Virginia State Action Plan Table 2025 Application/2023 Annual Report

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance 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.	By 2025, decrease the disparity in Black-White maternal mortality disparity ratio from 2.1 (2017) to 1.23 (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 Partnership with CDC Innovative Cardiovascular Health Initiative grantees to implement evidence-based strategies to improve cardiovascular health in pregnant and postpartum women			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	By 2025, reduce the rate of mistimed pregnancies from 25.3% (PRAMS 2018) to 21.8%	Work with stakeholders to remove policy, financial, and training barriers to contraceptive access		SPM 4: Pregnancy Intention: Mistimed or Unwanted pregnancy (wanted to become pregnant later or never)	

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parenting support.					
MCH Data Capacity: Maintain and expand state MCH data capacity, to include ongoing needs assessment activities, program evaluation, and modernized data visualization and integration.	By 2025, decrease the disparity in Black-White maternal mortality ratio from 2.1 (2017) to 1.23 (2025)	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 Reconvene Maternal Health Data and Quality Measures Task Force as mandated by HB2111 to evaluate maternal health data collection processes - completed			SOM 2: Maternal Mortality Disparity: Black/White Maternal Mortality Ratio
Oral Health: Maintain and expand access to oral health services across MCH populations.	By 2025, increase the percent of women who had a dental visit during pregnancy from 49.9% (PRAMS 2018) to 52.4%	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	ESM PDV-Pregnancy.1 - Number of Regional Oral Health Collaborative Projects that implemented work plans to increase dental visits among pregnant women	NPM - Percent of women who had a dental visit during pregnancy (Preventive Dental Visit - Pregnancy, Formerly NPM 13.1) - PDV-Pregnancy	NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS
Mental Health: Promote	By 2025, reduce the percent of women who reported loss of	Explore opportunities for providing support to families seeking fertility services and families experiencing miscarriage		SPM 6: Promotion and strengthening of optimal	

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mental health across MCH populations, to include reducing suicide and substance use.	interest or feeling depressed (post-partum depression) from 14.43% (PRAMS 2019) to 13.71%	Local Health District (LHD): Strengthen early identification, supports, and referrals for women's mental and behavioral health needs Update he maternal guidelines for VDH's five prenatal care clinics to include guidelines on maternal substance use and maternal mental health		mental/behavioral health and well-being through partnerships and programs	
MCH Data Capacity: Maintain and expand state MCH data capacity, to include ongoing needs assessment activities, program evaluation, and modernized data visualization and integration.	Strengthen data partnership with state Medicaid agency to develop shared strategies to advance utilization of one-year postpartum benefit	Hold monthly meetings between Title V and DMAS to identify common areas of focus and health quality metrics around postpartum care	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.
Perinatal/Infant Health					
Maternal and Infant Mortality Disparity: Eliminate the racial disparity in maternal and infant mortality rates by 2025.	Decrease the Black/White infant mortality ratio from 2.0 to 1.0 by June 30, 2025	Develop and mobilize strong interagency, multisector, and community partnerships to address infant mortality due to preventable injury Local Health Districts (LHD): Develop, mobilize, and participate in strong interagency, multisector, and community partnerships to address disparities in maternal and infant mortality rates Participate in strong intra-agency partnership to address rising congenital syphilis rates in Virginia	ESM BF.1 - Development of a coordinated action plan of gap-filling activities for breastfeeding programming across VDH divisions	NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF	NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly

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					NOM 9.5) - IM-SUID
MCH Data Capacity: Maintain and expand state MCH data capacity, to include ongoing needs assessment activities, program evaluation, and modernized data visualization and integration.	Decrease the disparity in Black-White infant mortality ratio from 2.0 (2019) to 1.2 (2025)	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			SOM 1: Infant Mortality Disparity: Black/White Infant Mortality Ratio
Upstream / Cross-Sector Strategic Planning: Eliminate health inequities arising from social, political, economic, and environmental conditions through strategic, nontraditional partnerships.	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	Coordinate and expand Five-Star Breastfeeding-Friendly Hospital Recognition Program Local Health Districts: Identify the LHD capacity to successfully implement 10 steps to Breastfeeding Friendly Health Department Support Nurture RVA's development of an Online Birth and Early Parenting Resource Directory	ESM BF.1 - Development of a coordinated action plan of gap-filling activities for breastfeeding programming across VDH divisions	NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF	NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID
Mental Health: Promote mental health	By 2025, reduce the rate of infants born with Neonatal Abstinence Syndrome (NAS) from 5.9 (2020)	Develop, coordinate, and implement an action plan for substance exposed infants based on the 2020 Report to the General Assembly		SPM 6: Promotion and strengthening of optimal mental/behavioral health	

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across MCH populations, to include reducing suicide and substance use.	to 5.6 (2025) per 1,000 birth hospitalizations	Develop resources at the state level related to perinatal substance use Continue implementation and analysis of PRAMS supplement on perinatal cannabis use Formalize Cumberland Plateau Perinatal Rural Health Network		and well-being through partnerships and programs	
Child Health					
Finances as a Root Cause: Increase the financial agency and well-being of MCH populations.	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	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	***Inactive -*** *ESM IH-Child.1 - Number of maternity centers disseminated Virginia's injury prevention curriculum* ESM IH-Child.2 - Number of child safety seats disseminated through the LISSDEP network ESM IH-Child.3 - Percentage of stakeholders that disseminated Virginia's injury prevention curriculum with fidelity	NPM - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9 (Injury Hospitalization - Child, Formerly NPM 7.1) - IH-Child	NOM - Child Mortality rate, ages 1 through 9, per 100,000 (Child Mortality, Formerly NOM 15) - CM NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide
Strong Systems of Care for All Children: Strengthen the continuum supporting physical/socio-emotional development	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%	Support the development of high functioning community/regional partnerships led by 6 Smart Beginnings 'Hubs' that coordinate and improve local developmental screening and referral systems improvements	ESM DS.1 - Number of LHDs, community partners, and providers receiving developmental screening resources, training, or TA	NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (Developmental Screening, Formerly NPM 6) - DS	NOM - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

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(i.e. screening, assessment, referral, follow-up, coordinated community-based care).					
Oral Health: Maintain and expand access to oral health services across MCH populations.	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%	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	ESM PDV-Child.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 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child	NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS
Strong Systems of Care for All Children: Strengthen the continuum supporting physical/socio-emotional development (i.e. screening, assessment,	Increase the number of children without special health care needs, ages 0 through 17, who have a medical home	Utilize 5-year Needs Assessment to explore medical home strategies and coordinate with statewide partners to implement	ESM MH.1 - Number of providers in Virginia who have completed the medical home training module ESM MH.2 - Percentage of children served by the VA CYSHCN Program who report having a medical home	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX

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referral, follow-up, coordinated community-based care).					NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC
Adolescent Health					
Reproductive Justice & Support: Promote equitable access to choice-centered reproduction-related services, including sex education, family planning, fertility/grief support, and parenting support.	By 2025, reduce the rate of mistimed pregnancies from 25.3% (PRAMS 2018) to 21.8% by 2025	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 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.		SPM 4: Pregnancy Intention: Mistimed or Unwanted pregnancy (wanted to become pregnant later or never)	
Mental Health: Promote mental health across MCH populations, to include	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	Provide suicide prevention trainings to professionals interacting with youth and adolescents	ESM IH-Adolescent.1 - Number of gatekeepers trained in the prevention of suicide among youth	NPM - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19 (Injury Hospitalization -	NOM - Child Mortality rate, ages 1 through 9, per 100,000 (Child Mortality, Formerly NOM 15) - CM NOM - Adolescent mortality rate ages 10 through 19, per 100,000

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reducing suicide and substance use.				Adolescent, Formerly NPM 7.2) - IH-Adolescent	(Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide
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).	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%	Provide resources and professional development opportunities to school nurses Maintain data capacity for school health immunization data	ESM TR.1 - Number of providers in Virginia who have completed the transition training module. ESM TR.2 - Percentage of Virginia school divisions reporting into the VDOE school health data system	NPM - 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 (Transition, Formerly NPM 12) - TR	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC
Oral Health: Maintain and expand access to oral health services across MCH populations.	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%	Continue cross collaboration with school-based oral health programs	ESM PDV-Child.1 - Number of Regional Oral Health Collaborative Projects that implemented work plans to increase dental visits among	NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child	NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC NOM - Percent of children with

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			children (ages 0-11 years) and adolescents (ages 12-17 years)		special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS
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, follow-up, coordinated community-based care).	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%	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)	ESM MH.1 - Number of providers in Virginia who have completed the medical home training module ESM MH.2 - Percentage of children served by the VA CYSHCN Program who report having a medical home	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC
Strong Systems of	By June 30, 2025, increase the proportion of adolescents with	Seek new partners and continue to promote the online training modules for healthcare providers and families to educate them on the importance of	ESM TR.1 - Number of providers in	NPM - Percent of adolescents with and	NOM - Percent of children with special health care needs

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Care for All Children: Strengthen the continuum supporting physical/socio-emotional development (i.e. screening, assessment, referral, follow-up, coordinated community-based care).	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%	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	Virginia who have completed the transition training module. ESM TR.2 - Percentage of Virginia school divisions reporting into the VDOE school health data system	without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR	(CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC
Finances as a Root Cause: Increase the financial agency and well-being of MCH populations.	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%	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)	***Inactive -*** *ESM AI.1 - Number of Managed Care Organizations (MCO) and Care Connection for Children (CCC) Care Coordinators that attend statewide meeting* ***Inactive -*** *ESM AI.2 - Number of Managed Care Organization (MCO) and Care Connection for Children (CCC) regions that commit to partnering with each other to reduce barriers* ESM AI.3 - Increase	NPM - Percent of children, ages 0 through 17, who are continuously and adequately insured (Adequate Insurance, Formerly NPM 15) - AI	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by

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			percentage of uninsured children served by Child Development Clinics (CDCs) who are referred to Medicaid (if eligible) and/or other financial resources		age 24 months (Childhood Vaccination, Formerly NOM 22.1) - VAX-Child NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC
Community, Family, & Youth Leadership:	Support and document family engagement in 100% of CYSHCN programs (i.e., Care Connection	Through the CYSHCN network, facilitate access to comprehensive medical and support services that are collaborative, family-centered, culturally competent, fiscally responsible, community-based, coordinated,		SPM 5: Cross-Cutting (Family Leadership): Percentage	

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Provide dedicated space, technical assistance, and financial resources to advance community leadership in state and local maternal and child health initiatives.	for Children, Child Development Centers, Bleeding Disorders Program, Sickle Cell Program) annually	and outcome-oriented to CYSHCN and their families (CYSHCN National Standard: Easy to Use Services and Supports/Care Coordination)		of VDH CYSHCN programs that annually demonstrate active incorporation of family engagement (i.e., Care Connection for Children, 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.	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	Maintain paid Youth Advisor roles at VDH to provide expertise, guidance, and feedback on current and future public health initiatives across all MCH populations; fund a statewide Youth Advisory Council (YAC) that incorporates diverse youth voices into public health in Virginia 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		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	By 2025, provide dedicated space, technical assistance, and learning opportunities that advance racial equity across MCH workforce	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		SPM 3: MCH Workforce Development (Racial Equity): Provide dedicated space, technical assistance, and learning	

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institutional racism within OFHS programs, policies, and practices to improve maternal and child health.		in CityMatCH Alignment for Action Learning Collaborative Local Health District (LHD) Strategy: Increase opportunities for workforce development for LHDs to align with MCH leadership competencies Create a workgroup across OFHS to revise the 2021 Maternal Health Strategic Plan		opportunities that advance racial equity among MCH workforce.	
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 100% referral rate, and improve/streamline processes by which all infants with confirmed newborn screening disorders are referred to CYSHCN care coordination services	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		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	Maintain 100% Referral rate and improve/streamline processes by which all infants with confirmed newborn screening disorders are referred to CYSHCN care coordination services	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		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	

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conditions through strategic, nontraditional partnerships.					