.5 %	0.1 %	9,582	100,343
2016	9.6 %	0.1 %	9,792	102,422
2015	9.2 %	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% points or >1.2 times the estimate, 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
2018	25.9 %	0.1 %	25,893	99,797
2017	25.1 %	0.1 %	25,147	100,343
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	25.2 %	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% points or >1.2 times the estimate, 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
2018/Q2-2019/Q1	1.0 %			
2018/Q1-2018/Q4	1.0 %			
2017/Q4-2018/Q3	1.0 %			
2017/Q3-2018/Q2	1.0 %			
2017/Q2-2018/Q1	1.0 %			
2017/Q1-2017/Q4	1.0 %			
2016/Q4-2017/Q3	1.0 %			
2016/Q3-2017/Q2	1.0 %			
2016/Q2-2017/Q1	1.0 %			
2016/Q1-2016/Q4	1.0 %			
2015/Q4-2016/Q3	1.0 %			
2015/Q3-2016/Q2	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:

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
2017	5.4	0.2	540	100,609
2016	5.6	0.2	579	102,737
2015	5.5	0.2	566	103,560
2014	5.6	0.2	582	103,562
2013	6.3	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
2017	5.9	0.2	592	100,391
2016	5.8	0.2	599	102,460
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
2017	4.0	0.2	399	100,391
2016	3.8	0.2	387	102,460
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
2017	1.9	0.1	193	100,391
2016	2.1	0.1	212	102,460
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	2.4	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
2017	212.2	14.6	213	100,391
2016	205.9	14.2	211	102,460
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
2017	97.6	9.9	98	100,391
2016	114.2	10.6	117	102,460
2015	84.2	9.0	87	103,303
2014	101.6	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
2018	7.5 %	1.3 %	6,908	92,292
2017	7.3 %	1.2 %	6,723	92,156
2016	8.4 %	1.4 %	7,975	95,548
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 confidence interval width >20% points or >1.2 times the estimate 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
2017	7.7	0.3	709	91,688
2016	6.7	0.3	636	94,439
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)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

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

Federally available Data (FAD) for this measure is not available/reportable.

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
2017_2018	10.4 %	1.6 %	183,802	1,765,309
2016_2017	12.2 %	1.6 %	213,906	1,750,946
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
2018	14.0	1.2	130	926,120
2017	17.0	1.4	157	925,835
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
2018	32.0	1.7	343	1,070,646
2017	28.7	1.6	306	1,064,407
2016	30.4	1.7	323	1,062,972
2015	29.5	1.7	313	1,059,818
2014	26.1	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	29.6	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
2016_2018	9.9	0.8	160	1,623,012
2015_2017	9.8	0.8	159	1,619,060
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
2016_2018	11.6	0.8	188	1,623,012
2015_2017	9.9	0.8	161	1,619,060
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
2017_2018	20.9 %	1.7 %	389,683	1,863,052
2016_2017	21.0 %	1.5 %	391,467	1,864,161
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
2017_2018	18.2 %	3.8 %	70,872	389,683
2016_2017	19.8 %	3.7 %	77,681	391,467
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
2017_2018	4.6 %	1.1 %	73,660	1,616,650
2016_2017	3.2 %	0.6 %	51,310	1,579,497
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
2017_2018	9.7 %	1.4 %	156,226	1,605,708
2016_2017	9.7 %	1.2 %	153,338	1,574,511
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
2017_2018	49.7 %	5.8 %	94,052	189,236
2016_2017	56.4 %	5.1 %	108,269	192,099
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
2017_2018	91.1 %	1.3 %	1,695,882	1,861,519
2016_2017	93.7 %	0.9 %	1,745,549	1,863,556
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
2016	15.3 %	0.2 %	7,235	47,376
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 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	12.7 %	0.9 %	46,280	363,195
2015	12.9 %	0.9 %	38,651	300,053
2013	12.0 %	0.6 %	42,251	351,219
2011	11.1 %	1.2 %	40,621	365,962

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate 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
2017_2018	13.2 %	2.1 %	108,022	820,588
2016_2017	13.2 %	1.8 %	102,942	782,456
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
2018	4.4 %	0.2 %	82,865	1,867,261
2017	4.5 %	0.2 %	83,047	1,865,872
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 >20% points, >1.2 times the estimate, or that is inestimable 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
2018	77.8 %	3.9 %	114,557	147,174
2017	77.1 %	4.1 %	114,410	148,412
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 width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable 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
2018_2019	69.6 %	1.6 %	1,225,859	1,761,798
2017_2018	65.2 %	2.0 %	1,141,897	1,752,024
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 because the relative standard error is >0.3.

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	67.2 %	4.5 %	352,380	524,007
2017	75.6 %	3.4 %	398,447	526,872
2016	53.6 %	3.8 %	281,939	526,294
2015	50.4 %	4.1 %	264,630	524,771

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable 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
2018	90.3 %	2.7 %	473,264	524,007
2017	89.3 %	2.6 %	470,632	526,872
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 width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable 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
2018	79.7 %	3.7 %	417,432	524,007
2017	80.0 %	3.3 %	421,267	526,872
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 width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable 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
2018	14.3	0.2	3,803	266,855
2017	15.0	0.2	3,987	265,153
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	20.0	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
2018	13.5 %	1.7 %	12,376	91,962
2017	12.4 %	1.7 %	11,459	92,173
2016	12.9 %	1.7 %	12,138	94,152
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% points or >1.2 times the estimate 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
2017_2018	2.2 %	0.6 %	41,650	1,856,693
2016_2017	2.1 %	0.6 %	38,366	1,856,963
2016	1.6 % ϟ	0.6 % ϟ	30,045 ϟ	1,857,731 ϟ

Legends:

Indicator has an unweighted denominator <30 and is not reportable

ϟ 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 10
National Performance Measures (NPMs)

State: Virginia

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2019
Annual Objective	
Annual Indicator	82.9
Numerator	73,338
Denominator	88,459
Data Source	NIS
Data Source Year	2016

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	84.6	85.4	86.2	87.1	87.9

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: % increase needed to meet Goal of 5% increase based on 2016 NIS as state baseline data	
2.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: % increase needed to meet Goal of 10% based on 2016 NIS as state baseline	

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

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2019
Annual Objective	
Annual Indicator	26.4
Numerator	22,710
Denominator	85,942
Data Source	NIS
Data Source Year	2016

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	27.5	28.0	28.5	29.0	29.6

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: % increase needed to meet Goal of 10% based on 2016 NIS as state baseline	
2.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: % increase needed to meet Goal of 10% based on 2016 NIS as state baseline	

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**	**2018**	**2019**
Annual Objective			27.1	27.9
Annual Indicator		26.8	29.1	31.4
Numerator		67,562	59,469	54,036
Denominator		252,334	204,083	171,987
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

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						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	28.3	29.5	29.9	30.3	30.7	31.1

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: % increase needed to meet National 2016-2017 metric based on NSCH 2016-2017 as state baseline	

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**	**2018**	**2019**
Annual Objective	86.5	85.5	94.9	92.8
Annual Indicator	87.0	101.5	95.4	98.6
Numerator	899	785	982	1,013
Denominator	1,033,738	773,528	1,029,557	1,026,897
Data Source	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD
Data Source Year	2014	2015	2016	2017

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	90.7	88.7	86.7	84.8	82.9	81.0

Field Level Notes for Form 10 NPMs:

1. **Field Name:** **2020**

   Column Name: **Annual Objective**

   Field Note:
   Projections based on average annual percent change from 2008-2015 available 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**	**2018**	**2019**
Annual Objective	180	172	162.9	156.8
Annual Indicator	172.4	182.6	196.3	184.5
Numerator	1,826	1,451	2,087	1,964
Denominator	1,059,470	794,656	1,062,972	1,064,407
Data Source	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2014	2015	2016	2017

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	151.0	145.3	139.9	134.7	129.6	124.8

Field Level Notes for Form 10 NPMs:

1. **Field Name:** **2020**

   Column Name: **Annual Objective**

   Field Note:
   Projections based on average annual percent change from 2008-2015 available 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**	**2018**	**2019**
Annual Objective			44.9	46
Annual Indicator		42.7	44.2	48.4
Numerator		167,058	172,978	188,625
Denominator		391,428	391,467	389,683
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

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						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	47.1	49.4	50.3	51.3	52.3	53.2

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: % increase needed to meet Goal of 10% increase based on 2017-2018 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**	**2018**	**2019**
Annual Objective			19.3	19.5
Annual Indicator		18.8	28.1	26.5
Numerator		31,194	48,657	47,355
Denominator		166,277	172,958	179,018
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

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						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	19.7	27.0	27.6	28.1	28.6	28.6

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: % increase needed to meet Goal of 10% increase based on 2017-2018 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 - Adolescent Health - NONCSHCN

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - NONCSHCN	
	2019
Annual Objective	
Annual Indicator	11.6
Numerator	56,684
Denominator	489,697
Data Source	NSCH-NONCSHCN
Data Source Year	2017_2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	12.1	12.6	13.2	13.7	14.2

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
% increase needed to meet national 2017-2018 metric (14.2%) based on 2017-2018 state baseline metric

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	**2018**	**2019**
Annual Objective	45	49.7	50.8
Annual Indicator	46.5	44.7	49.9
Numerator	44,225	42,882	46,558
Denominator	95,088	95,839	93,304
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2016	2018

State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		45	49.7	50.8
Annual Indicator	43.6			
Numerator				
Denominator				
Data Source	PRAMS			
Data Source Year	2010-2011			
Provisional or Final ?	Provisional			

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	50.4	50.9	51.4	51.9	52.4	52.9

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
% increase needed to meet 5% goal based on 2018 VA PRAMS as 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**	**2018**	**2019**
Annual Objective			93.2	80.7
Annual Indicator		81.4	83.1	82.4
Numerator		1,407,907	1,448,110	1,463,318
Denominator		1,729,004	1,741,839	1,775,616
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

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**	**2018**	**2019**
Annual Objective			79.7	80.7
Annual Indicator		77.8	78.4	78.9
Numerator				
Denominator				
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	79.7	80.5	81.3	82.1	82.9	83.7

Field Level Notes for Form 10 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:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2018: the data source is the latest available data year (2016_2017) 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.	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2019: the data source is the latest available data year (2017_2018) 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.	
4.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: % increase needed to meet Goal of 5% increase based on 2017_2018 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	2018	2019
Annual Objective			93.2	94.3
Annual Indicator	90.9	90.9	90.5	88.2
Numerator				
Denominator				
Data Source	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016	2016_2017	2017_2018
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	89.1	90.0	90.8	91.7	92.6	93.5

Field Level Notes for Form 10 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:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2018: the data source is the latest available data year (2016_2017) from the National Survey of Children's Health. Data is reported from age break-out for children age 12-17 years.	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2019: the data source is the latest available data year (2017_2018) from the National Survey of Children's Health. Data is reported from age break-out for children age 12-17 years.	
4.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: % increase needed to meet Goal of 5% increase based on 2017_2018 state baseline data	

NPM 15 - Percent of children, ages 0 through 17, who are continuously and adequately insured - Children with Special Health Care Needs

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2019
Annual Objective	
Annual Indicator	71.2
Numerator	1,323,014
Denominator	1,857,510
Data Source	NSCH
Data Source Year	2017_2018

State Provided Data	
	2019
Annual Objective	
Annual Indicator	71.3
Numerator	
Denominator	
Data Source	NSCH
Data Source Year	2017_2018
Provisional or Final ?	Final

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	72.0	72.7	73.4	74.2	74.9

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2019: the data source is the latest available data year (2017_2018) from the National Survey of Children's Health. Data is reported from SHCN status break-out for CYSHCN.	
2.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: % increase needed to meet Goal of 5% increase based on 2017_2018 state baseline data	

Form 10
National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)

State: Virginia

2016-2020: NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2017	**2018**	**2019**
Annual Objective	81	81.6	82.8
Annual Indicator	78.0	78.0	82.0
Numerator	73,007	73,211	75,207
Denominator	93,567	93,856	91,692
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2016	2018

State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective	78.5	81	81.6	82.8
Annual Indicator			75.9	82
Numerator				
Denominator				
Data Source			VA PRAMS	VA PRAMS
Data Source Year			2017	2018
Provisional or Final ?	Final		Final	Final

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2018: data reported is VA PRAMS (2017).	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2019: data reported is VA PRAMS (2018).	

2016-2020: NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2018	**2019**
Annual Objective		33.3
Annual Indicator	32.0	28.8
Numerator	28,740	25,307
Denominator	89,922	87,734
Data Source	PRAMS	PRAMS
Data Source Year	2016	2018

State Provided Data			
	2017	**2018**	**2019**
Annual Objective			33.3
Annual Indicator	73.3	75.7	73.8
Numerator			
Denominator			
Data Source	VA PRAMS	VA PRAMS	VA PRAMS
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 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 (2016). Question reads, “In the past 2 weeks, how often has your baby slept alone in his or her own crib or bed?” Indicator reported is percent of infants who always/often slept alone in his or her own crib or bed.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2018: data reported is most recent available data year for VA PRAMS (2017). Question reads, “In the past 2 weeks, how often has your baby slept alone in his or her own crib or bed?” Indicator reported is percent of infants who always/often slept alone in his or her own crib or bed.	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2019: data reported is most recent available data year for VA PRAMS (2086). Question reads, “In the past 2 weeks, how often has your baby slept alone in his or her own crib or bed?” Indicator reported is percent of infants who always/often slept alone in his or her own crib or bed.	

2016-2020: NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2018	**2019**
Annual Objective		48.2
Annual Indicator	44.6	46.9
Numerator	39,580	40,840
Denominator	88,829	87,067
Data Source	PRAMS	PRAMS
Data Source Year	2016	2018

State Provided Data			
	2017	**2018**	**2019**
Annual Objective			48.2
Annual Indicator	79.6	84.7	83.1
Numerator			
Denominator			
Data Source	VA PRAMS	VA PRAMS	VA PRAMS
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 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 (2016). Question reads, “How did your baby usually sleep in the past 2 weeks?" With a blanket, With toys cushions or pillows, or With crib bumper pads” Indicator reported is percent of infants who did not sleep with a blanket, With toys cushions or pillows, or With crib bumper pads	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2018: data reported is most recent available data year for VA PRAMS (2017). Question reads, “How did your baby usually sleep in the past 2 weeks?" With a blanket, With toys cushions or pillows, or With crib bumper pads” Indicator reported is percent of infants who did not sleep with a blanket, With toys cushions or pillows, or With crib bumper pads	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2019: data reported is most recent available data year for VA PRAMS (2018). Question reads, “How did your baby usually sleep in the past 2 weeks?" With a blanket, With toys cushions or pillows, or With crib bumper pads” Indicator reported is percent of infants who did not sleep with a blanket, With toys cushions or pillows, or With crib bumper pads	

Form 10
State Performance Measures (SPMs)

State: Virginia

SPM 1 - Cross-Cutting (Early and Continuous Screening): Percent of infants who are diagnosed with a newborn screening disorder that are referred to care coordination services in the CYSHCN program

Measure Status:	Active
State Provided Data	
	2019
Annual Objective	
Annual Indicator	100
Numerator	
Denominator	
Data Source	VDH Newborn Screening Program, VDH EHDI
Data Source Year	2018
Provisional or Final ?	Final

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10 SPMs:

None

SPM 2 - Cross-Cutting (Youth Leadership): Develop and sustain the Virginia Department of Health Youth Advisor Program

Measure Status:	Active

State Provided Data		
	2018	2019
Annual Objective		
Annual Indicator		Yes
Numerator		
Denominator		
Data Source		VDH Adolescent Health Program
Data Source Year		2019
Provisional or Final ?		Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Note for 2019 reporting year: The Adolescent Health Program is currently in the process of hiring two Youth Advisors, young people who will provide their expertise on VDH's public health programs and initiatives.

SPM 3 - MCH Workforce Development (Racial Equity): Develop and implement MCH workforce development policies addressing racial equity for all Title V program staff and subrecipient staff

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10 SPMs:

None

SPM 4 - Pregnancy Intention: Mistimed or Unwanted pregnancy (wanted to become pregnant later or never)

Measure Status:	Active
State Provided Data	
	2019
Annual Objective	
Annual Indicator	25.3
Numerator	
Denominator	
Data Source	VA PRAMS
Data Source Year	2018
Provisional or Final ?	Final

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	23.8	23.3	22.8	22.3	21.8

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 reporting year: 2018 VA PRAMS data; Survey Question: Thinking back to just before you got pregnant with your new baby, how did you feel about becoming pregnant?; Answer options included in analysis: "I wanted to be pregnant later" and "I didn't want to be pregnant then or at any time in the future"; Division of Population Health Data, Office of Family Health Services.	
2.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: % decrease of 10% (HP2020 method) based on 2018 VA PRAMS baseline data	

Form 10
State Performance Measures (SPMs) (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 4 - Unintended Pregnancy: Proportion of females ages 15-44 using Tier 1 (most effective) contraceptive methods

Measure Status:			**Active**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective	2.6	33.3	34.1
Annual Indicator	35.5	31	65.1
Numerator			
Denominator			
Data Source	VA PRAMS	VA PRAMS	VA PRAMS
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 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... Updated to 2016 VA PRAMS on 6.12.2019

2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Note for 2018 reporting year: 2017 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; 2016-2017 combined 33.2%

3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Note for 2019 reporting year: 2018 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.

2016-2020: SPM 6 - Cross-cutting (Family Engagement): Implement and develop report on survey of families served by the VDH Care Connection for Children (CCC) programs

Measure Status:			Active
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			0
Annual Indicator		Yes	Yes
Numerator			
Denominator			
Data Source		VDH CYSHCN Program	VDH CYSHCN Program
Data Source Year		2018	2019
Provisional or Final ?		Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for 2018 reporting year: The Care Connection for Children (CCC) Family Survey was developed during FY18 with implementation and completion during FY18 and FY19.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 reporting year: The Care Connection for Children (CCC) Family Survey Report was drafted during FY18 and completed in November 2018 (FY19). The report was attached to the FY18 Report/FY20 Application. The team presented results to CCC directors and stakeholder, and also participated in an AMCHP 2020 workshop during FY20.	

2016-2020: SPM 7 - Cross-Cutting (Early and Continual Screening): Percent of infants with confirmed newborn screening disorders who are enrolled in supportive services no later than 6 months of age

Measure Status:	Active

Baseline data was not available/provided.

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Note for 2019 reporting year: This measure is replaced with SPM 1 - Cross-Cutting (Early and Continual Screening): Percent of infants who are diagnosed with a newborn screening disorder that are referred to care coordination services in the CYSHCN program.

Form 10
State Outcome Measures (SOMs)

State: Virginia

SOM 1 - Infant Mortality Disparity: Infant Mortality Disparity Ratio

Measure Status:	Active

State Provided Data		
	2018	2019
Annual Objective		
Annual Indicator	2.2	2
Numerator	9.6	9.7
Denominator	4.4	4.9
Data Source	VDH OIM	VDH OIM
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	1.8	1.7	1.6	1.5	1.4	1.3

Field Level Notes for Form 10 SOMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2018: the data source is the latest available data year (2017) from the VDH Division of Health Statistics. Data reported is the black/white infant mortality rates per 1000 for VA residents	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2019: the data source is the latest available data year (2018) from the VDH Division of Health Statistics. Data reported is the black/white infant mortality rates	

SOM 2 - Maternal Mortality Disparity: Maternal Mortality Disparity Ratio

Measure Status:	Active

State Provided Data		
	2018	2019
Annual Objective		
Annual Indicator	3.3	1.9
Numerator	36.6	52.6
Denominator	11	27.7
Data Source	CDC WONDER Online Database	CDC WONDER Online Database
Data Source Year	2011-2015	2013-2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	2.8	2.4	2.1	1.7	1.4	1.0

Field Level Notes for Form 10 SOMs:

1. **Field Name:** **2018**

   Column Name: **State Provided Data**

   Field Note:
   Note for reporting year 2018: the data source is the CDC WONDER Online Database, Mortality files, 2011-2015 from America's Health Rankings (2018). Data from the VA Maternal Mortality Review show the following for 2013:
   VA maternal mortality ratio (42 days) = 4.9
   VA White maternal mortality ratio (42 days) = 3.1
   VA Black maternal mortality ratio (42 days) = 13.9

2. **Field Name:** **2019**

   Column Name: **State Provided Data**

   Field Note:
   Note for reporting year 2019: the data source is the CDC WONDER Online Database, Mortality files, 2013-2017 from America's Health Rankings (2019). Data from the VA Maternal Mortality Review show the following for 2015:
   VA maternal mortality ratio (42 days) = 1.0
   VA White maternal mortality ratio (42 days) = 0.0
   VA Black maternal mortality ratio (42 days) = 4.6

Form 10
Evidence-Based or –Informed Strategy Measure (ESM)

State: Virginia

ESM 4.1 - Development of a coordinated action plan of gap-filling activities for breastfeeding programming across VDH divisions

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10 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	2018	2019
Annual Objective	7	15	20
Annual Indicator	15	30	30
Numerator			
Denominator			
Data Source	VDH Division of Child and Family Health	VDH Division of Child and Family Health	VDH Division of Child and Family Health
Data Source Year	2016-2017	2017-2018	2018-2019
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	25.0	35.0	50.0	100.0	100.0	100.0

Field Level Notes for Form 10 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.

2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Data note for reporting year 2018: Trainings were done with the local health department staff administering Resource Mothers, Healthy Start, MIECHV and other non-evidence based home visiting programs.

3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Data note for reporting year 2019: Work with the Virginia Early Childhood Foundation and selection of the 6 hub sites began late summer 2019. Hubs started surveying the screening landscape and establishing relationships and partnerships to support on-going systems collaboration and infrastructure building. Within the hubs, over 50 potential or informal partners were identified across hubs. Partners included several local coalitions which are themselves comprised of multiple stakeholders with capacity for resource sharing and cross-sector collaboration. Systems coordination activities included hosting informational meetings, identifying potential partners, learning which entities are already conducting screens and assessing how screens are being conducted (paper, online, ASQ or other, referral capacity, etc.).

ESM 6.2 - 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

State Provided Data			
	2017	2018	2019
Annual Objective			0
Annual Indicator			Yes
Numerator			
Denominator			
Data Source			VDH Division of Child and Family Health
Data Source Year			2019
Provisional or Final ?			Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Not for 2018 reporting year: During FY 2018 and 2019, the module is under development. Contracts for uploading the final approved module to a training web site were under negotiation during FY 18.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 reporting year: The field note from last year does not apply to this project. A state strategic plan was developed from three stakeholder meetings from 2017-2018. A subrecipient agreement was initiated with the Virginia Early Childhood Foundation to forward progress within three key activity areas of the Developmental Screening Initiative: Partnerships and Systems Coordination, Increasing Child Development Screening, and Messaging based on the State Strategic Plan.	

ESM 6.3 - 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	2018	2019
Annual Objective	100	125	200
Annual Indicator	0	0	100
Numerator			
Denominator			
Data Source	VDH Division of Child and Family Health	VDH Division of Child and Family Health	VDH Division of Child and Family Health
Data Source Year	2016-2017	2017-2018	2018-2019
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	250.0	300.0	350.0	400.0	425.0	430.0

Field Level Notes for Form 10 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.

2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Note for reporting year 2018: The agency migrated to a new platform; substantial revisions were required to re-establish the web page, therefore data is not available for FY 2018.

3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Note for 2019 reporting year: ASQ navigators have been out in the community conveying the importance of developmental screening during face-to-face meetings with significant stakeholders. The South Hampton Roads Developmental Screening Initiative has its own page conveying information about the benefits of developmental screening on the GHRconnects.org webpage. DSI hubs are discussing possibilities for sharing and collaborating with messaging resources.

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**	**2018**	**2019**
Annual Objective		0	10	15
Annual Indicator	0	0	0	12
Numerator	0	0	0	3
Denominator	60	60	53	25
Data Source	Office of Family Health Services, VDH	Office of Family Health Services, VDH	VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Provisional	Final

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	20.0	25.0	30.0	35.0	40.0	45.0

Field Level Notes for Form 10 ESMs:

1. **Field Name:** **2018**

   Column Name: **State Provided Data**

   Field Note:
   Note for 2018 reporting year: Numerator 0; Deliverable addressed development of the curriculum for FY18.

2. **Field Name:** **2019**

   Column Name: **State Provided Data**

   Field Note:
   Note for 2019 reporting year: During FY19, IVPP worked with 25 maternity hospitals to continue technical assistance in the readiness and implementation of Project Patience. During the course of the year, 3 Bon Secours maternity hospitals agreed to infuse the VDH curriculum into their current Love and Learn maternity hospital education. 1 VDH Local Health District adopted Project Patience content on Violence Prevention and Abusive Head Trauma prevention as an extension of 1 Northern Virginia hospital. The remaining hospitals are anticipated to embed the curriculum into its process given a two year approval cycle. The total number of maternity centers with prenatal courses including Virginia’s injury prevention curriculum is expected to rise in FY20 and FY21.

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

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			2,549
Annual Indicator		2,596	1,560
Numerator			
Denominator			
Data Source		VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program
Data Source Year		2018	2019
Provisional or Final ?		Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	2,549.0	2,549.0	2,549.0	2,549.0	2,549.0	2,549.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for 2018 reporting year: During FY18, 2,244 convertible safety seats and 352 boosters, totaling 2,596 were distributed to income eligible families.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 reporting year: The Low Income Safety Seat Distribution and Education Program, LISSDEP, network distributed 1,342 convertible seats and 218 booster seats, totaling 1,560 seats distributed to income eligible families, however, the network experienced a decrease in eligibility applications by clientele during the FY19. The program continued its programmatic evaluation to determine root cause(s) and uncover vulnerable communities within the network.	

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

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			10
Annual Indicator		102	195
Numerator			
Denominator			
Data Source		VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program
Data Source Year		2018	2019
Provisional or Final ?		Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	20.0	20.0	20.0	20.0	20.0	20.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for 2018 reporting year: 102 gatekeepers were trained in the prevention of suicide among youth for FY18	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 reporting year: During FY19, IVPP contracted with the James Madison Campus Suicide Prevention Center to coordinate Applied Suicide Intervention Skills Trainings, Recognizing and Responding to Suicide Risk trainings and Suicide to Hope evidence based trainings that are recognized by the Suicide Prevention Resource Center, the US Department of Health and Human Services and the Substance Abuse and Mental Health Services Administration (SAMSHA) for a total of 195 gatekeepers trained during the contracted period.	

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

Measure Status:			Active	
State Provided Data				
	2016	2017	2018	2019
Annual Objective		25	100	250
Annual Indicator	0	0	0	0
Numerator				
Denominator				
Data Source	Division of Child and Family Health	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	400.0	425.0	450.0	475.0	500.0	500.0

Field Level Notes for Form 10 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	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for 2018 reporting year: The program did not meet the annual target for this ESM because the modules are still under development. As was described in last year's report, the execution of the contract was a very difficult task to achieve and took the better part of a year. Since the execution of the contract, VDH has submitted outlines of the agency's content expectations for transition and medical home. The intent is for UVA to create online training modules for each topic that will have a provider and family track. Both will be free for families who live in Virginia and for providers who practice in the state (CME's will be offered).	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 reporting year: It is important to note that the modules were released in the fall of 2019 and VDH/UVA are working on a plan to promote them fully. The official public launch date of the module is November 24, 2019. As of January 27, 2020, Medical Home provider completed = 10 and Medical Home provider in progress = 11.	

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	2018	2019
Annual Objective		90	91.5	93
Annual Indicator	89.2	98.9	96.8	99
Numerator	4,061	4,391	4,239	4,788
Denominator	4,555	4,439	4,377	4,835
Data Source	Office of Family Health Services, VDH	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	94.5	96.0	97.5	98.0	99.5	99.5

Field Level Notes for Form 10 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).	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for 2018 reporting year: Data provided for this ESM includes 3 of the 4 Children and Youth with Special Health Care Needs Programs (Child Development Centers, Sickle Cell, and Bleeding Disorders). The Care Connection for Children Program collects data regarding primary care provider but it is via survey. The 2018 survey result showed that 97.5% of parents surveyed report that their child has a primary care provider. It should also be noted that the Bleeding Disorders Program serves people of all ages, however the data represents clients under the age of 21.	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2018 reporting year: During the previous fiscal year, 95% of bleeding disorders pediatric clients, 97.5% of CCC clients, 99% of CDC clients, and 98% of sickle cell clients reported having a primary care provider. Overall, 97.3% of CYSHCN program clients reported having a primary care provider. It is important to note that this figure does not include adults that the bleeding disorders program serves and the CCC numbers were taken from the last program survey that was done in 2018.	

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

Measure Status:			Active	
State Provided Data				
	2016	2017	2018	2019
Annual Objective		25	100	250
Annual Indicator	0	0	0	0
Numerator				
Denominator				
Data Source	Division of Child and Family Health	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Provisional	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	400.0	425.0	450.0	475.0	500.0	525.0

Field Level Notes for Form 10 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	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for 2018 reporting year: The program did not meet the annual target for this ESM because the modules are still under development. As was described in last year's report, the execution of the contract was a very difficult task to achieve and took the better part of a year. Since the execution of the contract, VDH has submitted outlines of the agency's content expectations for transition and medical home. The intent is for UVA to create online training modules for each topic that will have a provider and family track. Both will be free for families who live in Virginia and for providers who practice in the state (CME's will be offered).	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2018 reporting year: It is important to note that the modules were released in the fall of 2019 and VDH/UVA are working on a plan to promote them fully. The official public launch date of the module is November 24, 2019. As of January 27, 2020, Transition provider completed = 10 and Transition provider in progress = 14.	

ESM 12.2 - Percentage of Virginia schools reporting into the VDOE school health data system

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	75.0	77.0	79.0	81.0	83.0

Field Level Notes for Form 10 ESMs:

None

ESM 13.1.1 - Number of Regional Oral Health Collaborative Projects that implemented work plans to increase dental visits among pregnant women

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			6
Annual Indicator		3	4
Numerator			
Denominator			
Data Source		VDH Oral Health Program documentation	VDH Oral Health Program documentation
Data Source Year		2018	2019
Provisional or Final ?		Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	6.0	6.0	6.0	6.0	7.0	7.0

Field Level Notes for Form 10 ESMs:

1. **Field Name:** **2018**

   Column Name: **State Provided Data**

   Field Note:
   Note for 2018 reporting year: There were 3 Regional Oral Health Collaborative Projects that implemented work plans to increase dental visits among pregnant women in FY18. South Hampton Roads, Northern Virginia, Richmond/Petersburg; Central Virginia, Newport News and Southside to come in 2019. SWVA to come in 2020.

2. **Field Name:** **2019**

   Column Name: **State Provided Data**

   Field Note:
   Note for 2019 reporting year: There were 4 Regional Oral Health Collaborative Projects that implemented work plans to increase dental visits among children (ages 0-11 years) and adolescents (ages 12-17 years) in FY19. Richmond/Petersburg, South Hampton Roads, Northern Virginia, and Newport News.

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

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			6
Annual Indicator		3	4
Numerator			
Denominator			
Data Source		VDH Oral Health Program documentation	VDH Oral Health Program documentation
Data Source Year		2018	2019
Provisional or Final ?		Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	6.0	6.0	6.0	6.0	7.0	7.0

Field Level Notes for Form 10 ESMs:

1. **Field Name:** **2018**

   Column Name: **State Provided Data**

   Field Note:
   Note for 2018 reporting year: There were 3 Regional Oral Health Collaborative Projects that implemented work plans to increase dental visits among among children (ages 0-11 years) and adolescents (ages 12-17 years). South Hampton Roads, Northern Virginia, Richmond/Petersburg; Central Virginia, Newport News and Southside to come in 2019. SWVA to come in 2020.

2. **Field Name:** **2019**

   Column Name: **State Provided Data**

   Field Note:
   Note for 2019 reporting year: There were 4 Regional Oral Health Collaborative Projects that implemented work plans to increase dental visits among pregnant women in FY19. Richmond/Petersburg, South Hampton Roads, Northern Virginia, and Newport News.

ESM 15.1 - Number of Managed Care Organizations (MCO) and Care Connection for Children (CCC) Care Coordinators that attend statewide meeting

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	40.0	40.0	40.0	40.0	40.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
Note for 2019 reporting year: Program estimate that initial participation will be 20 CCC care coordinators and 20 MCO care coordinators

ESM 15.2 - Number of Managed Care Organization (MCO) and Care Connection for Children (CCC) regions that commit to partnering with each other to reduce barriers

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	3.0	3.0	4.0	5.0	6.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
Note for 2019 reporting year: Program estimate that initial participation will be 3 regions of the 6 total regions

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 5.2 - Number of visits to the SafeSleepVA.com website

Measure Status:			**Active**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective	150	200	250
Annual Indicator	1,373	2,756	2,628
Numerator			
Denominator			
Data Source	VDH-OFHS Communications Specialist	VDH-OFHS Communications	VDH-OFHS Communications
Data Source Year	2017	2018	2019
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 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)	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for 2018 Reporting Year: This was pulled from number of “pageviews” to the SafeSleepVa.com website; provided by the Office of Communications – OFHS VDH Analytics 2019	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 Reporting Year: This was pulled from number of “pageviews” to the SafeSleepVa.com website; provided by the Office of Communications – OFHS VDH Analytics 2019	

2016-2020: ESM 5.3 - Number of individuals counseled/educated about Safe Sleep environments

Measure Status:			Active
State Provided Data			
	2017	**2018**	**2019**
Annual Objective		10,000	10,000
Annual Indicator	9,924	20,216	22,658
Numerator			
Denominator			
Data Source	Maternal/Infant Health Program - LHD Reports	Maternal/Infant Health Program - LHD Reports	Maternal/Infant Health Program - LHD Reports
Data Source Year	2017	2018	2019
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 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	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for 2018 reporting year: This was reported by the 23 LHDs who had selected Safe Sleep as a priority. Each LHD had a different approach to educating parents and family members, some went to Child Care facilities and provided the education to parents, others educated all their car seat class attendees on a Safe Sleep environment. Other LHDs provided education to families at health fairs, PTA school meetings, at post-partum visits, WIC clients and upon receiving a positive pregnancy test if they presented to the LHDs for a pregnancy test.	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 reporting year: This was reported by the LHDs who had selected Safe Sleep as a priority. Each LHD had a different approach to educating parents and family members, some went to Child Care facilities and provided the education to parents, others educated all their car seat class attendees on a Safe Sleep environment. Other LHDs provided education to families at health fairs, PTA school meetings, at post-partum visits, WIC clients and upon receiving a positive pregnancy test if they presented to the LHDs for a pregnancy test. Some LHDs began training community providers and organizations to give safe sleep education, broadening reach.	

2016-2020: 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**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			500
Annual Indicator		562	823
Numerator			
Denominator			
Data Source		VDH Maternal and Infant Health Program documents	VDH Maternal and Infant Health Program documents
Data Source Year		2019	2019
Provisional or Final ?		Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for 2018 reporting year: This was reported by the 23 LHDs who had selected Safe Sleep as a priority. Each LHD had a different approach to educating providers, some went to Child Care facilities and provided the education, others trained home visitors about a Safe Sleep environment and provide motivational interview techniques to make a home a safe sleep environment. Other LHDs provided education to hospital L&D staff, pediatrician offices, WIC staff and/or all staff in the LHD who interact with families with infants.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 reporting year: This was reported by the 26 LHDs who had selected Safe Sleep as a priority. Each LHD had a different approach to educating providers, some went to Child Care facilities and provided the education, others trained home visitors about a Safe Sleep environment and provide motivational interview techniques to make a home a safe sleep environment. Other LHDs provided education to hospital L&D staff, pediatrician offices, WIC staff and/or all staff in the LHD who interact with families with infants. FQHCs and other community partners such as local churches and other non-profit orgs received training.	

2016-2020: ESM 5.5 - Interdisciplinary Workforce Development - Number of Local Health Departments (LHD) attending VDH technical assistance for safe sleep environment.

Measure Status:			**Active**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			35
Annual Indicator			35
Numerator			
Denominator			
Data Source			VDH Maternal and Infant Health Program documents/a
Data Source Year			2019
Provisional or Final ?			Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Note for 2019 reporting year: The LHDs attend live bimonthly polycoms, if they aren't available all polycoms were recorded and placed on the intranet for them to view at their convenience. The format for the polycoms consist of any updates, budget discussion, data about topic for that polycom, key presentation by topic for that polycom, selected LHDs present what they are doing related to the topic presented (lessons learned, challenges, opportunities and provide their own lens of success), upcoming deadlines, questions. As new staff are onboarded they are required to review TA polycoms.

2016-2020: ESM 5.6 - Interdisciplinary Workforce Development - Number of home visitors completing Early Impact Virginia training modules that discuss safe sleep environment.

Measure Status:			Active
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			375
Annual Indicator			243
Numerator			
Denominator			
Data Source			VDH Home visiting programs
Data Source Year			2019
Provisional or Final ?			Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for 2018 reporting year: Number of home visitors is compiled from JMU trainings and EIV trainings for the period noted. 84% of MIECHV sites reported safe sleep measures adhered to and 89% of Healthy Start sites reported safe sleep measures adhered to. For FY18 174 home visitors completed Early Impact Virginia training modules that discuss safe sleep environment.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 reporting year: The Safe Sleep trainings provided through The Institute consists of 4 modules that all cover safe sleep and environment in various contexts. Home visitors are only required to take them once but can repeat them as their training plans deems necessary. Each module averages about 100-200 participants annually. Due to this, an average was calculated to address this ESM. This gives a more accurate reflection of objective calculations. A total of 243 home visitors completed one or more of the following modules - Infant Care--The ABCs of Safe Sleep for Infants (92), Child Development--Secrets of Baby Behavior (111), and Promoting Safe and Healthy Homes (40).	

2016-2020: ESM 7.1.3 - Number of healthcare providers receiving Project ECHO content in reducing the impact of NAS

Measure Status:			Active
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			25
Annual Indicator			119
Numerator			
Denominator			
Data Source			VDH - Injury and Violence Prevention Program
Data Source Year			2019
Provisional or Final ?			Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for 2018 reporting year: Numerator 0; FY18 budget was not released to IVP until mid year. Contract process with UVA was extended over six months. Project ECHO lab was released in November 2018. The number of healthcare providers at current state for FY19 has exceeded the annual objectives.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 reporting year: During FY19, IVPP worked with the University of Virginia which held bi-weekly Project ECHO sessions from December 2018 to May 2019. 12 NAS ECHO labs were held during that time period. The remaining of the contracted period was spent evaluating progress and developing content for the following FY period. Content was delivered to 119 MDs, NPs, PAs and other healthcare providers caring for patients diagnosed and at risk for NAS. Content for each session was drawn form the SAMSHA Clinical Guide for Managing Pregnant and Parenting Patients with Opioid Use Disorder and their Infants.	

2016-2020: ESM 11.3 - Percentage of children enrolled in public schools who report a primary care provider

Measure Status:			Active	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		40	42.5	45
Annual Indicator	30.6	0	0	0
Numerator	200,000			
Denominator	653,103			
Data Source	Virginia Department of Education	Virginia Department of Education	Virginia Department of Education	Virginia Department of Education
Data Source Year	2015-2016	2016-2017	2017-2018	2018-2019
Provisional or Final ?	Final	Final	Final	Provisional

Field Level Notes for Form 10 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.

2. **Field Name:** **2018**

   Column Name: **State Provided Data**

   Field Note:
   Note for 2018 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.

3. **Field Name:** **2019**

   Column Name: **State Provided Data**

   Field Note:
   Note for 2019 reporting year: Data not available this reporting year due to revision of the school nurse survey. The state Title V coordinator, epidemiologist, and school nurse consultant are developing plans with the Department of Education school nurse contact to review processes and maximize opportunity for data collection.

Form 10
State Performance Measure (SPM) Detail Sheets

State: Virginia

SPM 1 - Cross-Cutting (Early and Continuous Screening): Percent of infants who are diagnosed with a newborn screening disorder that are referred to care coordination services in the CYSHCN program
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Increase the percentage of infants with confirmed newborn screening disorders who enter care coordination
Definition:	

Numerator:	Number of infants with a confirmed newborn screening disorders who are referred to care coordination
Denominator:	Total number of infants with a confirmed newborn screening disorder
Unit Type:	Percentage
Unit Number:	100

Healthy People 2020 Objective:	Related to Maternal, Infant, and Child Health (MICH) Objective 29-1: Increase the proportion of children (aged 10-35 months) who have been screened for an Autism Spectrum Disorder and other developmental delays.
Data Sources and Data Issues:	Data Source: NBS, EHDI Program, VISITS, VaCARES; Data lag is 2 years
Significance:	Early identification of developmental disorders is critical to the well-being of children and their families. The Virginia MCH priority for early and continual screening supports optimal physical, mental health and social emotional development for all children.

SPM 2 - Cross-Cutting (Youth Leadership): Develop and sustain the Virginia Department of Health Youth Advisor Program
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	To ensure VDH's Title V Programming is increasing family and youth leadership in Title V-funded initiatives.
Definition:	**Numerator:** N/A **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	VDH Adolescent Health Program documents
Significance:	One of the emerging priorities of VDH's Title V Program is increasing family and youth engagement in Title V-funded initiatives. As a result, VDH's Adolescent Health Program must establish a structure that consistently brings youth voice into adolescent health programs.

SPM 3 - MCH Workforce Development (Racial Equity): Develop and implement MCH workforce development policies addressing racial equity for all Title V program staff and subrecipient staff
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Eliminate drivers of structural and institutional racism
Definition:	

Numerator:	0
Denominator:	0
Unit Type:	Text
Unit Number:	Yes/No

Healthy People 2020 Objective:	One of Healthy People 2030's 5 overarching goals is specifically related to SDOH: "Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all." In line with this goal, Healthy People 2030 features many objectives related to SDOH. These objectives highlight the importance of "upstream" factors — usually unrelated to health care delivery — in improving health and reducing health disparities.
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Child and Family Health
Significance:	The 10 Essential Public Health Services (EPHS) provide a framework for public health to protect and promote the health of all people in all communities.. For the past 25 years, the EPHS have served as a well-recognized framework for carrying out the mission of public health. The 2020 revised version places equity firmly at its core, actively promoting policies, systems, and overall community conditions that enable optimal health for all and seek to remove systemic and structural barriers that have resulted in health inequities. Such barriers include poverty, racism, gender discrimination, ableism, and other forms of oppression. Everyone should have a fair and just opportunity to achieve optimal health and well-being.

SPM 4 - Pregnancy Intention: Mistimed or Unwanted pregnancy (wanted to become pregnant later or never)
Population Domain(s) – Women/Maternal Health, Adolescent Health

Measure Status:	Active
Goal:	Virginians have access to equitable choice-centered reproduction-related services, including sex education, family planning, fertility/grief support, and parenting support.
Definition:	**Numerator:** Number of women responding that they wanted to become pregnant later or never **Denominator:** Number of live births **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. 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 - Cross-Cutting (Family Leadership): Percentage of VDH CYSHCN programs (i.e. Care Connection for Children, Child Development Centers, Bleeding Disorders Program, Sickle Cell Program) actively incorporating family engagement annually
Population Domain(s) – Children with Special Health Care Needs

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:	Number of CYSHCN programs documenting family engagement in work plans and annual reports
Denominator:	Number of CYSHCN programs
Unit Type:	Percentage
Unit Number:	100

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 10
State Performance Measure (SPM) Detail Sheets (2016-2020 Needs Assessment Cycle)

2016-2020: 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.

2016-2020: 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.

2016-2020: SPM 7 - Cross-Cutting (Early and Continual Screening): Percent of infants with confirmed newborn screening disorders who are enrolled in supportive services no later than 6 months of age
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Increase the percentage of infants with confirmed hearing loss who are enrolled in Early Intervention (EI) services by six months of age
Definition:	**Numerator:** Number of infants with confirmed newborn screening disorders who are enrolled in supportive services by 6 months of age **Denominator:** Total number of infants up to 6 months of age with confirmed newborn screening disorders **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Related to Maternal, Infant, and Child Health (MICH) Objective 29-1: Increase the proportion of children (aged 10-35 months) who have been screened for an Autism Spectrum Disorder and other developmental delays.
Data Sources and Data Issues:	Data Source: NBS, EHDI Program, VISITS, VaCARES; Data lag is 2 years
Significance:	Early identification of developmental disorders is critical to the well-being of children and their families. The Virginia MCH priority for early and continual screening supports optimal physical, mental health and social emotional development for all children.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Virginia

SOM 1 - Infant Mortality Disparity: Infant Mortality Disparity Ratio
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	Decrease the infant mortality disparity ratio for non-Hispanic White and non-Hispanic Black from 2.15 (2017) to 1.57 by 2022.
Definition:	**Numerator:** Rate of non-Hispanic Black infant mortality **Denominator:** Rate of non-Hispanic White infant mortality **Unit Type:** Ratio **Unit Number:** 1
Healthy People 2020 Objective:	MICH-1: Reduce the rate of fetal and infant deaths
Data Sources and Data Issues:	Virginia Department of Health, Office of Information Management, Division of Health Statistics; compiled by the Division of Population Health Data, Office of Family Health Services
Significance:	A significant disparity exists in infant deaths between racial groups, especially for infants born to Black women. Black women had an infant mortality rate in 2013 at 12.2, 2.4 times that for White women (5.2). Goal 2.3 of Virginia's Plan for Well-Being is that the Racial Disparity in Virginia's Infant Mortality Rate is Eliminated.

SOM 2 - Maternal Mortality Disparity: Maternal Mortality Disparity Ratio
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	Decrease the racial disparity in the maternal mortality rate in Virginia
Definition:	

Numerator:	Rate of Black maternal mortality
Denominator:	Rate of White maternal mortality
Unit Type:	Ratio
Unit Number:	1

Healthy People 2020 Objective:	MICH-5: Reduce the rate of maternal mortality.
Data Sources and Data Issues:	CDC WONDER Online Database, America's Health Rankings and Virginia Maternal Mortality Review Committee (MMRC); Also of note are significant data quality concerns for death certificate coding within the National Vital Statistics System (NVSS)
Significance:	Maternal mortality is a sentinel indicator of health and health care quality worldwide. There are also significant racial disparities with Black women having rates of maternal mortality over two times as high as White women in Virginia. On June 5, 2019 Virginia's governor announced a goal to eliminate the racial disparity in the maternal mortality rate in Virginia by 2025.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Virginia

ESM 4.1 - Development of a coordinated action plan of gap-filling activities for breastfeeding programming across VDH divisions
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Advance equity in breastfeeding, parenting, and childcare supports to further development of baby-friendly communities in Virginia
Definition:	**Numerator:** N/A **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	VDH Division of Child & Family Health program documentation
Significance:	The VDH Title V MCH needs assessment identified strong social supports and services as a need for families. Support system and service needs focused on financial stress and issues, access to and navigation within housing and transportation, lack of community, essential supplies for infants like diapers, breastfeeding, and mental health counseling.

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 - 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 6.3 - 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 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
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
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 7.2.1 - 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
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
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
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 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
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 12.2 - Percentage of Virginia schools reporting into the VDOE school health data system
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:	Maintain and expand MCH data capacity regarding school health
Definition:	**Numerator:** Number of Virginia schools reporting into the VDOE school health data system **Denominator:** Number of Virginia schools **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	VDH and VDOE School Health Nurse Documentation (numerator); VDOE Statistics and Reports, Enrollment & Demographic tables, Local and Regional Schools and Centers (denominator) (http://www.doe.virginia.gov/statistics_reports/enrollment/index.shtml)
Significance:	School nurses recognize the importance of each student having a medical home and healthcare transition services, as supported by the American Academy of Pediatrics, American Academy of Family Physicians and American College of Physicians. Poor health has the potential to impact negatively the youth and young adults' academic and vocational outcomes. Health and health care are cited as two of the major barriers to making successful transitions. The VDH School Health Nurse Consultant partnership with the VDOE School Nurse Consultant is critical to understanding scope of needs and services regarding school health in Virginia.

ESM 13.1.1 - Number of Regional Oral Health Collaborative Projects 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
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 Collaborative Projects 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 Collaborative Projects 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
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 Collaborative Projects 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.

ESM 15.1 - Number of Managed Care Organizations (MCO) and Care Connection for Children (CCC) Care Coordinators that attend statewide meeting
NPM 15 – Percent of children, ages 0 through 17, who are continuously and adequately insured

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	Increase the adequacy of insurance for children and youth with special health care needs (CYSHCN).
Definition:	

Numerator:	Number MCO and CCC Care Coordinators that attend statewide meeting
Denominator:	N/A
Unit Type:	Count
Unit Number:	1,000

Data Sources and Data Issues:	VDH CYSHCN Program Documents
Significance:	The VDH Title V MCH needs assessment identified that health insurance for health care services for CYSHCN is both an asset and a frustration for families. The assessment also demonstrated that parents struggle to understand their insurance and what it provides. Examples of barriers mentioned included: filling out required paperwork; understanding information about insurance/confusion; being able to access certain medications; language issues; not having insurance at all; and MCO/benefit changes mid-year that at times may disrupt services provided.

ESM 15.2 - Number of Managed Care Organization (MCO) and Care Connection for Children (CCC) regions that commit to partnering with each other to reduce barriers
NPM 15 – Percent of children, ages 0 through 17, who are continuously and adequately insured

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	Increase the adequacy of insurance for children and youth with special health care needs (CYSHCN).
Definition:	

Numerator:	Number of MCO/CCC regions that commit to partnering with each other
Denominator:	N/A
Unit Type:	Count
Unit Number:	100

Data Sources and Data Issues:	VDH CYSHCN Program Documents
Significance:	The VDH Title V MCH needs assessment identified that health insurance for health care services for CYSHCN is both an asset and a frustration for families. The assessment also demonstrated that parents struggle to understand their insurance and what it provides. Examples of barriers mentioned included: filling out required paperwork; understanding information about insurance/confusion; being able to access certain medications; language issues; not having insurance at all; and MCO/benefit changes mid-year that at times may disrupt services provided.

Form 10
Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 5.2 - Number of visits to the SafeSleepVA.com website
2016-2020: 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.

2016-2020: ESM 5.3 - Number of individuals counseled/educated about Safe Sleep environments
2016-2020: 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.

2016-2020: 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
2016-2020: 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.

2016-2020: ESM 5.5 - Interdisciplinary Workforce Development - Number of Local Health Departments (LHD) attending VDH technical assistance for safe sleep environment.
2016-2020: 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.

2016-2020: ESM 5.6 - Interdisciplinary Workforce Development - Number of home visitors completing Early Impact Virginia training modules that discuss safe sleep environment.
2016-2020: 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.

2016-2020: 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
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.

2016-2020: 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).

Form 11
Other State Data

State: Virginia

The Form 11 data are available for review via the link below.

Form 11 Data