Virginia State Action Plan Table 2024 Application/2022 Annual Report

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
Women/Maternal Health					
Maternal and Infant Mortality Disparity: Eliminate the racial disparity in maternal and infant mortality rates by 2025.	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 Title V representation in selected workgroups Local Health District (LHD): Develop, mobilize, and participate in strong interagency, multisector, and community partnerships to address disparities in maternal and infant mortality rates	By 2025, decrease the disparity in Black-White maternal mortality disparity ratio from 2.1 (2017) to 1.23 (2025)			SOM 2: Maternal Mortality Disparity: Black/White Maternal Mortality Ratio
Reproductive Justice & Support: Promote equitable access to choice-centered reproduction-related services, including sex education, family planning, fertility/grief support, and parenting support.	Work with stakeholders to remove policy, financial, and training barriers to contraceptive access	By 2025, reduce the rate of mistimed pregnancies from 25.3% (PRAMS 2018) to 21.8%	SPM 4: Pregnancy Intention: Mistimed or Unwanted pregnancy (wanted to become pregnant later or never)		
MCH Data Capacity:	Sustain state maternal mortality and child fatality review programs, engaging with cross-sector partners and addressing social determinants	By 2025, decrease the disparity in Black-White maternal mortality			SOM 2: Maternal Mortality Disparity: Black/White Maternal

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Maintain and expand state MCH data capacity, to include ongoing needs assessment activities, program evaluation, and modernized data visualization and integration.	of health in development of MMRT and CFRT recommendations Convene Maternal Health Data and Quality Measures Task Force as mandated by HB2111 to evaluate maternal health data collection processes - completed	ratio from 2.1 (2017) to 1.23 (2025)			Mortality Ratio
Oral Health: Maintain and expand access to oral health services across MCH populations.	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 Continue to foster a 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 and adolescents ages 1-17 Convene statewide groups focused on targeted oral health issues and facilitate collaboration and work plan development, and provide leadership and oversight to guide initiatives	By 2025, increase the percent of women who had a dental visit during pregnancy from 49.9% (PRAMS 2018) to 52.4%	NPM 13.1: Percent of women who had a preventive dental visit during pregnancy	ESM 13.1.1: Number of Regional Oral Health Collaborative Projects that implemented work plans to increase dental visits among pregnant women	NOM 14: Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year 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 19: Percent of children, ages 0 through 17, in excellent or very good health
Mental Health: Promote mental health across MCH populations, to include reducing suicide and substance use.	Explore opportunities for providing support to families seeking fertility services and families experiencing miscarriage Local Health District (LHD): Strengthen early identification, supports, and referrals for women's mental and behavioral health needs	By 2025, reduce the percent of women who reported loss of interest or feeling depressed (post-partum depression) from 14.43% (PRAMS 2019) to 13.71%	SPM 6: Promotion and strengthening of optimal mental/behavioral health and well-being through partnerships and programs		

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Perinatal/Infant Health					
Maternal and Infant Mortality Disparity: Eliminate the racial disparity in maternal and infant mortality rates by 2025.	Develop and mobilize strong interagency, multisector, and community partnerships to address infant mortality due to preventable injury Develop, coordinate, and implement an action plan for substance-exposed infants based on the 2020 Report to the General Assembly Local Health Districts (LHD): Develop, mobilize, and participate in strong interagency, multisector, and community partnerships to address disparities in maternal and infant mortality rates	Decrease the Black/White infant mortality ratio from 2.0 to 1.0 by June 30, 2025	NPM 4: A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	ESM 4.1: Development of a coordinated action plan of gap-filling activities for breastfeeding programming across VDH divisions	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: Sudden Unexpected Infant Death (SUID) rate per 100,000 live births
MCH Data Capacity: Maintain and expand state MCH data capacity, to include ongoing needs assessment activities, program evaluation, and modernized data visualization and integration.	Sustain state maternal mortality and child fatality review programs, engaging with cross-sector partners and addressing social determinants of health in development of MMRT and CFRT recommendations Create and implement a system through which data from existing BabyCare programs is synthesized and utilized for data-driven decision making and program strengthening	Decrease the disparity in Black-White infant mortality ratio from 2.0 (2019) to 1.2 (2025)			SOM 1: Infant Mortality Disparity: Black/White Infant Mortality Ratio
Upstream / Cross-Sector Strategic Planning: Eliminate health inequities arising from social, political,	Coordinate and expand Five-Star Breastfeeding-Friendly Hospital Recognition Program Local Health District (LHD) strategy: Identify the LHD capacity to successfully implement 10 Steps to Breastfeeding-Friendly Health Department	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	NPM 4: A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	ESM 4.1: Development of a coordinated action plan of gap-filling activities for breastfeeding programming across VDH divisions	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: Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

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economic, and environmental conditions through strategic, nontraditional partnerships.					
Mental Health: Promote mental health across MCH populations, to include reducing suicide and substance use.	Develop, coordinate, and implement an action plan for substance exposed infants based on the 2020 Report to the General Assembly Develop perinatal cannabis resources at the state level Continue implementation and analysis of PRAMS supplement on perinatal cannabis use	By 2025, reduce the rate of infants born with Neonatal Abstinence Syndrome (NAS) from 5.9 (2020) to 5.6 (2025) per 1,000 birth hospitalizations	SPM 6: Promotion and strengthening of optimal mental/behavioral health and well-being through partnerships and programs		
Child Health					
Finances as a Root Cause: Increase the financial agency and well-being of MCH populations.	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 Work in tandem with interagency teams focused on the intersection between child health and transportation	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	NPM 7.1: Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9	***Inactive -*** *ESM 7.1.1: Number of maternity centers disseminated Virginia's injury prevention curriculum* ESM 7.1.2: Number of child safety seats disseminated through the LISSDEP network ESM 7.1.3: Percentage of stakeholders that disseminated Virginia's injury prevention curriculum with fidelity	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
Strong	Support the development of high functioning community/regional	By June 30, 2025, increase the	NPM 6: Percent of	ESM 6.1: Number of	NOM 13: Percent of children

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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).	partnerships led by 6 Smart Beginnings 'Hubs' that coordinate and improve local developmental screening and referral systems improvements	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%	children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	LHDs, community partners, and providers receiving developmental screening resources, training, or TA	meeting the criteria developed for school readiness (DEVELOPMENTAL) NOM 19: Percent of children, ages 0 through 17, in excellent or very good health
Oral Health: Maintain and expand access to oral health services across MCH populations.	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 regional Oral Health Alliances to foster regional efforts and initiatives throughout the Commonwealth 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 ages 1-17 Convene statewide groups focused on targeted oral health issues and facilitate collaboration and work plan development, and provide leadership and oversight to guide initiatives	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%	NPM 13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	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)	NOM 14: Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year 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 19: Percent of children, ages 0 through 17, in excellent or very good health
Adolescent Health					
Reproductive Justice & Support: Promote	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,	By 2025, reduce the rate of mistimed pregnancies from 25.3% (PRAMS 2018) to 21.8% by 2025	SPM 4: Pregnancy Intention: Mistimed or Unwanted pregnancy (wanted to become		

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equitable access to choice-centered reproduction-related services, including sex education, family planning, fertility/grief support, and parenting support.	and required Assure Resource Mothers staff are trained in the Growing Great Kids curriculum, a skills-driven program designed to promote healthy child development and strengthen protective factors for families in a home visiting setting, and increase capacity of youth-serving agencies to implement AIM4TM, an evidence-based pregnancy prevention program designed for parenting teens Local Health District (LHD) Strategy: Conduct community/environmental scan and gap analysis regarding adolescent reproductive health – assessing community, public and private partners that provide outreach, education, and appropriate reproductive health services to adolescents.		pregnant later or never)		
Mental Health: Promote mental health across MCH populations, to include reducing suicide and substance use.	Provide suicide prevention trainings to professionals interacting with youth and adolescents	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	NPM 7.2: Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19	ESM 7.2.1: Number of gatekeepers trained in the prevention of suicide among youth	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
Strong Systems of Care for All Children: Strengthen the continuum supporting physical/socio-emotional	Provide resources and professional development opportunities to school nurses Maintain data capacity for school health immunization data	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%	NPM 12: Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care	ESM 12.1: Number of providers in Virginia who have completed the transition training module. ESM 12.2: Percentage of Virginia school	NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

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development (i.e. screening, assessment, referral, follow-up, coordinated community-based care).				divisions reporting into the VDOE school health data system	
Oral Health: Maintain and expand access to oral health services across MCH populations.	Continue cross collaboration with school-based oral health programs	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%	NPM 13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	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)	NOM 14: Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year 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 19: Percent of children, ages 0 through 17, in excellent or very good health
Children with Special Health Care Needs					
Strong Systems of Care for All Children: Strengthen the continuum supporting physical/socio-emotional development (i.e. screening, assessment, referral,	Seek new partners to promote the UVA/VDH collaborative online training module for healthcare providers and families regarding comprehensive care approach to the provision of a medical home for children (including (CYSHCN) Assure children with special health care needs receive coordinated, ongoing, comprehensive care within a medical home (CYSHCN National Standard: Medical Home)	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 50.6%	NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	ESM 11.1: Number of providers in Virginia who have completed the medical home training module ESM 11.2: Percentage of children served by the VA CYSHCN Program who report having a medical home	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

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follow-up, coordinated community-based care).					NOM 25: Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year
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).	Seek new partners and continue to promote the online training modules for healthcare providers and families to educate them on the importance of healthcare transition (including those with special health care needs) 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) Utilize Division of Population Health Data epidemiologists and state family delegate to administer transition survey statewide (Standard: Got Transition's Six Core Elements of Health Care Transition - Transition Completion & Youth and Family Engagement) - COMPLETED	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%	NPM 12: Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care	ESM 12.1: Number of providers in Virginia who have completed the transition training module. ESM 12.2: Percentage of Virginia school divisions reporting into the VDOE school health data system	NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
Finances as a Root Cause: Increase the financial agency and well-being of MCH populations.	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) 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)	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%	NPM 15: Percent of children, ages 0 through 17, who are continuously and adequately insured	***Inactive -*** *ESM 15.1: Number of Managed Care Organizations (MCO) and Care Connection for Children (CCC) Care Coordinators that attend statewide meeting* ***Inactive -*** *ESM 15.2: Number of Managed Care Organization (MCO) and Care Connection for*	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

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				Children (CCC) regions that commit to partnering with each other to reduce barriers ESM 15.3: Increase percentage of uninsured children served by Child Development Clinics (CDCs) who are referred to Medicaid (if eligible) and/or other financial resources	NOM 22.1: Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months 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 unable to obtain needed health care in the past year
Community, Family, & Youth Leadership: Provide dedicated space, technical assistance, and financial	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 CYSHCN and their families (CYSHCN National Standard: Easy to Use Services and Supports/Care Coordination)	Support and document family engagement in 100% of CYSHCN programs (i.e., Care Connection for Children, Child Development Centers, Bleeding Disorders Program, Sickle Cell Program) annually	SPM 5: Cross-Cutting (Family Leadership): Percentage of VDH CYSHCN programs that annually demonstrate active incorporation of family engagement (i.e., Care Connection for Children,		

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resources to advance community leadership in state and local maternal and child health initiatives.			Child Development Centers, Bleeding Disorders Program, Sickle Cell Program)		
Cross-Cutting/Systems Building					
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.	Expand Youth Advisor role, providing expertise, guidance and feedback on current and future public health initiatives across all MCH populations Fund, develop, and establish regional Youth Advisory Councils with representation cross the Commonwealth Finalize an equitable family engagement definition and framework, and create a state performance measure that directly measures the percent of family engagement in decision-making across VA's Title V programs	By 2025, 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 2: Cross-Cutting (Youth Leadership): Develop and sustain the Virginia Department of Health Youth Advisor Program		
Racism: Explore and eliminate drivers of structural and institutional racism within OFHS programs, policies, and practices to	Engage with Urban Baby Beginnings in AMCHPS' Healthy Beginnings with Title V: Advancing Anti-Racism in Preterm Birth Prevention Learning and Practice Cohort Partner with Blue Ridge Health District and Birth Sisters of Charlottesville in CityMatCH Alignment for Action Learning Collaborative Increase opportunities for workforce development for local health districts to align with MCH leadership competencies Create a workgroup across OFHS to revise the 2021 Maternal Health	By 2025, provide dedicated space, technical assistance, and learning opportunities that advance racial equity across MCH workforce	SPM 3: MCH Workforce Development (Racial Equity): Provide dedicated space, technical assistance, and learning opportunities that advance racial equity among MCH workforce.		

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improve maternal and child health.	Strategic Plan				
MCH Data Capacity: Maintain and expand state MCH data capacity, to include ongoing needs assessment activities, program evaluation, and modernized data visualization and integration.	Maintain the VaCARES Registry and expand capacity to document and track referrals of infants from the Newborn Screening Program to CYSHCN programs Partner with NYMAC (New York - Mid-Atlantic Regional Genetics Network) to assess and respond to state needs related to genetic services	Maintain 100% referral rate, and improve/streamline processes by which all infants with confirmed newborn screening disorders are referred to CYSHCN care coordination services	SPM 1: Cross-Cutting (Early and Continuous Screening): Percent of infants diagnosed with a newborn screening disorder who are referred to care coordination services in the CYSHCN program		
Upstream / Cross-Sector Strategic Planning: Eliminate health inequities arising from social, political, economic, and environmental conditions through strategic, nontraditional partnerships.	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	Maintain 100% Referral rate and improve/streamline processes by which all infants with confirmed newborn screening disorders are referred to CYSHCN care coordination services	SPM 1: Cross-Cutting (Early and Continuous Screening): Percent of infants diagnosed with a newborn screening disorder who are referred to care coordination services in the CYSHCN program		