Vermont 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					
Ensure optimal health prior to pregnancy	By the end of 2025, increase to 90% the percentage of women that advised by a healthcare worker to abstain from alcohol during pregnancy. By late 2023, outreach to 100% of prenatal and pediatric providers regarding the risks of alcohol use during pregnancy (if COVID-19 allows). Beginning in late 2022, annually outreach to 75% of pregnant women, and their circles of care, the risks of alcohol use during pregnancy (due to COVID-19, this work may not reach 75%, but we are keeping it as a goal).	1. Implement new social marketing campaign (“One More Conversation”) to communicate risks of substance use during pregnancy, targeted to health care professionals, pregnant women, and circles of supports (partners, families, friends) that is informed by the data and a formative research report that was part of the first phase of this project. 2. Collaborate with the Vermont Blueprint for Health on the Women’s Health Initiative and reproductive health and family planning providers to support women’s health specialty practices to communicate risks of alcohol, smoking or vaping tobacco and cannabis use in pregnancy, and conduct IPV screening and contraceptive counseling. 3. Expand the use of One Key Question to promote pregnancy intention screening in primary care and targeted preconception and family planning counseling. 4. Identify and develop promotional and educational tools and materials on preconception health for the: a) VDH website; b) distribution to health care providers and community partners; and c) distribution to the general public. 5. Work collaboratively with WIC, nurse home visiting (Strong Families Vermont), and other home visiting programs and families to ensure preconception health planning and communicate risks of alcohol use and other substance use in pregnancy with clients.		SPM 3: Percent of Women advised by a healthcare worker to abstain from alcohol during pregnancy	
Reduce the risk of chronic disease across the lifespan	By 2023, increase the percentage of pregnant women who contact 802Quits (or other cessation resources) by 25% By 2023, increase the percentage of families with young children	1. Implement new social marketing campaign (“One More Conversation”) to communicate risks of substance use during pregnancy, targeted to health care professionals, pregnant women, and circles of supports (partners, families, friends). 2. Collaborate with Medicaid to promote billing among pediatricians and Ob/Gyns for cessation counseling.	ESM SMK-Pregnancy.1 - % of pregnant smokers who register with the QuitLine or QuitOnline	NPM - Percent of women who smoke during pregnancy (Smoking - Pregnancy, Formerly NPM 14.1) - SMK-Pregnancy	NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM NOM - Maternal mortality rate

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	who contact 802Quits (or other cessation resources) by 25%	3. Work with local WIC offices and home visiting programs to ensure all clients have access to smoking cessation resources/ referrals (802Quits Network): a) Educational and promotional materials for all WIC clients; b) Regular chart audits of WIC clients to assure appropriate referral and follow-up. 4. Support outreach/ promotion of 802Quits with medical/ social service community: a) Regional MCH coalitions promote messaging around the risks of smoking in pregnancy and cessation resources; b) MCH Coordinators in local district offices round at local birth hospitals to identify patients who smoke and provide resource and referral; c) MCH Coordinators in local district offices share 802Quits outreach materials with partners. 5. Digital promotion of 802Quits pregnancy protocol (incentive payments, increased access to NRT, uncapped counseling sessions) 6. Work collaboratively with the Vermont chapter of ACOG to strengthen its membership and provide training and organizational support to ensure key public health messaging/ content is integrated into clinical services 7. Work with the Title X family planning network to support and strengthen referrals to 802Quits, and promote messaging around the risks of smoking in pregnancy and cessation resources as part of their preconception health counselling and Reproductive Life Planning efforts			per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality,

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					Formerly NOM 9.4) - IM-Preterm Related NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS
Ensure optimal health prior to pregnancy	Over the next five years increase the percentage of postpartum women who attended a postpartum check by 12 weeks by 3.3% overall, with tailored supports given to subpopulations with rates lower than the statewide average. And to increase the percentage of postpartum women who receive both care components during the visit by 4.1% overall, with tailored supports given to subpopulations with rates lower than the statewide average.	Assess the current landscape related to postpartum visits data to understand when the visits are occurring over the 12 week period and to disaggregate the data to look for gaps among sub-populations. Collaborate with our community providers and other AHS agencies to train the workforce on best contraceptive counseling practices using an evidence based model such as Patient Centered Counseling, or One Key Question. Expand the DULCE program into more medical homes.	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					
Promote optimal infant health and development	By 2024, increase the number of designated “Breastfeeding Friendly Employers” by 10% By 2024, increase the percentage of WIC recipients who utilize a peer counselor by 10% By the end of 2023, develop local	1. Continue to convene and improve Vermont’s Perinatal Quality Collaborative (PQC-VT), including new QI project on birth certificate quality 2. Implement Vermont’s Breastfeeding Strategic Plan and local action plans, developed pre-COVID 3. Promote “Baby Friendly” hospital initiative and Vermont 10-Steps approach to improve maternity care practices in support of breastfeeding	ESM BF.1 - % of 10 Step compliant or designated Baby-friendly hospitals	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

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	level breastfeeding implementation plans informed by state-level strategic plan By 2024, implement 50% of strategic priorities identified in breastfeeding strategic planning process.	4. Provide electric breast pumps to eligible WIC participants who are separated from their baby or working to increase milk production and not receiving Medicaid pump. 5. Coordinate training opportunities with the Vermont Lactation Consultants Association (VLCA), Home Health Agencies, Parent-Child Centers, Children's Integrated Services, Strong Families Vermont (home visiting), Help Me Grow, Head Start, EFNEP, AAP VT Chapter, medical care providers, and non-traditional partners (such as Recovery Coaches and informal peer networks). 6. Maintain the statewide breastfeeding peer counseling program. Maintain bi-lingual peer counselors who speak languages that are currently dominant in our communities. 7. Continue to promote awareness of Vermont breastfeeding laws and the breastfeeding provisions of the Affordable Care Act. 8. Conduct public health “detail visits” to OB, Pediatric, and Family Practice provider offices to strengthen the collaboration between WIC and health care providers with the goal of increasing rates of exclusive breastfeeding. 9. Promote and support community-clinical linkages to increase professional and peer support and care coordination. 10. Offer breastfeeding education to early childhood educators through professional development training opportunities and embed breastfeeding education and support in VT’s Quality Improvement and Rating System (QRIS).			NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID
Child Health					
Achieve a comprehensive, coordinated, and integrated state and community system of	By 2024, increase the percentage of pediatric, family practice, human service providers, and early educator trained in valid developmental and social/emotional screening tools to 20%	1. Promote and offer developmental monitoring and screening via Help Me Grow (HMG) Vermont – a comprehensive system that ensures that early detection of developmental and behavioral concerns leads to the connection of young children and their families to community-based services and medical homes: a) Host the Ages and Stages Questionnaires (ASQ) Enterprise Online System for families and providers to access screening tools at HelpMeGrowVT.org; b) Integrate HMG’s ASQ Enterprise Online system with	ESM DS.1 - Number of providers trained in developmental surveillance and screening	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	NOM - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR

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services for children	By 2024, increase the number of families who access a centralized resource hub (HMG/ Vermont 2-1-1) by 20% By 2024, increase HMG calls and referrals from providers by 20% By 2024, increase HMG follow up to families to ensure successful connection by 20%	the Universal Developmental Screening Registry (USDR); c) Embed developmental monitoring tools, as a complement to screening, in early childhood settings and medical homes (e.g. CDC's Act Early program materials, Bright Futures) 2. Offer trainings and activities for families and providers to increase their understanding of early child development, including social and emotional development, to address disparities, promote equity, and strengthen families: a) Ensure family engagement and ongoing family and consumer partnership; b) Offer Touchpoints training to pediatric health care providers and OBGYNs; c) Embed CDC's LTSAE tools and resources in OBGYN practices 3. Train providers to conduct developmental monitoring and screening and to use HMG's ASQ Online system, which will be integrated with Vermont's developmental screening registry, to ensure each child reaches their full potential: a) Train providers to use HMG's ASQ online system; b) Strengthen partnerships with Vermont's ACOs to leverage opportunities to focus on improving developmental screening rates; c) Create networking opportunities for providers from different sectors to align cross-sector Child Find efforts, improve access, and better support children and families; d) Scale up and spread ongoing training, individual TA, and coaching on developmental and social determinant screening for early childhood professionals across sectors (e.g. training with community of practice/coaching component). Offer VT Northern Lights professional development CEUs for early educators. 4. Ensure communities are fully plugged into a reliable grid of resources — including elements such as quality early care and learning opportunities, healthy food, and supportive relationships – to ensure that all children have what they need to thrive: a) Strengthen the resource grid by plugging families and communities into mental health supports and services including perinatal mood and anxiety disorders and trauma; b) Continue to update the list of mental health providers with expertise in perinatal mood and anxiety disorders and trauma treatment 5. Deliver care coordination and follow-up for families accessing the HMG resource hub to ensure young children get connected to the services they need at an early age when the benefit is greatest		Screening, Formerly NPM 6) - DS	NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS
Reduce the risk	By 2024, outreach to 50% of WIC	1. Fund (in part) the Physical Activity and Nutrition Director in the Health	ESM PA-Child.1 -	NPM - Percent of	NOM - Percent of children, ages

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of chronic disease across the lifespan	families with FitWIC physical activity and nutrition material Increase the number of classrooms or schools that sign on to 3-4-50, including a commitment to daily recess by 50% by 2024	Department's chronic disease division to provide leadership in this area. 2. Broadly promote the 3-4-50 initiative to early care and learning settings and schools to promote physical activity within the context of the school day and to parents and communities beyond the school day 3. Offer bonuses in our early care and learning quality rating system: Step Ahead Recognition System (STARS) for nutrition and physical activity 4. Working with Vermont's early care professional development system (Northern Lights at the Community College of Vermont) to increase professional development opportunities in physical activity and nutrition for early care and learning providers 5. Broadly promote the use of Vermont's FitWIC: materials for parents and their preschoolers. FitWIC Activities will help foster child health and development through active physical play: http://www.healthvermont.gov/sites/default/files/documents/2016/11/cyf_FitWIC-Activity-Book.pdf 6. Provide increase parent education through provider offices about the importance of physical activities in schools and how to advocate for that or how to find out what is already happening in schools 7. Increase distribution of AAP policy statement Crucial Role of Recess http://pediatrics.aappublications.org/content/131/1/183	Number of classrooms or schools that sign on to 3-4-50, including a commitment to daily recess	children, ages 6 through 11, who are physically active at least 60 minutes per day (Physical Activity, Formerly NPM 8.1) - PA-Child	0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS
Reduce the risk of chronic disease across the lifespan	By 2024 increase the percentage of children who access preventive oral health care in the past year.	1. Fund (in part) the role of the Oral Health Director in the Health Department's chronic disease division to provide oral health planning and programming related to pregnant women and children 2. MCH staff and the Oral Health Director will work with Communications and VT Oral Health Advisory Panel members to promote the implementation of Vermont's oral health periodicity schedule: current best practice guidance to pediatricians, family medicine providers, dentists, and families 3. MCH Coordinators work in tandem with co-located public health dental hygienists to assess dental health landscape and share resource availability with health care and community partners	ESM PDV-Child.1 - # of students participating in Vermont's 802Smiles Network of School Dental Health Programs receiving oral health services	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

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		4. Public health dental hygienists (PHDH) provide oral health assessment, fluoride varnish and silver diamine fluoride application, education & information to families enrolled in WIC 5. To increase the uptake of dental visits among pregnant women and young children, MCH Coordinators and PHDHs partner at the District office level provide outreach to: a) Ob/Gyns regarding: a) the expanded Medicaid benefit for pregnant women; b) Bright Futures guidelines; b) Dentists regarding a) evidence-based oral health practice; b) support for seeing patients beginning at age 1; c) Pediatricians regarding: a) oral health education and referral to a dental home; and b) fluoride varnish 6. MCH leadership serves on the statewide oral health advisory panel 7. Regional MCH coalitions promote oral health messaging 8. Work collaboratively with the Vermont chapter of ACOG to strengthen its membership and provide training and organizational support to ensure key public health messaging/ content is integrated into clinical services 9. Work collaboratively with the Chronic Disease and Disability Advisory Group to promote access to preventive oral health care for VT children with intellectual disabilities. 10. Provide oversight to the 802Smiles Network of school dental health programs in participating schools to help to ensure that every child has access to preventive, restorative and continuous care in a dental office 11. MCH leadership serves on the 802Smiles Network of school dental health programs Planning Committee, which is dedicated to expanding the availability of school-based dental health services in VT			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
Promote protective factors and resiliency among Vermont's	By 2024, increase the percentage of families accessing HMG that received positive parenting information/resilience resources by 50%	1. Partner with Agency of Human Services Trauma Prevention and Resilience Director and serve on agency-wide steering committee to help set priorities and identify and plan activities related to workforce development needs across the Agency 2. Incorporate the Strengthening Families Framework and Youth Thrive into all		SPM 1: % of children 6 month to 5 years who meet all 4 flourishing items	

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families		relevant work, with an emphasis on preventing and mitigating the impact of toxic stress 3. Enhance utilization of HMG VT by providers and consumers/caregivers: a) Evaluate the impact of HMG VT by asking protective factors survey questions to understand the extent to which the system is strengthening families and enhancing protective factors; b) Promote the protective factors to parents and professionals via HelpMeGrowVT.org and Facebook@helpmegrowvt 4. Domestic and sexual violence prevention activities: a) Continue Healthy Moms, Happy Babies evidence-based training on domestic violence and home visiting; b) MCH Coordinators in local district offices participate in local domestic/ sexual violence community response and/or prevention teams; c) MCH leadership participates on the statewide Domestic Violence Fatality Review Commission; d) MCH leadership participates in the Blueprint for Health's Women's Health Initiative and advises on domestic violence screening, referral and response and other key content areas related to family planning, and preconception health; e) Domestic and sexual violence surveillance through incorporation of questions into BRFSS 5. Educate providers and community partners on the impact of Adverse Childhood Experiences and mitigating strategies: a) Present epidemiological data to a variety of professional audiences on ACEs; b) Participate in state and local community planning sessions to address trauma in health care, schools, and communities 6. Continue to provide leadership and technical assistance around COVID recovery and pandemic-related mental health concerns among children and families, in partnership with child care, schools, and out-of-school programming.			
Achieve a comprehensive, coordinated, and integrated state and community system of services for	Over the next 5-years, increase the percentage of children with a medical home by 6.1%.	Offer an integrated system of care for children and their families, through partnerships with Help Me Grow, our F2F Vermont Family Network (VFN) and our offices of local health through the work of Family and Child Health Coordinators (FCHCs). Offer a centralized, coordinated information and referral system (CIRS) via Help Me Grow Vermont (HMGVT) to ensure the connection of young children and their families to community-based services and medical homes, with care coordination and follow-up for families. Care coordination with medical homes and community-based services for children	ESM MH.1 - % of families in CSHN's Medicaid Programs supported to access a Medical Home and/or Care Coordination when indicated through	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	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.

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children		with medical complexity, in partnership with VFN. FCHCs will work with families to connect them to a medical home and additional support services such as WIC within their district.	programmatic outreach.		
Adolescent Health					
Youth choose healthy behaviors and thrive	By 2024, increase awareness among health care providers of the importance of annual preventive health visits for adolescents to 75% By 2024, increase awareness among parents/ caregivers and patients (adolescents) on the importance of preventive health visits for adolescents to 75% By 2024, increase access to preventive health visits in medical homes and school-based health centers by 20%	1. Continue to support Vermont RAYS, with the goal to actively engage adolescents and young adults in goals and strategies to create more youth-friendly services in the primary care sites, building opportunities for meaningful youth engagement, and elevating youth voices in MCH communications campaigns and outreach strategies. 2. Partner with practices to increase both access to and quality of well care visits for the adolescent and young adult. Identify local barriers to adolescent well-care visits and help identify and test new strategies to ameliorate these barriers, through TA and QI coaching provided by the VCHIP, Youth Health Improvement Initiative. 3. MCH Coordinators and school liaisons will promote Bright Futures 4th edition with health care providers and community partners (including public schools), including annual well care visits for all school-aged children and youth. Promotion may range from general awareness related activities such as ensuring providers and community partners are aware that Bright Futures is Vermont's EPSDT periodicity schedule, to topic specific initiative's such as promoting annual well care visits for adolescents, or universal developmental screening as recommended by Bright Futures. Promotion may include verbal communications, distributing specific written resources, describing initiatives, website updates, support for regional community meetings, etc. 4. Explore opportunities to further assess and convene school-based health centers in Vermont schools through a peer collaborative approach, and promote connections to medical homes, lessons learned, and shared performance measures 5. Fund a travel and committee work stipend for School Nurse participation in Vermont's School Nurse Advisory Committee whose primary role is to: a) review/ update the Standard of Practice: School Health Services manual; b) maintain and update the new school nurse orientation; c) Strengthen school nurse workforce development. Each of these items reflects Bright Futures,	***Inactive -*** *ESM AWV.1 - Number of public schools implementing the PATCH for Teens curriculum as part of their Health Education Curriculum* ESM AWV.2 - % of VT RAYS indicating they gained skills and feel empowered to address issues impacting their health care or the health care of their peers.	NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV	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 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

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		EPSDT administrative objectives, medical and dental home access, coordination with providers, and reducing barriers to accessing care 6. VDH School Liaisons and the Vermont Child Health Improvement Program will provide TA and strategies to school nurses to facilitate connections between schools and medical homes 7. Identify and develop communication materials and social media strategies for providers, parents/ care takers, and adolescents, to be used in tandem with EPSDT outreach and informing letters, school nurse materials, and patient handouts, as informed by our work on creating a multi-year EPSDT outreach and informing plan 8. Strengthen partnerships with Vermont's ACOs to leverage opportunities to focus on improving adolescent well-care visits 9. Maintain several new web pages promoting adolescent health, school health, the Whole School, Whole Community, Whole Child model, and Bright Futures, and more 10. Identify and work with key community partners that serve Vermont's New American population to identify outreach and engagement strategies to promote messaging around annual well-care visits and other child preventive health measures 11. Promote the PATCH for Teens Toolkit with Health Educators in public schools serving youth. 12. Support Adolescent Medicine Specialist to train and provide TA to youth serving community providers, school-based health educators, and health care practices related to adolescent sexual and reproductive health 13. Revisit our most recently updated sports clearance form and health information to reflect plain language, and be informed by youth which highlights the importance of annual well care visits 14. Leverage newly formed or reinvigorated relationships (established during the COVID-19 pandemic) between medical homes and School Nurses to			good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS 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 - Teen birth rate, ages 15

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		continue to improve communication, consultation, team-based care, and increase and improve access to preventive services			through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB
Youth choose healthy behaviors and thrive	By 2024, increase the number of middle and high schools participating in youth empowerment projects by 50% By 2024, increase the number of Vermont youth trained on M3 by 50% By 2024, increase the percent of youth that agree or disagree that in their community they feel they matter to people to 63%	1. Continue the highly successful "Getting to Y" program – “Getting to Y” is an opportunity for students to take a lead in bringing meaning to their own YRBS data, and take steps to strengthen their school and community based on their findings by addressing risks and promoting strengths 2. Provide training to school-based youth-adult teams on concrete tools to dispel the common myth that intelligence is fixed and how the brain processes information (Personal Power and Community Connections (P2C2)); schools receive ongoing coaching and support as they implement these training activities 3. Collaborate with VT Afterschool Inc. to support activities that enhance opportunities for positive youth development, leadership and youth voice, and training of afterschool professionals 4. Partner with the Governor’s team and state leadership around the expansion of equitable summer and afterschool opportunities (funded in part by regulated cannabis revenue) 5. Participate in the VT9to26 coalition and look for opportunities to promote MCH priority areas identified by our Adolescent Health Unit 6. Provide leadership to the Youth Systems Advisory Council, a statewide initiative to support collaboration and coordination across youth serving systems. 7. Provide leadership to the Youth Thrive Statewide Implementation Team, and promote Youth Thrive as a key framework to support positive youth development		SPM 2: % of adolescents that feel they matter to people in their community	
Children live in safe and supported communities	By 2024, increase the percentage of youth and adults screened for suicidality in the primary care setting by 25%	1. Participate on the Vermont Suicide Prevention Coalition and the Vermont Suicide Data Committee 2. In partnership with the Vermont Child Health Improvement Program, collect and report on quality improvement data from pediatric practices on depression screening		SPM 4: Percent of high school students who made a plan to attempt suicide in the past 12 months	

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		3. Promote suicide screening in primary care using the nationally recognized Zero Suicide approach 4. Continue to have MCH and DMH Leadership engaged for the AYA CoIIN for systems improvement in screening youth for depression and other factors that may lead to suicidality 5. Support presence of Umatter Youth and Young Adults Mental Health Wellness Promotion and community Action in 10 schools statewide 6. MCH Injury Prevention Coordinator participates on the VT Child Fatality Review Team and can use the reviews of youth suicide deaths to assess upstream prevention and include in formal recommendations in the annual legislative report 7. Develop a youth suicide prevention plan (as congruent with Title V MCH action planning) within the upcoming VT Injury Prevention plan that is being written using the newly released VT Injury Burden Document 8. Assess and act upon data analyses as produced by VDH injury data staff, NVDRS reporting, and ED-SNSRO surveillance of suicidality in emergency departments 9. Further develop and implement project with VCHIP on provider screening for youth suicide ideation, creating a plan, or suicide attempts 10. Develop working relationship with Department of Mental Health Child Adolescent and Family Unit to coordinate prevention approach with mental health community clinical treatment services. Incorporate stressors on youth from COVID-19			
Children with Special Health Care Needs					
Achieve a comprehensive, coordinated, and integrated state and community	Increase by 20% the percentage of children and youth with special health care needs receiving coordinated care By 2024, increase by 20% the	1. Lead efforts to improve and align delivery of care coordination for CYSHN in an evolving landscape with multiple sources of care coordination exist. Includes widespread stakeholder involvement, systems assessments, and presentation of findings to partners including leadership in VT Medicaid, OneCare VT, the Blueprint for Health.	***Inactive -*** *ESM TR.1 - % of CYSHN that have had a transition planning meeting by their 18th birthday*	NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the	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

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system of services for children	percentage of primary care practices that use the comprehensive, universal plan of care to share information and coordinate care with specialists and the entire care team By 2024, increase by 20% the percentage of primary care providers with proficiency to facilitate transitions from pediatric to adult care	2. Strengthen statewide efforts to improve collaborative approach to transitions through partnership with HireAbility VT, Vermont Family Network, and education partners. Includes supporting Transition Core Teams as well as organizing and funding trainings, conferences, and youth engagement activities, including a youth summit. 3. Expand use of homegrown Family Engagement toolkit to create authentic family partnerships with our programs to inform our work. 4. Partner with advocacy organizations and other state programs to address workforce issues, including the availability of nurses for technology dependent/medically complex and palliative care children, and direct care providers such as Personal Care Attendants. Includes working with Vermont Medicaid to implement innovative payment models and to identify policy opportunities, as well as work with various state partners to identify infrastructure investment opportunities, such as for workforce recruitment, retention, and training programs. 5. CSHN will maintain leadership role in new statewide Care Coordination Collaborative. Work will build on established relationships with medical homes, specialty clinics, hospitals, human services agencies, home health, early childhood providers, and families, to identify shared priority areas and promote high-quality service models, and shared improvement and evaluation strategies. CSHN will adapt and expand resources with consideration for regional differences, including rurality, cultural and linguistic differences, and other social determinants of health. 6. In consultative model with minimal instances of direct service care coordination, CSHN will provide resources, referrals, and provider education concerning the CYSCHN population, focused on anticipatory planning for adolescents: a) Collaboration with the Blueprint for Health (Vermont's medical home/ health reform initiative) to enhance care coordination in primary care; b) Represent CYSHN on regional Transition Core Teams that specialize in supporting youth in the area prepare and transition into adulthood; c) Provide leadership to Vermont pediatric practices through a care collaborative and train on strategies and tools for comprehensive and integrated care planning – using best practice; d) Promote the use of Bright Futures as Vermont's EPSDT periodicity schedule; e) Integrate use of new database and begin to	ESM TR.2 - # of families, transition-aged youth, and providers who participated in transition-focused trainings using established/high-quality/best- practice transition resources	transition to adult health care (Transition, Formerly NPM 12) - TR	17.2) - SOC

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
		map out reporting capabilities for a future release 7. Fund Vermont Family Network (VFN) to take the lead in the development and implementation of a multi-part webinar series addressing state-specific transition supports 8. Participate in division-wide assessment of cultural and linguistic competency and implement improvement recommendations.			
Achieve a comprehensive, coordinated, and integrated state and community system of services for children	To increase the number of children who have a medical home and who have public health insurance by 3.8% annually over the next five years.	Redesign application materials for Children's Personal Care Services to include a follow up and referral component, applying the 6 core elements of a well-functioning system of services. Follow up support provided by CPCS staff and CSHN Care Consultants will assist families to connect with medical homes, the transition to adulthood, access to needed resources in their regions, and referrals to various treatment and support services. Partner with Vermont Medicaid, the Vermont Child's Health Improvement Project, and other organizations to pursue systems improvement projects through policy initiatives, funding opportunities, and communities of practice.	ESM MH.1 - % of families in CSHN's Medicaid Programs supported to access a Medical Home and/or Care Coordination when indicated through programmatic outreach.	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	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.
Cross-Cutting/Systems Building					
Achieve a comprehensive, coordinated, and integrated state and community system of services for children	By 2024, 100% of MCH programs have family partnership across all levels of engagement By 2024, 75% of families in MCH programs who are satisfied with the services and programming	1. Continue long-standing partnership with Vermont Family Network 2. Assess needs and develop a new plan for family engagement work (due to contractor taking new position) 3. Convene advisory councils, including: CSHN, Hearing and Newborn Screening Advisory, ASD, mental health integration, and other state and local committees 4. Continue implementation of Family Leadership Series to successfully engage and sustain a strong group of passionate family leaders who are engaged in a variety of state boards and councils within the system of care for CYSHN 5. Support and partner with patient/family advisors and family partnership program at UVM Medical Center 6. Convene the Youth Health Advisory Council (YHAC)		SPM 5: Percent of MCH programs that partner with family members, youth, and/or community members	

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
		7. Provide leadership to the Youth Services Advisory Council (YSAC) 8. Include parent- and family-voice in all communications campaigns and outreach strategies			