Maternal and Child Health Services Title V Block Grant

Virginia

FY 2022 Application/ FY 2020 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

COMMONWEALTH of VIRGINIA
Department of Health

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RICHMOND, VA 23218

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August 27, 2021

Christopher Dykton, MA
Acting Director, Division of State and Community Health (DSCH)
Maternal Child Health Bureau (MCHB)
Health Resources and Services Administration (HRSA)
U.S. Department of Health and Human Services (DHHS)
5600 Fishers Lane, Rockville, MD 20857

Dear Mr. Dykton,

It is with pleasure that I submit the Virginia 2022 MCH Title V Block Grant application and 2020 Annual Report. The attached document provides a detailed report regarding the depth and breadth of Title V Funding utilization, and the funding impact on the lives of the women, infants, children, youth, and children with special healthcare needs in the Commonwealth.

We look forward to continued partnership.

Most sincerely,

Cynthia C. deSa

Cynthia C. deSa, MPH, MSW, LCSW
Maternal and Child Health Director-Title V Supervisor
Division of Child and Family Health
Virginia Department of Health
109 Governor Street, 9th Floor
Richmond, VA 23219

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2021 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: January 31, 2024.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

As the nation's oldest Federal-State partnership, the Title V Maternal and Child Health Services Block Grant aims to ensure the health and well-being of all mothers, children and families, including children and you with special healthcare needs (CYSHCN). Virginia's Title V Block Grant Application reflects the continued commitment to protect and promote the health and well-being of Virginian women, infants, children, youth and families. Virginia's Title V Leadership demonstrate subject matter expertise, individually and collectively across respective MCH domains, and approach programmatic collaboration through a community-based, family-centered, life-course framework.

WHO WE ARE: Virginia's Maternal and Child Health program is housed in the Virginia Department of Health (VDH), positioned within the Office of Family Health Services' Division of Child and Family Health. Title V Maternal and Child Health Services Block Grant collaborative leadership team includes:

Jennifer Macdonald, MPH, BSN, RN – Director, Division of Child Health Services
Meagan Robinson, Ph.D. – Director, Division of Population Health Data, Acting MCH Epidemiologist Lead
Cindy deSa, MPH, MSW, LCSW - Maternal and Child Health (MCH) and Title V Director
Marcus Allen, MPH - CSHCN Director
Dana Yarbrough, MS, MA – Virginia Title V Family Delegate
Toni Pintavalle, BS, MEd – Fiscal Grant Manager

WHAT WE DO: Title V serves as the foundational funding stream for state, regional and local MCH program, and is a critical public health infrastructure component. The Title V Team administers over 75 state programs and contracts across multiple statewide systems of services, including programs administered in local health districts, community collaborations and coalitions, and partnerships with other state and national organizations. Additionally, 15 state program managers, approximately 70 state-level staff and contractors and over 110 local health district staff are actively engaged in Title V-related efforts. Title V funding supports the delivery of clinical services and health education within each of Virginia's 35 local health districts (LHDs). Title V Leadership represents maternal and child health on state and local coalitions and collaboratives, partners with other state agencies such as Virginia's Department of Education (DOE), Department of Medical Assistant Services (DMAS), Department of Social Services (DSS), and Department of Behavioral Health Delivery Services (DBHDS). Federal partnerships and collaborations include, but not limited to: Title X, MIECHV, Healthy Start, Preventive Health and Health Services (PHHS) Block Grant.

Title V's scope includes (but is not limited to): newborn screening including early hearing detection/intervention, early childhood, including infant health and home visiting, reproductive health, developmental screening, school health, services for CYSHCN including care coordination, behavioral/development and insurance case management programs, injury prevention, dental health, maternal and infant mortality review, data/evaluation infrastructure.

HOW 2021-2025 PRIORITIES WERE DETERMINED: Virginia continuously assesses the needs of the maternal and child health population through ongoing annual formal programmatic assessments, and informal observational and environmental

monitoring, surveillance and assessments to identify shifts in needs, resources and priorities. These efforts are detailed in the State Action Plan, which is reviewed and updated as needed to reflect noted changes in MCH priority needs. At the beginning of each five-year grant cycle, Virginia conducts a statewide needs assessment to inform programmatic strategy and priority/goal setting across the six Title V domains. The priority needs are then aligned with evidence-informed strategy measures and associated state and national objectives to guide programmatic planning and performance. Title V data needs are fulfilled by the State Systems Development Initiative (SSDI) Grant Program, with staff providing MCH data support to inform program planning and resource allocation. Virginia's SSDI maintains representation on the Virginia PRAMS Steering Committee. The public-facing MCH Dashboard is regularly monitored and updated. SSDI leverages partnerships across the state to broadly inform identification of MCH priorities, alignment with Title V national and state performance and outcome measures, and action plan development and implementation.

The qualitative and quantitative results from the 2020 Needs Assessments identified broad priorities that expand across all of the Title V Domains. Virginia's Title V Program intends to approach these identified needs broadly and comprehensively across all domains.

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

2021-2025 MCH Priority Needs	Women Maternal Health	Perinatal Infant Health	Child Health	Adolescent Health	CYSHCN	Cross-Cutting Systems Building
Upstream/cross-sector strategic planning						X
Community, family & youth partnerships					X	
Mental health			X	X		
Finances as a root cause			X		X	
Racism as a root cause						X
Maternal & infant mortality disparity	X	X				
MCH data capacity	X	X				
Reproductive justice and support	X			X		
Strong systems of care for all children			X	X	X	
Oral Health	X		X	X		

Virginia's 2021-2025 MCH Priority Needs

- **Upstream/cross-sector strategic planning -** Eliminate health inequities arising from social, political, economic and environmental conditions through strategic, nontraditional partnerships
- **Community, family & youth partnerships -** Provide dedicated space, technical assistance, and financial resources to advance community leadership
- **Mental health -** Promote mental health across MCH Populations, to include reducing suicide and substance use/abuse
- **Finances as a root cause -** Increase the financial agency and well-being of MCH populations
- **Racism as a root cause -** Explore and eliminate drivers of structural and institutional racism within programs, policies and practices to improve maternal and child health, to include providing racial equity training to internal staff and sub-recipients
- **Maternal & infant mortality disparity-** Eliminate the racial disparity in maternal and infant mortality rates by 2025
- **MCH data capacity -** Maintain and expand state MCH data capacity, to include ongoing needs assessment activities, program evaluation, and modernized data visualization and integration
- **Reproductive justice and support -** Promote equitable access to choice-centered, reproduction-related services, including sex education, family planning, fertility/grief support, and parenting support
- **Strong systems of care for all children-** Strengthen the continuum supporting physical/socio-emotional development (i.e., screening, assessment, referral, followup, coordinated community-based care)
- **Oral Health -** Maintain and expand access to oral health services across MCH populations

2021-2025 Title V National Performance Measures (NPMs) by Domain

- NPM4: Breastfeeding (Perinatal/Infant)
- NPM 6: Developmental Screening (Child)
- NPM 7: Injury Hospitalization (Child, Adolescent)
- NPM 11: Medical Home (CYSHCN)
- NPM 12: Transition (CYSHCN, Adolescent)
- NPM 13: Preventive Dental Visit (Women/Maternal, Child, Adolescent)
- NPM 15: Adequate Insurance (CYSHCN)

2021-2025 State Performance Measures (SPMs)

- Pregnancy Intention
- Family Leadership
- Youth Leadership
- Early and continuous screening

2021-2025 State Outcome Measures (SOMs)

- Maternal mortality disparity
- Infant mortality disparity

POPULATION DOMAIN HIGHLIGHTS

Performance Measures and Outcomes	
Virginia ranks 18th for the overall health of women and children (2019)	
Women Maternal Health	• 7th overall for the health of women (2020) • 48.4% of moms had a preventive dental visit during pregnancy (NPM 13.1) • Percentage of women reporting that they wanted to become pregnant later or never was 27.1% (2019) • 44.4% of pregnancies were described by women as unintended (2019) • Maternal **morbidity** rate was 69.2 per 10,000 delivery hospitalizations (non-Hispanic White – 55.3; non-Hispanic Black – 102.3; ≥35 years – 90.4) (NOM 2) • Maternal **mortality** rate was 18.5 per 100,000 live births (non-Hispanic White – 14.1; non-Hispanic Black – 38.2) (NOM 3) • Leading causes of pregnancy-associated deaths were cardiac disorders, accidental overdoses, motor vehicle accidents, homicide, and suicide • Percentage of women who experience postpartum depressive symptoms following a recent live birth was 14.4% (2019)
Perinatal Infant Health	• 23rd overall for the health of infants (2019) • 88.5% of moms ever breastfed and 25% breastfed for 1-10 weeks – 55% were breastfeeding at the time of the VA PRAMS survey (White – 57.1%; Hispanic – 50.3%; Black – 41.4%) • Infant mortality rate was 5.9 per 1,000 live births (White – 4.7; Black – 10.6; Other – 4.0) (2019) • Leading causes of infant mortality were birth defects, disorders related to short gestation and low birth weight, and sudden infant death syndrome
Child Health	• 15th overall for the health of children (2020) • Percent of children, ages 9-35 months, who received a developmental screening using a parent-completed screening tool in the past year is 29.9% (NPM 6) • Rate of hospitalization for non-fatal injury among children was 88.4 per 100,000 (<1 year – 187.4; 1-4 years – 96.7; 5-9 years – 62.6) (NPM 7.1) • 93.1% of children age 1-5 years and 91.1% of children age 6-11 years had a preventive dental visit (NPM 13.2)

Adolescent Health	• Rate of hospitalization for non-fatal injury among adolescents was 168.1 per 100,000 (10-14 years – 87.4; 15-19 years – 246.7) (NPM 7.2)
	• 46.7% of **middle school students** experienced at least one form of bullying, bullying on school property or cyberbullying (2019)
	  ◦ Those who experienced cyberbullying, were more likely to report suicidality (47.9%), not feeling good about themselves (46.8%), ever drank alcohol (31.0%) and ever used electronic vapor products (24.3%).
	• 22.6% of **high school students** were victims of any form of bullying (2019)
	  ◦ Those who experienced cyberbullying, were more likely to report feeling sad for 2 weeks or more (59.6%), current alcohol use (42.5%), suicidality (41.0%), purposely hurting themselves without wanting to die (36.4%), electronic vapor products use (35.5%) and current marijuana use (29.0%).
	• 16.5% of adolescents received services necessary to make transitions to adult health care (NPM 12)
	• 86.6% of adolescents had a preventive dental visit (NPM 13.2)
	• Teen pregnancy rate is 18.1 per 1,000 females age 15 to 19 years

CSHCN	• Percent of children with special health care needs (CSHCN) is 19.3% (NOM 17.1) • 48.6% of CSHCN had a medical home (NPM 11) • 14.5% of CSHCN age 12-17 years were engaged in transition services to adult health care (NPM 12) • 66.9% of CSHCN continuously and adequately insured (NPM 15)
Cross-Cutting Systems Building	• Expand capacity to document and track referrals of infants from the Newborn Screening Program to CSHCN programs • Develop and sustain the VDH Youth Advisor Program • Implement MCH workforce development policies addressing racial equity • Maintain and expand family engagement

III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts

Title V Funds sustain core state MCH infrastructure, through approximately 75 existing contracts with health systems, health districts, and state/community partners to support regional and local MCH systems-building, clinical services, and education.

Virginia's Title V Program:

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

III.A.3. MCH Success Story

CHILD HEALTH SUCCESS

Within Smart Beginnings Greater Roanoke, the Virginia Quality Initiative (which serves the Piedmont region) provided seven virtual trainings reaching a total of 55 childcare providers to bolster awareness of child development. Smart Beginnings Southeast is leveraging existing relationships with home visiting partners to provide information for at risk families with infants. United Way of Southwest Virginia reports that DSI partners have targeted "at risk" populations through the use of phone interviews followed by developmental milestone packets delivered to families in more rural areas, as well as frequent communication with grandparents who are raising grandchildren and may not be comfortable utilizing digital platforms. Additionally, United Way of Southwest Virginia reports leveraging existing relationships with community organizations, for example, using sites such as food box distribution and connections for job opportunities, to distribute developmental screening information. United Way of South Hampton Roads continues discussions with pediatrics-based providers, including in the local tri-health military network, to explore potential for advancing Medicaid reimbursement for screening and referral services. While conversations are in early stages, the promise of Medicaid providers and other publicly-funded services partners being compensated for screening and referral services that reach often-marginalized communities, primarily due to shared social and economic characteristics of the population, is important.

ADOLESCENT HEALTH SUCCESS

The COVID-19 pandemic presented many challenges for the youth-serving programs in Virginia. Young people became particularly hard to reach, and the main avenue that grantees usually use to serve young people – schools – were largely overwhelmed by the pandemic and had little capacity to partner with outside agencies. Planned Parenthood of the South Atlantic (PPSAT), a grantee through Virginia Title V's *Get Real: Comprehensive Sexual Education That Works initiative*, pivoted to virtual programming with ease and was able to begin serving young people weeks after funding began. PPSAT facilitators decided to recruit their own program participants, bypassing the challenges that other grantees were facing while trying to partner with schools. PPSAT's virtual programs were effective and popular; on average 87% of young people were satisfied with the program. Young people who attended virtual sessions were observed by the Title V staff to be engaged, participatory, and most importantly, learning. Given the challenges of teaching any class online – let alone sexuality education – PPSAT's quick adoption of online learning and overall success in the virtual classroom was impressive.

CSHCN SUCCESS

The Care Connection for Children (CCC) program works tirelessly to support families of children with special health care needs via care coordination services. This is a time-intensive process but the impact can be considerable. The CYSHCN success story for this year comes from the Blue Ridge Care Connection for Children at the University of Virginia. One of the MCH funded care coordinators at this center provides care coordination services for a family with two adopted children who have severe disabilities. The parents are older and live in a home without a downstairs bathroom. According to the mother, walking upstairs with her six year old to bathe her just wasn't possible and the family needed a downstairs bathroom. The mother had a hard time finding help to make this happen, was at her wits end, and was ready to give up. However, her care coordinator (at the Blue Ridge CCC) encouraged her to keep trying to get support. She gave her contact information for the supervisors at her Medicaid MCO and when that did not work out, she put the mother in touch with Virginia's state Medicaid agency. That got the ball rolling and the family now has a bathroom that is accessible for both girls. This client stated, "If…..hadn't come through like she did, I'd still be carrying my youngest child up the steps and dreading bath time". She also stated, "….. and the BRCC are worth their weight in gold to us. They are so knowledgeable and persevering. I find them remarkable in this day and age". The example above demonstrates the power of care coordination. CCC program staff help families with standard things like medication and durable medical equipment but they go well beyond that. Staff are eager to support families no matter the need to make life better for the children they get to serve. A copy of the hand written letter from the family is attached.

III.B. Overview of the State

Oversight and Authority

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

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

The VDH state health improvement plan (SHIP), known in Virginia as the Plan for Well-Being lays out the foundation for giving everyone a chance to live a healthy life:

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

The scope of the agency's services includes ensuring food and water safety, disease and injury prevention and surveillance, emergency preparedness, health equity, and setting licensure and certification standards. As the leading public health agency in the state, the central office is located in Richmond, the state's capital. The State Board of Health provides leadership in planning and policy development and supports VDH in implementing a coordinated, prevention-oriented program that promotes and protects the health of all Virginians. The agency is led by the State Health Commissioner, with additional oversight from deputy commissioners distributed across four main operating divisions: Public Health & Preparedness, Administration, Community Health Services, and Population Health.

Virginia's MCH Program

VDH is responsible for the administration of programs carried out with allotments under Title V. Virginia's MCH program implements strategies that have broad population health impact. The VDH Office of Family Health Services (OFHS) houses the state Title V program and complementary MCH programs. OFHS programs include the Women, Infants, and Children's Nutrition Program (WIC) in the **Division of Community Nutrition**; disease prevention and health promotion in the **Division of Prevention and Health Promotion**; protecting and improving the health of women, infants, children, adolescents, and their families in the **Division of Child and Family Health**; and providing scientific integrity and quality data analysis, reporting, and program evaluation related to these populations in the **Division of Population Health Data**. MCH block grant funding is allocated by formula to each of Virginia's 35 local health districts to support local MCH implementation, with two of these districts being governed locally.

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

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

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

economic, and environmental conditions through strategic, nontraditional partnerships.

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

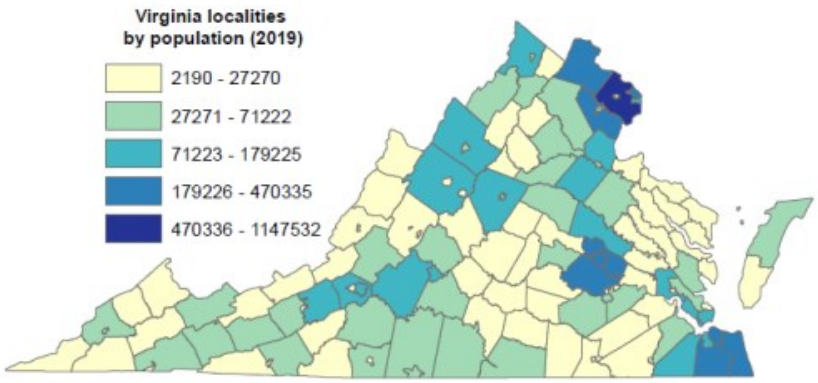
Geography

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

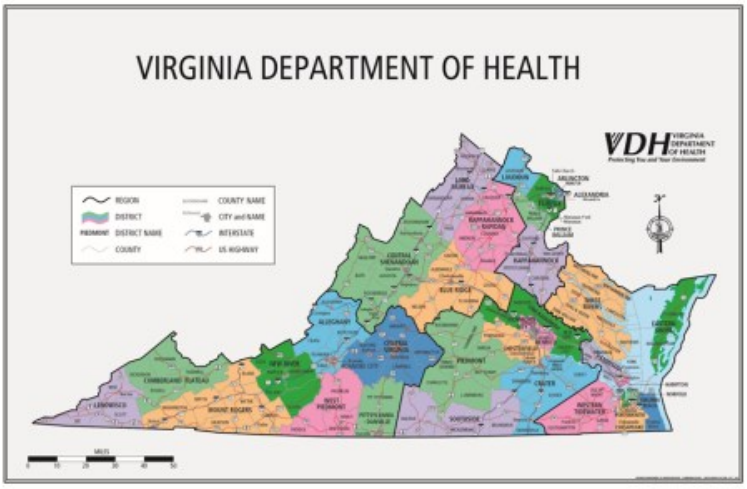
Population Density & Urbanization

Virginia has 11 Metropolitan Statistical Areas, with Northern Virginia (Washington-Arlington-Alexandria), Hampton Roads (Virginia Beach-Norfolk-Newport News), and Richmond-Petersburg being the three most populous. The Commonwealth is divided into 133 localities (95 counties and 38 independent cities) with a population density of 206.7 per square mile. The largest independent cities are Virginia Beach (449,974), Chesapeake (244,835), Norfolk (242,742), the state's capital Richmond City (230,436) and Newport News City (179,225). Norfolk forms the urban core of the Hampton Roads metropolitan area, which has a population over 1.7 million people and is the site of the world's largest naval base, Naval Station Norfolk.

Over 3.1 million people, 36% of the population, live in Northern Virginia. The most populous jurisdiction (and county) in the state is Fairfax County in Northern Virginia, with a climbing population of nearly 1.15 million. Fairfax County has a major urban business and shopping center in Tysons Corner, Virginia's largest office market. Neighboring Prince William County (470,335) is Virginia's second most populous county, and is home to Marine Corps Base Quantico, the FBI Academy and Manassas National Battlefield Park. According to an article in the Washington Post, analysis of U.S. Census Bureau data has shown that Prince William County has leapfrogged Virginia Beach to become the second-most-populous jurisdiction in Virginia. Three out of four of the state's largest counties, now in Northern Virginia, account for 23.8% of the state's population growth. Loudoun County in Northern Virginia with its 413,538 residents surpasses Chesterfield County in the Richmond MSA with its 352,802 residents.



Virginia is a place where state averages hide the contrasting stories of its subpopulations. There are approximately 1.0 million residents living within rural areas of the state, compared to over 7.5 million within urban areas. Virginia Department of Health has grouped the Commonwealth's localities into 35 health districts and 5 health regions. The Northern region, composed of Alexandria, Arlington, Fairfax, Loudoun, and Prince William health districts, is densely populated and include 3 of the 50 richest places in America according to Bloomberg, 2020. Conversely, the Southwest region, made up of Alleghany, Central Virginia, Cumberland Plateau, Lenowisco, Mount Rogers, New River, Pittsylvania/Danville, Roanoke City, and West Piedmont health districts, is rural with a rugged and mountainous terrain and is the least populous and least racial/ethnically diverse. Its terrain and vast geographic area pose many transportation barriers. The Central region is composed of Chesterfield, Crater, Chickahominy, Henrico, Piedmont, Richmond City, and Southside health districts. The Northwestern region is made up of Central Shenandoah, Lord Fairfax, Rappahannock, Rappahannock/Rapidan, and Blue Ridge (formerly Thomas Jefferson) health districts. These two regions have a mix of urban, suburban and rural areas. The urban areas are home to large state colleges/universities and are business districts. The suburban areas are more residential than industrial. The rural areas are agricultural. The Eastern region, composed of Chesapeake, Eastern Shore, Hampton, Norfolk City, Peninsula, Portsmouth, Three Rivers, Virginia Beach, Western Tidewater health districts, runs along the east coast (Chesapeake Bay and Atlantic Ocean) and includes the Eastern Shore, a peninsula separated from the mainland by the Chesapeake Bay. The Eastern Shore Health District is sparsely populated and has a high level of poverty. The Eastern area has the largest concentration of military bases and facilities of any metropolitan area in the world. The coastal area has many bridges and tunnels that create transportation barriers to services. Individuals in the area also experience severe traffic congestion on a daily basis. Occasionally, hurricanes and tropical storms affect the area and can result in flooding and environmental health concerns.



Demographics

Virginia is the 12th most populous state in the U.S., with an estimated population of over 8.6 million people (World Population Review). There were 49.2% of the population reporting male and 50.8% female (2019: ACS 5-Year Estimates Data Profiles, Demographic and Housing Estimates).

Race/Ethnicity

Among people reporting one race alone, 67.6% identified as White, 19.2% identified as Black, 0.3% American Indian and Alaska Native, 6.4% Asian, and 0.1% Native Hawaiian and Pacific Islander (2019: ACS 5-Year Estimates Data Profiles, Demographic and Housing Estimates). There were 9.4% of individuals that identified as Hispanic or Latino. According to the Census Bureau, Virginia ranks 9th in having the largest African American population (HHS Office of Minority Health Resource Center).

There were over 1.69 million women of childbearing age (15-44 years) in 2019, with race and ethnicity composition consisting of 58.0% non-Hispanic White, 21.5% non-Hispanic black, 8.9% non-Hispanic Asian or Pacific Islander, 0.3% non-Hispanic Native American or Alaska Native, and 11.3% Hispanic (any race) (2019 Virginia resident population estimates). The Virginia population, like that of the nation, is becoming more racially and ethnically diverse where 12.4% of the population are foreign-born (2019: ACS 5-Year Estimates Data Profiles, Selected Social Characteristics).

Age and Sex

The median age of Virginians is 38.2 years. Persons age 65 years and older represent 15.0% of the population (U.S. Census Bureau, QuickFacts, Virginia). There were 190,459 grandparents, and among those, 35.1% were responsible for their grandchildren (2019: ACS 5-Year Estimates Data Profiles, Demographic and Housing Estimates). There were 22.1% of persons under 18 years, 6.0% under 5 years, and 96.8 males per 100 females.

Economic Well-Being

Educational Attainment

Educational attainment is a predictor of personal wealth and well-being and is directly related to social disparities. In Virginia, 6.2% have a 9th to 12th grade education with no diploma, 24.0% are high school graduates or equivalent, 22.0% have a bachelor's degree, and 16.8% have a graduate or professional degree (2019: ACS 5-Year Estimates

Data Profiles, Selected Social Characteristics).

Economy/Income/Poverty

Virginia's economy is diverse, including local and federal government, military, farming, business, manufacturing, tourism, and healthcare/medical. Virginia has 4.4 million civilian workers, and 16.6% are in service occupations. The unemployment rate in Virginia was 4.6% as per ACS 2019, below the national rate of 5.3%. The median household income in Virginia is $74,222 compared to $62,843 in the U.S.

Compared to the U.S. population, a lower percentage of Virginia families lived in households with incomes below the federal poverty level (7.1% vs. 9.5% for the U.S.) and also a lower percentage of children under age 18 lived in households with incomes below the federal poverty level (11.2% vs. 15.1% for the U.S.). However, wealth varies significantly across the state. The percentage of children living in poverty was 13.3% in 2019 (KIDSCOUNT Data Center). For the years 2018-2019, 13.9% of children with special health care needs lived in families with incomes less than 100% of the federal poverty level (2018-2019 National Survey of Children's Health (NSCH)). This is in comparison to children without special health care needs, of which 14.4% are in families with incomes less than 100% of the federal poverty level.

Housing

The factors that relate to housing have the potential to affect health in major ways. These factors include physical conditions within homes, conditions in the neighborhoods surrounding homes, and housing affordability. Among occupied housing units in Virginia, 33.7% are rented. In renter-occupied units, nearly half (47.8%) pay 30 percent or more of their household income to rent (2019: ACS 5-Year Estimates Data Profiles, Selected Housing Characteristics). In 2019, 64% of Virginia children lived in low-income households with high housing cost burden (KIDSCOUNT Data Center). The median rent in Virginia is $1,234. The median home value for owner-occupied units in Virginia is $273,100 (2019) compared to $243,500 in 2014, a 12.2% increase in median home value. Communities without safe and affordable housing affect the overall ability of families to make healthy choices and access to quality homes.

Food Security

Food insecurity is a social and economic condition where access to food is limited or uncertain. In Virginia, 799,620 people are facing hunger, and 1 in 9 are children (Hunger in Virginia). According to 2020 America's Health Rankings, 10.1% of Virginia households were unable to provide adequate food for one or more household members due to lack of resources. Charity and government assistance programs are necessary to help bridge the meal gap. In 202 there were 42.3% of children who received Supplemental Nutrition Assistance Program (SNAP) benefits (KIDSCOUNT Data Center).

Primary Care Access and Health Insurance Coverage

Based on the 2019 ACS 5-Year Estimates, 91.4% of Virginians have health insurance of some kind, where 76.0% were private and 28.2% were public. Among those under age 19, there were 5% without health insurance. Among the uninsured population, 15.4% are young adults age 26 to 34 (2019: ACS 5-Year Estimates Subject Tables, Selected Characteristics of Health Insurance). Others that are uninsured include 7.4% of those that identify as White compared to 9.9% of African Americans, 12.2% American Indian and Alaska Native, and 24.0% Hispanic or Latino. Twenty-two percent of those with less than a high school education were uninsured.

In 2019, the Bureau of Labor Statistics reported 4,230 Family Medicine Physicians in Virginia, and 570 obstetricians/ gynecologists. There were 490 pediatricians, 3,430 dentists with 80 of those being specialists, and 160 Oral and Maxillofacial Surgeons in the state. There are needs recognized across the state that can be unique to different areas of the state, such as transportation barriers and availability of providers. There were 106 counties/cities in Virginia designated as Primary Care Health Professional Shortage Areas (HPSAs), 98 in Dental

Care, and 74 in Mental Health (HRSA Data Warehouse). Virginia expanded the Medicaid program on January 1, 2019, a significant change in health care policy that was realized without the expenditure of state dollars. More than 380,000 Virginia adults are enrolled and receiving services under the new eligibility rules.

Community and Social Well-Being

Social and emotional support

Research has supported that social and emotional support from others can be protective for health. Overall, 31.3% of Virginia children were living in single parent households (KIDSCOUNT Data Center). There were 4% of children in the care of grandparents. The majority of Virginia parents (80.6%) report that they have someone to turn to for day-to-day emotional support with parenting or raising children (NCHS 2018-2019). There were 70.3% of high school students that have an adult to go to for help with a serious problem (71.4% male, 69.2% female) (Virginia YRBS).

Racism and Discrimination

Racism and discrimination are among other social determinants of health that negatively influence health. During their pregnancy, mothers expressed experiencing discrimination or harassment due to their race, ethnicity or culture (6.1%); insurance or Medicaid status (4.5%); weight (5.45%); and marital status (4.26%). Among those reporting discrimination or harassment due to their race, ethnicity or culture, 12.05% were Black and 4.13% were Hispanic (Virginia PRAMS). Among high school students, 16.8% have been a victim of teasing or name-calling because of their actual or perceived race or ethnic background, and 11.8% because of their actual or perceived sexual orientation in the past year.

Performance Measures and Outcomes

DOMAIN: Women's/Maternal Health

According to America's Health Rankings (2020), Virginia ranks 7th overall for the health of women, and 15th for the overall health of children.

NPM 13.1: Preventive Dental Visit During Pregnancy – Data from the Pregnancy Risk Assessment Monitoring System (PRAMS) showed that 48.4% of moms had a preventive dental visit during pregnancy (2019). Preventive dental care in pregnancy is recommended by the American College of Obstetricians and Gynecologists (ACOG) to improve lifelong oral hygiene habits and dietary behavior for women and their families.

SPM 4: Pregnancy Intention: Mistimed or Unwanted Pregnancy – The percentage of women reporting that they wanted to become pregnant later or never was 27.1% (2019 VA PRAMS). The concept of unintended pregnancy helps in understanding the fertility of populations and the unmet need for contraception and family planning (CDC 2019). In Virginia 44.4% of pregnancies were described by women as unintended.

NOM 3: Maternal Mortality – Maternal mortality is a sentinel indicator of health and health care quality worldwide. In 2019 Virginia's governor announced a goal to eliminate the racial disparity in the maternal mortality rate in Virginia by 2025. The maternal mortality rate was 18.5 per 100,000 live births, with a rate of 14.1 per 100,000 among White women and 38.2 per 100,000 among Black women (2015-2019). The Black/White Maternal Mortality Ratio was 2.7 (SOM 2).

NOM 2: Severe Maternal Morbidity – The rate of severe maternal morbidity in Virginia is 69.2 per 10,000 delivery hospitalizations, where hemorrhage accounts for 30.4 per 10,000 (2018). Disparities exist among race/ethnicity (non-Hispanic Black – 102.3), health insurance (Medicaid – 80.6, Other Public – 102.8), and maternal age (≥35

Years – 90.4).

Mental Health - The percentage of women who experience postpartum depressive symptoms following a recent live birth was 14.43% (Virginia PRAMS).

DOMAIN: Perinatal/Infant Health

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

NPM 4: Breastfeeding – Research shows that breastfeeding provides many health benefits for moms and babies, including lower risk of type 2 diabetes and certain cancers for moms, and protection from illness for babies. Virginia PRAMS (2019) showed 88.5% of respondents ever breastfed, 25.0% breastfed for 1-10 weeks, and 55.0% were breastfeeding at the time of the survey. There were some differences observed in continuation by race, where by the time of the survey 57.1% of White moms were breastfeeding at the time of the survey, 50.3% of Hispanic moms, and 41.4% of Black moms.

NOM 9.1: Infant Mortality – Infant mortality is a sentinel measure of population health that reflects the underlying well-being of mothers and families, as well as the broader community and social environment that cultivate health and access to health-promoting resources. The infant mortality rate in Virginia is 5.9 per 1,000 live births (Virginia Vital Statistics System, 2019). A significant disparity exists in infant deaths between racial groups in Virginia, where non-Hispanic Black women had an infant mortality rate of 10.8, twice that for non-Hispanic White women (4.8 per 1,000 live births). Goal 2.3 of the Virginia Plan for Well-Being is to eliminate the racial disparity in Virginia's infant mortality rates. The Black/White Infant Mortality Ratio is 2.3 (SOM 1).

NOM 9.5: Sudden Unexpected Infant Deaths (SUID) – Sleep-related infant deaths are among the leading causes of infant death. The SUID rate in Virginia is 95.4 per 100,000 live births (Virginia Vital Statistics System, 2019); with disparities among race/ethnicity (non-Hispanic Black – 232.7), health insurance (Medicaid – 214.7, Uninsured – 158.6), and maternal age (<20 Years – 241.1).

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

DOMAIN: Child Health

According to America's Health Rankings (2020), Virginia ranks 15th overall for the health of children. The child mortality rate was 15.1 per 100,000 children ages 1-9 (NOM 15).

NPM 6: Developmental Screening – The percent of children, ages 9-35 months, who received a developmental screening using a parent-completed screening tool in the past year is 29.9% (2018-2019) in Virginia, compared to the U.S. at 36.4%. Early identification of developmental disorders is critical to child well-being and is an integral function of primary care.

NPM 7.1: Injury Hospitalization (ages 0-9 years) – Data from the Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases (SID) showed the rate of hospitalization for non-fatal injury among children was 88.4 per 100,000 in 2018. Among age groups, the annual indicator was 187.4 for children less than one year of age, 96.7

among children ages 1-4, and 62.6 among children ages 5-9. Reducing the burden of nonfatal injury can greatly improve the life course trajectory of infants and children, resulting in improved quality of life and cost savings.

NPM 13.2: Preventive Dental Visit (ages 1-11 years) – The NSCH showed that 63.0% of children age 1-5 years and 89.0% of children age 6-11 years had a preventive dental visit (2018-2019). Insufficient access to oral health care and effective preventive services affects children's health, education, and ability to prosper.

DOMAIN: Adolescent Health

The adolescent mortality rate was 29 per 100,000 children ages 10-19 (NOM 16.1). The adolescent motor vehicle mortality rate was 9.3 per 100,000 adolescents ages 15-19 (NOM 16.2).

NPM 7.2: Injury Hospitalization (ages 10-19 years) – The HCUP-SID showed the rate of hospitalization for non-fatal injury among adolescents was 168.1 per 100,000 in 2018. The annual indicator was 87.4 among age 10-14 years and 246.7 among age 15-19 years. Among students who reported that they seriously considered attempting suicide, 82.0% reported having felt sad, empty, hopeless, angry, or anxious; 40.8% attempted suicide; 24.9% were physically hurt by someone they were dating or going out with; 36.2% were bullied on school property; 29.2% were bullied electronically; and only 54.2% had at an adult they can talk to (Virginia Youth Survey, 2017). The adolescent suicide rate was 11.9 per 100,000 adolescents ages 15-19 (NOM 16.3).

NPM 12: Transition (ages 12-17 years) – The NSCH (2018-2019) showed only 16.5% of adolescents received services necessary to make transitions to adult health care. Health care transition focuses on building independent health care skills – including self-advocacy, preparing for the adult model of care, and transferring to new providers.

NPM 13.2: Preventive Dental Visit (ages 12-17 years) – The NSCH (2018-2019) showed that 86.6% of adolescents had a preventive dental visit.

Pregnancy Intention – The teen pregnancy rate in Virginia is 18.1 per 1,000 females age 15 to 19 years ((Virginia Vital Statistics System, 2019)). Differences exist among race/ethnicity and regions within the state. Hispanic/Latinx and non-Hispanic Black teens had the highest teen pregnancy rates in 2019 at 33.0 and 25.0 respectfully. The Eastern (23.6), Southwest (22.6), and Central (19.9) regions had rates higher than the state rate. The public savings in 2015 due to declines in the teen birth rate totaled $72 million (Power to Decide, 2020).

DOMAIN: Children with Special Health Care Needs

The percent of children with special health care needs (CSHCN), ages 0 through 17, in Virginia is 19.3% (NSCH 2018-2019).

NPM 11: Medical Home (CSHCN ages 0-17 years) – The NSCH (2018-2019) showed that 48.6% of CSHCN had a medical home. Children with a stable and continuous source of health care are more likely to receive appropriate preventive care.

NPM 12: Transition (CSHCN ages 12-17 years) – The NSCH (2018-2019) showed that 14.5% of CSHCN age 12-17 years were engaged in transition services to adult health care.

NPM 15: Continuous and Adequate Insurance (CSHCN ages 12-17 years) – The NSCH (2018-2019) showed that 66.9% of CSHCN were continuously and adequately insured. There were 32.3% of CSHCN that had public insurance, 61.6% private insurance, and 2.1% uninsured.

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

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

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

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

State Statutes and Other Regulations

Statutes

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

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

Section 32.1-64.1 through 69.2 also codifies the Virginia Early Hearing Detection and Intervention (EHDI), the dried blood spot (DBS) and Critical Congenital Heart Disease (CCHD) newborn screening (NBS) programs, as well as the Virginia Congenital Anomalies Reporting and Education System (VaCARES) program, the state's birth defect surveillance program. Associated regulations for EHDI, DBS and CCHD can be found in Chapters 71 and 80 of the Department of Health's Administrative Code.

Updates to Previously Reported Virginia Legislation and Initiatives

Virginia House Bill 1157 (2018 General Assembly) provides that the Department of Health shall serve as the lead agency with responsibility for the development, coordination, and implementation of a plan for services for substance-exposed infants in the Commonwealth. It details that plans shall (i) support a trauma-informed approach to identification and treatment of substance-exposed infants and their caregivers and (ii) include (a) options for improving screening and identification of substance-using pregnant women, (b) use of multidisciplinary approaches to intervention and service delivery during the prenatal period and following the birth of the substance-exposed child, and (c) referral among providers serving substance-exposed infants and their families and caregivers. The report

and plan have been approved and was been posted to the legislative information system in May 2021.

House Bill 907 (2020 General Assembly) directed the Board of Health to adopt regulations to implement an adult comprehensive sickle cell network, as well as provided funding to support the adult clinics' infrastructure. The regulations were drafted and approved for the Virginia Administrative Code and became effective 5/27/2021. VDH is now moving forward with issuing requests for proposals and contracts to aid the clinics' in building the needed infrastructure to improve the quality of care for adults living with SCD.

Children's Cabinet: In June 2018 Virginia Governor Ralph Northam issued Executive Order No. 11 reestablishing the Children's Cabinet (Press Release). The First Lady is leading the effort to improve quality of and access to early childhood education programs across Virginia, support the early childhood education workforce, and ensure that Virginia makes the most of early childhood education resources. The Children's Cabinet prioritizes issues including early childhood development and school readiness, nutrition and food security, and systems of trauma informed care and safety for school-aged youth. Information on the latest meetings of the Cabinet and workgroups can be found here https://www.governor.virginia.gov/childrens-cabinet/meeting-materials/

New Legislation and Initiatives

The 2020 and 2021 General Assembly sessions brought forth legislation that impacts Virginia's MCH populations and VDH MCH staff have been involved in various capacities of their implementation. The following are significant legislation that passed, but not inclusive all efforts:

- House Bill 687 (2020) Establishment of a Doula Certification Process and State Registry
- House Bill 826 (2020) Plan for Virginia Medicaid doula benefit and establishment of work group
- House Bill 1506 (2020) Pharmacists prescribing, dispensing and administration of controlled substances (including contraception)
- House Bill 1950 (2021) Plan for the establishment of a Fetal Infant Mortality Review team and process.
- House Bill 1995 (2021) Establishment of the Rare Disease Advisory Council
- House Bill 2019 (2021) Administration of stock albuterol inhalers in public elementary and secondary schools
- House Bill 2111(2021) Establishment of Maternal Health Data and Quality Measures Task Force
- Senate Bill 1406 (2021) Legalization of marijuana
- Budget Amendment (2021) Establishment of the Doula Task Force

Ongoing Needs Assessment Activities

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

The ongoing mechanisms that provide data and/or information that inform Title V are:

1. In depth collaboration with the Division of Population Health Data's (DPHD) ongoing surveillance analysis and evaluation efforts, including population health surveys (PRAMS, BRFSS, YRBS) and participation in Community Health Assessments (CHAs) and State Health Assessments (SHA).
2. Staff participation on state and regional boards and councils. MCH staff provide expertise, consultation, and support on epidemiology, data collection, analysis, interpretation, and reporting.
3. In collaboration with the DPHD MCH Epidemiology Unit, the CYSHCN Program conducts a standardized survey of families of CYSHCN served by regional Care Connection for Children (CCC) Centers. The statewide survey is conducted every 5 years to assess family satisfaction and utilization of services, and to identify areas of program improvement.

Virginia has created tools and mechanisms used by programs, local health districts, and stake holders to monitor MCH outcome and performance measures.

1. Public-facing Dashboards: The population health data portal provides data on common indicators at the state, region, district and locality level. The MCH Dashboard is currently undergoing revisions to include updated data, visualizations, and racial/ethnicity disaggregation. The Health Behavior dashboard provides BRFSS profiles for health districts in Virginia. The Injury and Violence Dashboard provides hospitalization data by mechanism and intent at the state, region, district and locality levels. MCH staff also contribute to the Opioid Addiction dashboard, providing subject matter expertise on the Overdose Surveillance and Prevention Workgroup and data on substance misuse, hospitalizations and Neonatal Abstinence Syndrome (NAS).
2. Development of data briefs/fact sheets: The DPHD often develops data briefs and annual reports that are widely shared via presentations and access on the VDH website, including Virginia PRAMS and YRBS Annual Surveillance Data.
3. Performance Measure Update: The MCH epidemiology team provides an annual presentation to Title V staff and stakeholders on updates to performance measures and their related outcome measures, utilizing the Federally Available Data (FAD) Resource Document.

Through these tools we can readily identify trends and monitor progress related to state plan measures and objectives. Utilizing these tools, we raise awareness and increase capacity for staff, stakeholders, and partners to identify and discuss emerging issues, target programming efforts, and act as appropriate.

Plan for Well-Being (PfWB): Virginia Department of Health is currently implementing and in the process of updating a state health assessment (SHA) and state health improvement planning (SHIP), known as the Virginia Plan for Well-Being (PfWB). Additionally, all 35 health districts in the Commonwealth have completed or are engaged in the process of completing of a community health assessment (CHA) and a community health improvement plan (CHIP). The PfWB and CHIPs have a particular focus and emphasis on addressing the social determinants of health and the

root causes of health inequities and disparities at the state and community level. Title V MCH staff are involved to provide insights, data, and expertise regarding MCH populations.

Operationalizing Five-Year Needs Assessment Process and Findings

The VDH MCH team continues to maximize the input of internal and external partners, and engagement of families and consumers regarding work related to the Title V Needs Assessment and State Action Plan for coordinated cross-sector strategic planning. State Title V efforts to operationalize needs assessment findings through strategic planning include participation in the following:

- PEW Health Impact Project's Calling All Sectors Initiative: The goal of this project is to create and support cross-sector, multiagency teams that will use evidence-based strategies to target social and economic drivers of health other than individuals' behavior and access to medical care. VDH is partnering with the Virginia Hospital and Healthcare Association (VHHA) and the Virginia Neonatal Perinatal Collaborative (VNPC) to implement the Maternal Health Collaborative and connect hospital systems with community based organizations to create action around social determinants of health to decrease the disparity of certain health outcomes in black maternal populations.
- CityMatCH Alignment for Action Learning Collaborative: The purpose of this project is to better align state- and local-level MCH work. Virginia's Title V leadership is providing consultation and partnering with the Blue Ridge Health District to assist in their plan of providing opportunities for anti-racism and implicit bias training for OB-GYN, Family Medicine and Pediatric providers as well as to facilitate maternal child health career paths for persons of color.
- Healthy Beginnings Learning & Practice cohort: As part of the Healthy Beginnings with Title V: Advancing Anti-Racism in Preterm Birth Prevention program, VDH MCH is partnered with the local organization *Urban Baby Beginnings* to identify and address racism in policy, data and funding structures at the state level that sustain inequities in perinatal health, including preterm birth, in Black, Latine/x, Indigenous, Asian, Pacific Islander, and other communities of color.
- National Maternal Child Health Workforce Development Center cohort: VDH's Title V staff is partnering with family based organizations to determine what a well-functioning, MCH system would like that is co-powered with families. This cohort is an opportunity to ensure families equitably benefit from working together with local and state MCH leaders to develop and implement better polices, programs, and practices. The outcome is that family engagement and equitable collaboration become a core value across all MCH programs.

The primary focus since completing needs assessment and application/annual report activities in 2020 has centered on the COVID-19 pandemic response, where MCH programs and team members have had to shift focus to program sustainability efforts to maintain the provision of services and support continuity for families and individuals, and to address the local and state needs associated with the pandemic.

Changes in MCH Population Health Status, Emerging Public Health Issues & MCH Program Response

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

COVID-19

The COVID-19 pandemic affected many people and programs within the state, including Title V MCH programs within the Office of Family Health Services and Local Health Districts. Engagement of MCH staff throughout pandemic response efforts has provided opportunities to share awareness, guidance and population needs.

Additionally, involvement has provided a foundation for the team to monitor and assess health outcomes following the pandemic. Members of the Title V MCH staff were integral to and participated in specific COVID-19 response activities outlined below.

- Health Information Team: coordinating, developing, updating, approving, and posting of COVID-19 guidance (e.g., exposure, testing, vaccine) for a variety of audiences including other state agencies, public health workforce, providers, families, and the public.
- COVID-19 Informatics and Data Visualization: coordinating, developing, and maintaining data pipelines, visualizations, and quality assurance; sharing accurate and timely information and resources; providing updates to the Governor, State Health Officer/Secretary, and/or agency leadership.
- Surveillance and Contact Tracing: providing support to local health districts for case monitoring, reporting and tool development
- Community Mitigation Team: planning and developing mitigation guidance in collaboration with other state agencies for multiple community sectors, including, but not limited to, child care, K-12 schools, higher education and multiple recreational venues
- Call Center: providing real time guidance to citizen questions
- Mass Vaccination: assisting health district staff in implementing plans for provision of vaccine to their respective citizens
- Receipt, Store, and Stage (RSS) national stockpile sites: Providing on-site physical assistance and off site logistical support to RSS operations

COVID-19 Health Disparities: to monitor the impact of COVID-19 on the MCH population, an internal-facing dashboard was created to display diagnosis among those noted as pregnant, and children and adolescents. As of August 8, 2021 total cases in pregnant women totaled 4,630, with 287 hospitalizations and 645 among those noted as healthcare workers. Among children and adolescents age 0 to 19 years, there have been 116,609 cases, 701 hospitalizations, and 7,210 outbreak associated cases.

Maternal/Infant Health

A focus of the MCH initiative continues to be the reduction of infant mortality and maternal mortality disparities. The rates of infant and maternal mortality among the black population still remains twice and nearly three times that of their White counterparts. To address these disparities, overall MCH efforts are focusing on contributing factors to mortality such as access to care (e.g., increasing home visiting), family planning (e.g., increased access to highly and moderately effective contraceptives), maternal/care-giver behaviors (e.g., safe sleep environments and substance use disorder), and community and family engagement. These efforts are partially funded by Title V and are supported mostly by other federal grants (e.g., MIECHV, Title X). Virginia is in the process of increasing alignment of the goals and objectives of its various MCH funding streams into a shared “MCH Agenda.” This will leverage synergies of collective impact to greater improve the health of women, children and families.

In response to Governor Ralph Northam’s goal of eliminating the racial disparity in maternal mortality by 2025, the Secretary of Health and Human Services released Virginia’s Maternal Health Strategic Plan in April 2021. The administration undertook a series of maternal health listening sessions and community forums across the Commonwealth with multiple stakeholders, including many with lived experiences, to inform the plan’s six strategies and twenty recommendations. The six focus areas include insurance coverage, healthcare environment, criminal justice and child welfare response, community-based services, contraception and data collection. Recommendations specifically mention Title V Maternal Child Health block grant funding as a strategy in expanding access to community-led maternal health programs.

Mental Health, Substance Use, Injury and Violence

Virginia's 2020 Needs Assessment revealed a cross-cutting priority in mental health across populations, which states to promote mental health across MCH populations, including reducing injury/suicide and substance use. The COVID-19 pandemic has not only magnified mental health challenges, but also increased substance use, suicidal ideation, and violence, both interpersonal and violent crime. These elevated, adverse issues were related to the morbidity and mortality caused by the disease and to mitigation activities, including the impact of physical distancing and stay-at-home orders.[1] According to a CDC report, 40.9% of U.S. adults reported struggling with mental health or substance abuse. Similarly in Virginia research from the Eastern Virginia Medical School, while preliminary findings come from a limited sample, showed that among 450 respondents, one in four reported signs and symptoms of moderate to severe anxiety or moderate to severe depression.[2] According to the American Medical Association many states have seen increases in opioid-related mortality.[3] In Virginia, preliminary 2021 Quarter 1 data showed the largest number of fatal drug overdoses, all substances, ever seen in Virginia (n=677). Since March 2020, fatal overdoses increased significantly and continue to remain record breaking through 2021. Fatal overdoses, all substances, increased 41.9% in 2020 compared to 2019.[4] Also according to Virginia State Police, murders and aggravated assaults have spiked across the state, where there were 528 homicides in Virginia in 2020, more than a 23% increase from 2019, and an 11% increase in aggravated assaults.[5]

Virginia's Title V teams, in close collaboration with multiple state sister agencies and organizations, are working on this priority.

VDH's Injury and Violence Prevention Program (IVPP) has leveraged Title V funding to expand Project Echo®: Neonatal Abstinence Syndrome (NAS) prevention labs equipping providers with the skills to provide case management and harm reduction services to women at risk for, or with a history of, substance misuse, abuse, and addiction during childbearing age; all with the goal for prevention of NAS.

IVPP staff supporting ongoing suicide prevention efforts partnered with the Department of Education (DOE) to develop school guidance on suicide prevention including detailed planning of resources related to prevention, intervention, and postvention in schools. Additionally, staff worked to connect and expand individuals working in the suicide prevention field, identifying additional partners to participate in the Suicide Prevention Interagency Advisory Group (SPIAG). SPIAG serves as the primary mechanism for connecting and disseminating best practice suicide prevention information and data.

Finally, staff have begun working on the Virginia Suicide Prevention Plan across the Lifespan which has resulted in a number of partnerships and identified areas for additional growth. These steps have positioned staff working on suicide prevention funded projects to achieve the activities outlined below for the October 2021 – September 2022 grant year. IVPP will continue its work to ensure a comprehensive suicide prevention program statewide by increasing the number of gatekeepers serving disparate populations and (state plan).

IVPP also leads Project Patience Version 2.0 is an initiative advancing statewide delivery of prenatal and postpartum education on child maltreatment and infant injury prevention to newborn and infant parents and caregivers prior to their maternity hospital discharge to home or setting after birth and/or as they access community level settings, inclusive of service receipt from libraries and health departments. Priority populations include mothers of NAS infants and pregnant women at risk for or with a history of addiction.

The Code of Virginia § 32.1-73.12 directs VDH to serve as the lead agency for the development, coordination, and implementation of a plan for services for substance-exposed infants (SEI) in the Commonwealth. *The Plan for Services for Substance Exposed Infants* (see Supporting Document 2) was approved by the Commissioner of Health in FY21. In FY22, under the direction of the Maternal Infant Consultant, coordination and implementation of the plan will begin.

Mental health assessment and coordination of support services are a priority of Title V supported programs. In close collaboration with other state agencies and organizations, they help to address the mental health needs of women, children, adolescents and families through screening and education. These include, but not limited to, home visiting, Resource Mothers, adolescent family life programs and CYSHCN child development centers work. Local health districts also have the opportunity to focus on mental health in their MCH work plans which are currently in development for FY22.

The Virginia Mental Health Access Program (VMAP) focuses on the connection of pediatricians to local/regional child psychiatrists to advise them on mental health concerns of young children with the goal of reduced wait time for mental health assessment and treatment of young children. Due to the lack of resources and low number of child psychiatrists in Virginia this program strives to minimize barriers to treatment and provide support to local pediatricians who see children with mental health issues. This initiative is led by the Virginia Department of Behavioral Health and Developmental Service (DBHDS) and VDH provides consultation and funding that focuses on the educational components of the program.

Title V Program Capacity

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

Leadership

Since the Department of Health is within the Executive Branch of Virginia's Government, the issues impacting MCH populations have a direct linkage to the Governor and subsequently Secretary of Health and Human services for Virginia. Executive Branch leadership has strategic focus on women's health, children and youth, and has initiated several efforts to expand state capacity to improve the health and well-being of MCH populations and families (e.g. Maternal Health Strategic Plan).

Organizational Structure

The Health and Human Services Secretariat oversees the state health and human services agencies (i.e. Department of Health, Department of Medical Assistance Services, Department of Behavioral Health and Developmental Services, and Department of Social Services). The Code of Virginia authorizes the Department of Health to prepare and submit the Title V plan. The Commissioner of Health is authorized to administer the plan and expend the funds. The grant is administered within the Office of Family Health Services, Division of Child and Family Health. The Title V Director manages the state programs, provides strategic direction and ensures coordination with other state and federal MCH programs. The Title V - MCH Director reports to the Director of the Division of Child & Family Health and is responsible for strategic and day-to-day operations (e.g. overseeing grant activities, liaising with program managers, monitoring grant expenditures) and prepares and submits the Title V grant. The Director of the Children and Youth with Special Healthcare Needs program also reports to the Director of the Division of Child & Family Health. The CYSHCN Director provides oversight and management of the Child Development Centers, Care Coordination for Children Centers and Bleeding Disorders programs in Virginia. A Shared Business Services (SBS) team submits fiscal reports on behalf of agency programs .Title V funding supports a dedicated SBS staff to monitor the MCH block grant budget and provide fiscal guidance related to funding. Funded teams are described in the MCH Workforce Development section (III.E.2.b.i.) of this submission. See attached organizational chart for details on how funded programs are organized within the VDH.

Agency Capacity

Title V funds are used to improve the health of women, pregnant women, infants, children and adolescents with and without special health care needs, and families in Virginia. An emphasis is placed on reaching populations with fewer resources, programs and services and those communities most greatly impacted by adversity and the root causes of disparities.

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

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

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

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

Title V Partnerships and Collaborations

Virginia Title V has prioritized increasing diversity and inclusiveness of local partners as well as an emphasis on authentic inclusion of families and community-based organizations. Virginia's partnerships are described in the Public/Private Partnerships section (III.E.2.b.v.a.).

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

III.C.2.a. Process Description

Background

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

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

Process Description and Oversight

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

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

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

- Convene a project team of staff to implement the assessment.
- Identify lead-team structure.
- Develop work plans and timelines.
- Develop the overall approach to the assessment using the Block Grant guidance.
- Adopt guiding principles for the assessment.
- Adopt frameworks, principles, and tools from the MCH Needs Assessment Toolkit to guide data collection and needs assessment efforts.
- Perform key quantitative data collection methods and develop LiveStories boards for data products.

- Identify new and existing data sets and reports related to the MCH population to leverage assessment purposes.
- Work with the Early Childhood and MIECHV programs and partners to ensure alignment with needs assessments.
- Developed qualitative data collection methods and tools.

Guiding Frameworks

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

Methodology

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

Stakeholder Engagement, Existing Efforts and Resources

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

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

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

Data Collection

Quantitative Data

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

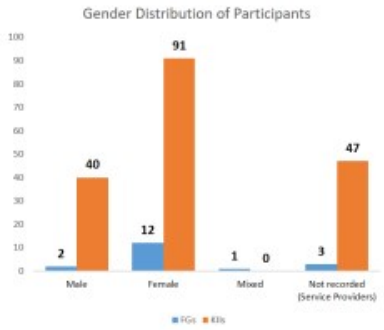
Updates for these dashboards are ongoing as these are meant to be living documents for broader use as part of ongoing assessment used by MCH stakeholders. The Virginia MCH LiveStories serve as a significant resource to inform stakeholders about the health status of the Virginia MCH population.

Qualitative Data

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

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

We sought inclusion and diversity within the population domains with certain lived experiences. KIIs and FGs with residents who speak Spanish (10), are within the refugee/immigrant community (8), have been incarcerated (3) or were in foster care (2), are women of color (2), identify as LGBTQ+ (1), and women who have experienced infertility (1).



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

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

Prioritization Process

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

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

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

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

Capacity and Partnerships/Collaboration

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

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

III.C.2.b. Findings

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

Population Needs

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

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

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

General Findings and Themes from Quantitative Data Collection

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

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

General Findings and Themes from Qualitative Data Collection

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

Women of Reproductive Age

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

Pregnant Women and Mothers of Young Children

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

Adolescents

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

Parents of CYSHCN

Health insurance for health care services is an asset and a frustration. Care coordination involves knowledge of the services, where they exist, and how to access them. Community-based resources promote inclusive recreation and acceptance in social settings. Dental care is a long-standing issue for children with special health care needs. Therapies and support services are challenging to access but effective when secured. Afterschool, summer, and respite (temporary relief) care are inconsistent across localities and expected level of support is lacking.

Men

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

MCH Providers and Systems

Many gaps and unmet needs exist among the current maternal and child health (MCH) providers and systems in which they function, from the individual to policy levels. Focusing MCH interventions on the individual patient is a common approach but too narrow to be effective. Relationships within families are known sources of influences to improved health but providers and systems do not readily provide support at this level. MCH providers describe system gaps related to capacity, coordination and availability of services, including specialists, itinerant care, medical homes, mental health, dental health, and hemophilia care. Community-level health influence is based on the relationships between organizations and the

connection with social determinants and factors such as transportation, housing, food security, childcare, and employment. National, state, local laws and regulations governs health care access, including Medicaid expansion. MCH providers demonstrate implicit bias in their practice and systems of healthcare have chronically oppressed and disenfranchised people of color, immigrants and non-native English speakers, persons of low socioeconomic status, incarcerated persons, people with disabilities, and those who identify as LGBTQ+. Many MCH providers in Virginia offer education, advocacy, health promotion, chronic disease management, preventive screenings, case management and care coordination, developmental evaluations, leadership and systems development, and general health care. Resolving the gaps may include more transparency on health care costs, culturally-responsive services, supporting the family unit in care settings, integration of medical-mental-dental care, employ telemedicine and satellite clinics, and move MCHBG funds to greatest needs in locality.

Summary of Key Population Health Findings

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

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

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

Since the VDH is within the Executive branch of Virginia's Government, the issues impacting MCH populations have a direct linkage to the Governor and subsequently Secretary of Health and Human services for Virginia. The Governor's Administration is supportive of women's health, children and youth and has initiated several efforts to expand state capacity to improve the health and well-being within these groups.

Organizational Structure

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

The Code of Virginia authorizes the VDH to prepare and submit the Title V plan.

The Commissioner of Health is authorized to administer the plan and expend the funds.

The grant is administered within the Office of Family Health Services.

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

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

A Shared Business Services team submits fiscal reports.

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

III.C.2.b.ii.b. Agency Capacity

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

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

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

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

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

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

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

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

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

Since the VDH is within the Executive branch of Virginia's Government, the issues affecting MCH populations have a direct linkage to the Governor and subsequently Secretary of Health and Human services for Virginia, which very supportive of women's health, children and youth and have initiated several efforts to expand state capacity to improve the health and well-being within these groups.

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

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

Title V Partnerships

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

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

Priority Need Selection

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

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

Priority Needs and Performance Measures

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

measures, and population domains.

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

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

Emerging Issues and Other Needs

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

III.D. Financial Narrative

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$12,092,401	$12,287,553	$12,128,653	$12,287,553
State Funds	$9,069,301	$9,215,665	$9,097,551	$9,215,665
Local Funds	$0	$0	$0	$0
Other Funds	$1,125,000	$1,618,704	$1,125,000	$1,618,704
Program Funds	$200,000	$2,086,819	$1,427,400	$1,852,807
SubTotal	$22,486,702	$25,208,741	$23,778,604	$24,974,729
Other Federal Funds	$12,847,299	$14,898,453	$16,914,458	$0
Total	$35,334,001	$40,107,194	$40,693,062	$24,974,729

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$12,287,553	$11,750,864	$12,287,553	
State Funds	$9,215,665	$6,169,903	$9,215,665	
Local Funds	$0	$0	$0	
Other Funds	$1,618,704	$1,625,174	$1,618,704	
Program Funds	$2,086,819	$1,547,972	$2,086,819	
SubTotal	$25,208,741	$21,093,913	$25,208,741	
Other Federal Funds	$16,989,838	$14,682,649	$0	
Total	$42,198,579	$35,776,562	$25,208,741	

	2022	
	Budgeted	Expended
Federal Allocation	$12,457,398	
State Funds	$6,092,387	
Local Funds	$0	
Other Funds	$1,702,690	
Program Funds	$1,547,972	
SubTotal	$21,800,447	
Other Federal Funds	$17,859,944	
Total	$39,660,391	

III.D.1. Expenditures

Form 2

In FY20, Virginia received a total federal allocation of $12,375,275. The allocation in Form 2 of the FY20 Budget portion of the MCH Budget/Expenditure Details shows an estimated budget of $12,287,553 (the FY19 allocation) as the allocation had not been awarded at the time of submission.

During the same period:

- The program expended $11,750,864 of federal funds and $9,343,049 of State MCH funds.
- A total of $1,625,174 in Other Funds was generated and expended (to perform newborn screening services, as required by the Virginia Assembly; state special funds generated as detailed in Cross-Cutting/Systems Domain application).
- A total of $1,547,972 in program income was generated and reinvested in delivery of Title V services.

FY20 expenditures for the state-federal Title V partnership totaled $21,093,913.

Sec. 505 (a)(4) requires that states maintain the level of funds provided by the state in fiscal year 1989. Virginia's maintenance of effort (MOE) amount from 1989 was $8,718,003. With a total state match of $9,343,049 (i.e. state, other and program income funds), Virginia has exceeded this requirement. Variances between the budgeted and expended amounts resulting from a slightly greater federal award (projected based on the FY18 award) and payroll coding corrections.

Form 3

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

Virginia has worked to align spending with the MCH pyramid by reducing direct patient care expenditures and increasing enabling services and public health systems investments. All expenditures support one or more of the 10 Essential Public Health Services.

III.D.2. Budget

The Title V MCH Block Grant budget for the FY22 Application allocated funds for MCH services, primary care for children and adolescents, and preventive and maintenance services for CYSHCN.

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

A sum of 1,625,174 in Other Funds is included for newborn screening services, as required by the Virginia General Assembly. These special revenue funds are generated through hospital fees assessed by the Division of Consolidated Laboratory Services. These funds not only sustain the program but ensure early screening, testing, and referral for all infants.

Services for CSHCN include an array of care coordination, insurance case management, and clinical services for persons under the age of 21 years who have or are at risk for disabilities, handicapping conditions, chronic illnesses and conditions or health related educational or behavioral problems, and development of community-based systems of care for such children and families. Program-generated income is reinvested in program operations.

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

The program budget includes the mandated state match of 4-to-3 ratio of federal to state funds and meets the maintenance of effort ("MOE") threshold. Sec. 505 (a)(4) of the state for MCH health programs (i.e. "state match") at a level of funds provided solely by level provided by the state in fiscal year 1989. The FY22 budget complies with both the state match and MOE mandates, as below:

FY22 Anticipated Federal Allocation: $12,457,398

FY22 Budgeted State Match: $9,343,049

(Virginia's 1989 MOE Threshold: $8,718,003)

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

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

III.E. Five-Year State Action Plan

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

State: Virginia

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

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

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

Virginia Department of Health (VDH) is led by Health Commissioner M. Norman Oliver, MD, MA, who was appointed by the governor in June 2018. Organizationally, Virginia's Title V Program, including CSHCN, is based in the Division of Child and Family Health, which is part of the Office of Family Health Services.

Virginia Title V Core Leadership Team includes:
Jennifer Macdonald, MPH, BSN, RN – Director, Division of Child and Family Health (DCFH)
Meagan Robinson, Ph.D. – Director, Division of Population Health Data (DPHD), Acting MCH Epidemiologist Lead
Cindy deSa, MPH, MSW, LCSW - Maternal and Child Health (MCH) and Title V Director
Marcus Allen, MPH - CSHCN Director
Dana Yarbrough, MS, MA – Virginia Title V Family Delegate
Toni Pintavalle, BS, MEd – Fiscal Grant Manager

Virginia's Title V Program acknowledges its role in the overall assurance of foundational public health services, and recognizes that those foundational programs are essential to all communities across the state. Prioritizing full alignment with the Virginia Department of Health's Strategic Plan, participating in State Needs Assessment planning and implementation only further ensures that the State's Title V population is represented, considered, and included in all essential services that only government can or will provide. The Title V program is essential in Governor Northam's goal of eliminating the racial disparities in maternal health outcomes by 2025; moreover, Title V's inclusion in this critical mandate, and its potential positive effects across all of Title V population, serves to emphasize the gravity and importance of Title V in the state of Virginia.

Additionally, Virginia's Title V Program acknowledges that although the state is often at or above the national average for key measures of maternal and child health, there are profound and avoidable health disparities and inequities across the state's MCH population. The qualitative and quantitative approach to the 2020 Needs Assessment determined the directional focus for the next five years, identifying ten broadly defined priority needs that are visible in all six MCH domains. Approaching these ten priority needs individually and collectively across domains reflects a true commitment to Virginia's women, mothers, infants, children, youth, and CYSHCN populations. This approach provides stronger collaboration across VDH Office of Family Health Services, and 35 local health districts governed under the Office of Community Health Services (CHS), recognizing that the life-course perspective approach is not completely linear in nature, and the populations served by Title V should be approached through coordinated, comprehensive systems.

Virginia's strategy for ensuring Title V Maternal and Child Health Block Grant funding is utilized with intention, effectiveness and efficiency includes:

DATA-INFORMED PROGRAM PLANNING & IMPLEMENTATION: Needs assessments conducted with both qualitative and quantitative methodology remain the driver for priority and gap identification and work plan development. Virginia's robust MCH epidemiology team drives, guides and supports all programmatic efforts through their ability to analyze data and identify trends, build and guide programmatic efforts through evaluation, and partner and exchange data as needed.

ADVANCING CORE COMMITMENTS TO FAMILY/COMMUNITY PARTNERSHIPS AND RACIAL EQUITY: Through both evidence-based and community-developed practices, Virginia's Title V program demonstrates its value and commitment to all populations, especially those who have been historically marginalized. The Title V Program seeks to understand the lived experiences of those we seek to serve, understand the rich landscape of their health priorities and challenges, and ground our decisions and resource allocations in evidence. By hearing, recognizing, and implementing those voices, Title V Program further shores up the commitment to the health and wellbeing that each Virginian deserves.

PARTNERSHIP-BASED, COLLABORATIVE APPROACH: Title V partners with organizations that work directly with communities at the community, local and state levels. These agencies, which includes the local health districts, are well positioned within the communities they serve, providing MCH services across all the population domains.

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

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

VIRGINIA'S MCH WORKFORCE

The Division of Child and Family Health (DCFH) has experienced and committed staff, all of whom bring passionate, unique and diverse professional and personal life experiences to their work in maternal and child health. All strive towards positioning themselves as collaborative statewide leaders and subject matter experts in their professional domains. Recruitment of qualified Title V staff, as well as retention and professional growth is of utmost importance. Complementary to the MCH Leadership Competencies, DCFH supports continued professional MCH leadership growth for DCFH Leadership and Team members. Each division identified opportunities for continued education relevant to the programmatic work, and staff are encouraged to participate, recognizing the important role of professional development in workforce capacity. Additionally, Title V program staff continuously provide technical assistance and support to their grantees and local health department staff. Title V funds support partially or in full the following positions:

DIVISION OF CHILD AND FAMILY HEALTH		
Position	**Direct reports**	**Changes/Updates**
Director, Division of Child and Family Health		
MCH/Title V Director	**District MCH Program Consultant	****New FY21-22**
NEWBORN SCREENING		
Birth Defects Surveillance Program Coordinator	Critical Congenital Heart Disease Coordinator	
Early Hearing Detection and Intervention (EHDI) Program Coordinator	cCMV Follow-up Coordinator EHDI Program Support	
MATERNAL AND INFANT HEALTH		
*Maternal and Infant Health Consultant	**MCH Breastfeeding Consultant	***Vacant** ****New FY21-22**
EARLY CHILD HEALTH		
Early Child Health Consultant		
Early Child Health Supervisor/MIECHV Director		
SCHOOL HEALTH		
School Health Nurse Consultant		
REPRODUCTIVE HEALTH		
Reproductive Health Supervisor/Title X Director	Family Planning QA Nurse Supervisor Adolescent Health Coordinator Youth Advisors (2)	
CYSHCN		
CYSHCN Director	Program Support Blood Disorders Program Coordinator Care Connection Staff (9)	

SHARED BUSINESS SERVICES		
Position	**Direct reports**	**Changes/Updates**
SBS Grants & Accounting Manager		

OFFICE OF FAMILY HEALTH SERVICES		
Position	**Direct reports**	**Changes/Updates**
Policy Analyst		

DIVISION OF PREVENTION AND HEALTH PROMOTION		
Position	**Direct reports**	**Changes/Updates**
Director, Division of Prevention and Health Promotion		
ORAL HEALTH		
Maternal, Infant & Adolescent Oral Health Consultant		**Vacant**
Special Needs Oral Health Coordinator		
INJURY AND VIOLENCE PREVENTION		
Injury & Violence Prevention Health Systems Coordinator		
Statewide Safety Seat Program Manager		
Injury & Violence Prevention Supervisor		

DIVISION OF POPULATION HEALTH DATA		
Position	**Direct reports**	**Changes/Updates**
Director, Division of Population Health Data	Division Support	
MCH EPIDEMIOLOGY		
*MCH Epidemiology Lead	Newborn Screening & Birth Defects Epi Reproductive & Perinatal Health Epi **Oral Health Epi/Evaluator (2) MCH Evaluator	***Vacant** ****Vacant**
Population Health Data Lead		**Vacant**
Cancer Epidemiologist		**Vacant**
Injury & Violence Prevention Epidemiologist		
Substance Abuse Prevention Epidemiologist		**New FY21-22**

OFFICE OF THE COMMISSIONER/OFFICE OF COMMUNICATIONS		
Position	**Direct reports**	**Changes/Updates**
MCH Communications/Branding Consultant		
Web & Social Media Specialist		

OFFICE OF CHIEF MEDICAL EXAMINER		
Position	**Direct reports**	**Changes/Updates**
Director, Division of Death Prevention		
Maternal Mortality Research Associate		
Child Fatality Research Associate		
Maternal Mortality Projects Manager		
Family Violence Programs Manager		

TITLE V TRAINING MODULES: PROMOTING HEALTHY COMMUNITIES

Title V partnered with University of Virginia Office of Continuing Medical Education and HIT Global to create Promoting Healthy Communities, an online learning consortium for continuing education opportunities. This partnership created an internet presence and virtual space for MCH-related content to be widely available to a broad audience. Additionally, this partnership allows MCH-related content to provide continuing education credits for physicians and nurses as part of their professional education needs; however, the modules are available to everyone for their individual and professional educational needs.

Promoting Healthy Communities offers 11 continuing education modules in three categories: www.promotinghealthycommunities.org

	Module Name	Enrollment Totals 7/1/19 – 6/30/20	Enrollment Totals 7/1/20– 6/30/21
www.bfconsortium.org	Breastfeeding Training	1,307	2,362
	Breastfeeding Refresher	235	203
www.newbornscreeningeducation.org	Critical Congenital Heart Disease Screening	162	193
	Critical Congenital Heart Disease Screening – What Parents Need to Know	70	93
	CCHD Webinar for Midwives	42	Module no longer active
	Introduction to Virginia's Early Hearing Detection & Intervention	57	8
	Newborn Dried Blood Spot Screening	280	425
www.promotinghealthycommunities.org	Healthcare Transition for Healthcare - Providers	45	49
	Healthcare Transition for Healthcare - Family	41	43
	Medical Home for Healthcare – Providers	37	43
	Medical Home for Healthcare – Family	20	20

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

Virginia Department of Health Office of Family Health Services (OFHS) has created an organizational culture that prioritizes family engagement and partnerships that are vital to improving its programs. OFHS serves for the health department as a touchstone for family participation. OFHS, in its adoption of AMCHP's definition of family engagement and partnership, moves to do more than just a set of family involvement activities by strategizing how to induct and integrate families into the complex world of health care and investing in families as leaders -- not only of their own family but also in systems change efforts. The AMCHP definition reads as follows: "Family engagement and partnership is defined as patients, families, their representatives, community programs/organizations, and health professionals working in active partnership at various levels across Maternal and Child Health/Title V – direct care, organizational design and governance, and policy making – to improve health and health care. This engagement and partnership is accomplished through the intentional practice of working with families for the ultimate goal of positive outcomes in all areas through the life course."

OFHS provides a number of opportunities for engaging and partnering for family input into MCH and CYSHCN programs, including: Parent feedback survey that assesses services provided by Care Connection for Children Centers; Contractual relationships with Parent to Parent of Virginia and the Family to Family Network of Virginia who provide outreach, mentoring and training to parents; Parents hired as family specialists/care coordinators at Care Connection for Children centers; Family representatives on the Virginia Early Hearing Detection & Intervention Advisory Committee and the Virginia Genetics Advisory Committee; and collaboration with the Virginia Leadership Education in Neurodevelopmental Disabilities.

Virginia's Title V Family Delegate partners in Maternal & Child Health through serving as:

1. Principle investigator and director of the Family to Family Health Information Center
2. Co-principal investigator and strategic direction manager of the Va-LEND program
3. Principal investigator for Virginia's infant mental health endorsement program
4. Principal investigator and co-lead of Virginia's Learn the Signs. Act Early! project
5. Co-lead with VDH of Virginia's state genetics team with NYMAC regional genetics center
6. Co-lead with VDH of Virginia's cohort with the MCH Workforce Development Center on building across state and local programs the equitable engagement with families
7. Co-lead with VDH of Virginia's Early Childhood Comprehensive Systems contract to build family leadership and identify policy, regulation and financial barriers to access to quality prenatal and early childhood systems and services

Through this work, the Family Delegate brings to Title V connections to larger systems and new partners, evidence-informed practices, ground level workforce issues, and a constant perspective of the importance of co-powering with ALL families.

Over the past 13 years, OFHS has worked collaboratively with the MCHB Family to Family Health Information Center (F2FHIC) housed within the Center for Family Involvement (CFI) at the Partnership for People with Disabilities at Virginia Commonwealth University. The Partnership is Virginia's university center for excellence in developmental disabilities and is also home to the Va-LEND program. Some examples of Title V – F2FHIC collaboration this reporting period include:

- Representation from Title V on a statewide **Family Engagement Network (FEN).** Having Title V serve on a state education parent priority project – the FEN facilitated by the CFI – affords opportunities to work with representatives from Virginia schools, military installations, family organizations, and institutes of higher education on best practices in engaging and partnering with families. Title V recently previewed a Transition module with the FEN. In exchange, FEN members are reminded by Title V involvement of the importance of health care in successful outcomes for students and families.
- Funding from the EHDI program to the CFI. Over the past 13 years, funding from the EHDI program to the CFI has supported **family to family support** to families of infants and toddlers diagnosed with hearing loss and engaged family leaders in **1-3-6 protocol systems change work**. Three to five families each year are trained and supported

to visit hospital newborn screening teams, audiology clinics and early intervention programs to learn more about the processes they use to communicate information to families and the types of referrals they make to families. And, these families co-facilitate the **EHDI Learning Communities** in their region that meet quarterly (at a minimum) to discuss and share resources on local gaps and concerns in supports and services to families of children who are deaf/hard of hearing. And, funds are provided to support local **family support groups** providing unbiased information to families whose young children are deaf/hard of hearing.

- Dana Yarbrough, CFI director, serves as Virginia's **Family Delegate**. In this role, Ms. Yarbrough attends and actively participates in OFHS planning meetings and co-leads special projects. She participates in Title V meetings related to developmental screening, Care Connection for Children, oral health, transition, and medical neighborhood. In addition, Ms. Yarbrough serves on AMCHP's Governance Board and brings information back to Virginia.
- Title V representation on CFI team. A member of the OFHS team participates in **bi-monthly CFI team meetings** that bring together 20 CFI staff and funders. These team meetings offer an opportunity for CFI team members to hear about current health department activities and for OFHS to receive training on family engagement and participation and learn about what is happening that is affecting access to and receipt of services and supports for over 2,000 CYSHCN and their families supported by the CFI each year.

Care Connection for Children located at Children's Hospital of the King's Daughters has two Title V-funded parent consultant staff that serve as Community Resource Coordinators. Both partner closely with the Tidewater Autism Society of America (TASA) chapter, and participate in the following: Virginia Beach Special Education Advisory Committee, Virginia Beach Special Education Policy Review Subcommittee, Hampton Roads Planning District Commission Inclusive Emergency Planning Committee, Hampton Roads Consortium for Children and Youth with Special Needs, CHKD Patient and Family Centered Advisory Council Unplanned Extubation Committee. Additionally, the parent representatives serve as Medicaid Waiver Mentor, participate in the CHKD High Cost/High Risk Case Management meetings, and Unite Us Referral Committee. Term just ended for the DMAS Medicaid Member Advisory Committee, through which there was membership of the the DMAS Senate Bill 213 Workgroup. This Workgroup was legislatively directed to evaluate the current Personal Maintenance Allowance amount for individuals receiving Medicaid-funded waiver services. In addition, the Workgroup was directed to examine the impact of the current Personal Maintenance Allowance amount, and other income limits, on the ability of Medicaid waiver service recipients to engage in meaningful work and live independently.

Emerging Issues

The COVID-19 pandemic has fully realized that families and systems are not fully prepared for telehealth, tele-intervention, tele-education. Additionally, there is identified need for more broad awareness of institutional bias/racism experienced by families by healthcare systems (e.g., delays in screenings/diagnostics, mortality rates higher for minority mothers/babies).

III.E.2.b.iii. MCH Data Capacity

III.E.2.b.iii.a. MCH Epidemiology Workforce

The Virginia MCH program is focused on data-driven, community-informed decision making as its foundation to improving outcomes and establishing priorities and objectives to meet the needs of Virginia's MCH population. Activities are supported and made possible through MCH leadership, a committed team, and epidemiology capacity.

The core Title V MCH Data Support Workforce is housed within the Office of Family Health Services (OFHS) Division of Population Health Data (DPHD). The division director provides oversight for the State Systems Development Initiative (SSDI). The MCH Epidemiology Unit is a centralized epidemiology unit in DPHD headed by the MCH Epidemiology Supervisor who serves as the Lead Epidemiologist for Title V. Additional capacity is available through a Reproductive and Perinatal Health (RPH) Epidemiologist and a Newborn Screening (NBS) Epidemiologist. The team also consists of two staff dedicated to oral health epidemiology and evaluation, supporting the state Dental Health Program within the OFHS Division of Health Promotion and Prevention. Two program evaluators within the unit support MCH programs regarding home-visiting (i.e. Healthy Start, MIECHV), newborn screening (i.e. EHDI), child and adolescent health. There is additional cross-cutting collaboration with the Injury and Violence Prevention (IVP) Epidemiologist within the DPHD Prevention and Health Promotion Unit, Cancer Epidemiologist/Evaluator in the Cancer Registry, and a Population Health Data Lead who provides data management, infrastructure, visualization and dissemination support to OFHS. Additional support has been proposed internally for a Substance Use Prevention Epidemiologist due to capacity needs to support overdose, injury and violence prevention, and marijuana legalization in the state.

MCH Data Support Workforce

The DPHD is dedicated to assuring the utilization of data to drive public health programming and initiatives, evidence-based practices, and improved outcomes. The positions and data housed in DPHD drives and conducts state and local needs assessments, assists programs with assessments and evaluations, and addresses epidemiologic needs of the OFHS. The following represents epidemiology, evaluation and analyst FTEs supported by Title V and SSDI.

Meagan Robinson, DrPH – 0.80 FTE **Director, Division of Population Health Data; SSDI Project Director**	
Funding	Title V MCH Block Grant; Cancer Registry
Education and Training	DrPH (Epidemiology and Biostatistics), Jackson State University MPH (Epidemiology and Biostatistics), Jackson State University BS (Biological Sciences), Mississippi State University
Roles and Responsibilities	• Provide broad epidemiologic and evaluation support to Title V as well as multiple OFHS programs. • Provide direction and oversight of the epidemiologic and evaluation teams supporting Office of Family Health Services, including teams with expertise in chronic disease, maternal and infant health, data and surveillance, data registries (Virginia Cancer Registry) and informatics. • Provide strategic direction for the advancement of analysis and visualization of data and the systems used for data analysis to enhance ability of programs to use data to drive action, including policy development.

Vacant – 0.75 FTE MCH Epidemiology Lead/Unit Supervisor; SSDI Coordinator, Lead Title V epidemiologist	
Funding	State Systems Development Initiative (SSDI); Title V MCH Block Grant; Virginia Neonatal Perinatal Collaborative (General Funds)
Education and Training	Preferred qualifications: Graduation from an accredited college or university with advanced degree in public health, epidemiology, or biostatistics or equivalent combination of education, training, and/or experience. MPH strongly preferred.
Roles and Responsibilities	• Provide expert epidemiologic, scientific, and technical leadership in designing and conducting epidemiologic investigation. • Provide advanced professional analytical work in the surveillance, detection, research, and needs assessment for the MCH populations. • Develop and design data collection, analysis, and dissemination methods. • Provide oversight of MCH monitoring and evaluation activities for OFHS programs (e.g. maternal/infant health, women's health, newborn screening, birth defects surveillance, home-visiting, child and adolescent health, CYSHCN).

Parker Brodsky, MPH – 0.50 FTE Newborn Screening Epidemiologist	
Funding	Early Hearing Detection and Intervention (EHDI); Title V MCH Block Grant; State Systems Development Initiative (SSDI)
Education and Training	MPH, University of Virginia BA (Global Public Health/ Biology), University of Virginia
Roles and Responsibilities	• Responsible for surveillance, communication, and investigation to EHDI, CYSHCN, Birth Defects and Newborn Screening programs. • Epidemiological and evaluation support, the coordination of assessment and analysis activities, and assisting in the development, reporting, and dissemination of national and state performance measures.

Evelyn Jones, MPH – 0.35 FTE Reproductve and Perinatal Health Epidemiologist	
Funding	Title X Family Planning; Title V MCH Block Grant; PEW Health Impact Project
Education and Training	MPH (Applied Public Health), Virginia Commonwealth University BS (Health Sciences/ Psychology), Virginia Commonwealth University
Roles and Responsibilities	• Responsible for surveillance, communication, evaluation and investigation to MCH programs; supporting Title X Family Planning services, Reproductive Health programs, PRAMS and other women's/maternal/infant health initiatives. • Epidemiological and evaluation support, the coordination of assessment and analysis activities, and assisting in the development, reporting, and dissemination of national and state performance measures.

Monalisa Mbaitsi, MPH – 0.25 FTE Dental Epidemiologist / Evaluator	
Funding	Title V MCH Block Grant; Oral Health Workforce Activities; Oral Health Outcomes Improvement Project; Dental Prevention Program (General Funds)
Education and Training	MPH (Global Health), Temple University BS (General Science/Chemistry), Virginia Commonwealth University
Roles and Responsibilities	• Conducts epidemiologic and evaluation activities for the state Dental Health Program, including monitoring and assessing the public health and disease burden, and evaluating program/project outcomes related to oral and dental health. • Oversight of surveillance and trend analysis; development and implementation of evaluation plans; technical assistance to program staff, contractors and partners; development of grant goals and objectives and progress reporting.

Vacant – 0.25 FTE Dental Epidemiologist / Evaluator (Epidemiologist Mid-level)	
Funding	Title V MCH Block Grant; Oral Health Workforce Activities; Oral Health Outcomes Improvement Project; Dental Prevention Program (General Funds)
Education and Training	Preferred qualifications: Graduation from an accredited college or university with advanced course work in public health, epidemiology, biostatistics, program evaluation or equivalent combination of education, training, and experience.
Roles and Responsibilities	• Conducts epidemiologic and evaluation activities for the state Dental Health Program, including monitoring and assessing the public health and disease burden, and evaluating program/project outcomes related to oral and dental health. • Oversight of surveillance and trend analysis; development and implementation of evaluation plans; technical assistance to program staff, contractors and partners; development of grant goals and objectives and progress reporting.

Jewel Wright, MPH – 0.12 FTE Program Evaluator	
Funding	Sexual Risk Avoidance Education (SRAE); Healthy Start; Early Hearing Detection and Intervention (EHDI), Title V MCH Block Grant
Education and Training	MPH, University of Washington BA (Liberal Arts/Community Health), The Evergreen State College
Roles and Responsibilities	• Program evaluation support to the Healthy Start Home Visiting Program, Sexual Risk Avoidance Education Program, EHDI and other maternal and child health programs as needed • Design and adapt evaluation protocols and tools for data collection; database management and analysis • Provide technical assistance to program staff for quality improvement using Continuous Quality Improvement frameworks and practices. • Developed and coordinated needs assessment/community profiles.

Lauren Yerkes, MPH – 0.25 FTE Injury and Violence Prevention (IVP) Epidemiologist	
Funding	Overdose Data to Action, Rape Prevention and Education, Title V MCH Block Grant, Suicide Prevention, Violence and Injury Prevention
Education and Training	MPH (Epidemiology), Virginia Commonwealth University BS (Human Development), Virginia Tech
Roles and Responsibilities	• Analyzes, performs quality assurance, and disseminates injury and violence data used by internal and external stakeholders to support program planning efforts, grant applications, and ongoing implementation of federally funded IVP initiatives. • Manages the ongoing development and enhancement of the IVP data visualizations and dashboards reflecting injury and violence surveillance and epidemiologic trends throughout the Commonwealth. • Proposes data-driven recommendations, develops evaluations, monitors IVP epidemiologic trends and patterns, and measures outcomes for IVP strategic plans and program growth and expansion. • Supports VDH MCH regarding neonatal abstinence syndrome (NAS) and sudden unintentional infant death (SUID) surveillance and other injury and violence-related cross-cutting topics.

Vacant – 1 FTE Population Health Data Lead (Agency Management Lead Analyst)	
Funding	Title V MCH Block Grant; State Systems Development Initiative (SSDI)
Education and Training	Preferred qualifications: A Master of Public Health (MPH) is strongly preferred from an accredited college or university with advanced coursework in public health data, epidemiology, statistical analysis, database management, computer programming, or website software and design, or equivalent combination of education, training, and experience.
Roles and Responsibilities	• Responsible for performing analysis, developing visualizations, and ensuring data management and infrastructure that lead to the provision of accurate and comprehensive information for data informed decision-making. • Performs data quality assurance for health data projects, and provides oversight and technical assistance in the inclusion of population health indicators from DPHD surveillance sources included in state and community health assessment and improvement planning. This position routinely consults with agency information management and informatics on updates to data storage, analytics and reporting layers.

Workforce Capacity

It's expected that individuals within mid-level or above epidemiologist positions in the DPHD hold a Masters-level degree (e.g., MPH, MS), and can show proficiency is working independently and in a team to make determinations about scope and direction of program planning. The DPHD director is a part of the Title V Leadership team. As noted in the attached organizational chart, the MCH Epidemiology Lead/Unit Supervisor reports to the DPHD director. The dental, NBS, and RPH epidemiologists, and program evaluators report to the MCH Epidemiology Lead.

Along with their employee work profile, to provide a solid foundation to support knowledge and understanding of MCH subject matter and data sources new MCH-focused epidemiologists are provided a position summery with key tasks, contacts, and resources. Within their first 30 days, a Development Plan is created that includes tasks to complete from MCH Navigator (i.e. online self-assessment, MCH Orientations, Epidemiology Training Bundle) and the AMCHP MCH Essentials Series (i.e. Using Data to Inform MCH Programs). The DPHD has a peer group philosophy for cross-training and problem solving, with an emphasis on learning. The MCH Epidemiology Unit are expected to engage in ongoing professional development beyond engaging in agency activities, to include HRSA MCHB trainings, CityMatCH MCH Epidemiology conferences and training courses, AMCHP conferences and learning labs, and Council of State and Territorial Epidemiologists (CSTE) opportunities, to name a few.

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

The Virginia (VA) SSDI program recognizes the importance of availability and accuracy of data to support all Virginia MCH programs, and is heavily involved in ensuring consistent annual access to widely used MCH data sources (including vital statistics, PRAMS, Medicaid, WIC, newborn screening, and hospital discharge). Direct and indirect access to these data sources allows for descriptive and inferential analyses that provide a wealth of information to inform Title V programming, assessment, and monitoring. The SSDI Grant provides capacity and support to improve our ability to share and link MCH data to drive public health practice and programming. Cross-program data sharing provides the foundation for special projects, and data analysis allows program staff to determine the efficacy of program activities.

MCH Data Systems

Through the VDH Office of Information Management (OIM), MCH epidemiology staff have direct, annual access to timely, electronic, and standardized Health Statistics data and Virginia Health Information (VHI) hospital discharge data via an Oracle-based server. This ensures continued access to data files of birth, death, fetal death, linked birth-infant death, induced terminations of pregnancy, and hospitalization data. OIM coordinates data loading and cleaning functions of these data sources. The team also has portal access to Virginia's All Payer Claims Database (APCD), a program that collects paid medical and pharmacy claims for Virginia residents with commercial, Medicaid and Medicare coverage across all types of healthcare services. Direct data access also includes the OIM developed Virginia Infant Screening and Infant Tracking System (VISITS II), a Web-based integrated data tracking and management system that directly supports the Virginia Congenital Anomalies Reporting and Education System (VaCARES) and the Virginia Early Hearing Detection and Intervention Program (VEHDI). There is annual linkage of birth to infant death, and birth defects, newborn screening, and newborn hearing screening data to birth records. Due to limited identifying information availability in VHI hospital discharge and APCD, there is limited to no linkage capability.

The peer group style of the DPHD allows the MCH Epidemiology Unit to cross-collaborate with data systems and epidemiology units within the division, including Injury/Violence Epidemiology and the Population Health Surveys Team. The Virginia Pregnancy Risk Assessment Monitoring Systems (VA PRAMS), which is a critical source of data for Title V performance measure reporting, is housed within the DPHD, along with the Behavioral Risk Factor Surveillance System (BRFSS) and the Virginia Youth Survey (Youth Risk Behavior Survey). The MCH Epidemiology Lead and the RPH Epidemiologist support and regularly collaborate with the VA PRAMS Coordinator/Epidemiologist to perform sampling, reports, data requests, and projects. On or near the 15th of each month the RPH epidemiologists coordinates with the PRAMS Coordinator/Epidemiologist to draw the monthly PRAMS sample. Annual the birth file is prepared and forwarded to CDC PRAMS for weighting. Through collaboration between VA SSDI, VA PRAMS and the OIM, we have been able to do timelier submission of this file (submitted around November/December of previous years, now submitted July/August in 2019 and 2020).

Title V Assessment, Monitoring, & Reporting

VA SSDI is actively involved in assuring that VA MCH meets requirements of the Title V performance measurement framework. The program is participates in and leads assessment, monitoring, reporting, and evaluation activities, where the SSDI Project Director (DPHD Director) provides oversight, the SSDI Coordinator (MCH Epidemiology Lead) ensures implementation, and with support from the other members of the epidemiological and MCH teams.

The SSDI Project Director, MCH Epidemiology Unit, and other DPHD epidemiological supports (e.g. Population

Health Surveys Unit, CHA/CHIP Coordinator) provided extensive support throughout the 2020 statewide MCH needs assessment process and ongoing throughout the five-year plan period. These teams were integral in implementing a mixed-methods approach for the needs assessment process, with a priority to maximize the input of internal and external partners, and engagement of families and consumers in a meaningful way.

As part of the ongoing epidemiologic support, monitoring and assessment, the SSDI grant and project director continue to assist with:

- Refinement of state action plan state specific performance measures and evidence-based strategy measures.
- Setting and refining annual performance measure objectives.
- Ongoing assessment by updating annual trends and analysis related to the needs assessment and priorities, including highlighting statistical significant findings.
- Developing and implementing program evaluation and data management plans.
- Support for funding opportunities (e.g. grant writing, data requests, analysis and interpretation).
- Developing and preparing resources (e.g. issue briefs, fact sheets, dashboards).
- Participation on internal and cross-agency/organization workgroups.

Key Program Activities, Products and Resources

VA SSDI continues to be an active participant among MCH leadership, programs, and agency initiatives to provide emerging, persisting or ongoing needs in response to staff requests, subject matter expertise, team projects and local requests for data. SSDI provides VA the capacity to support Title V program efforts in addressing the state's MCH priority needs, conducting the Five-Year Needs Assessment, implementing the Five-Year State Action Plan, and advancing data-driven MCH programming.

Support	Details
Title V MCH Block Grant	VA SSDI provides ongoing data support on the most current available data and trends in selected Title V indicators and priorities. In coordination with the Title V/MCH Program team, National, State, and Evidence-based Strategy Measures are evaluated following the statewide MCH Needs Assessment and annually to assess program work plans and capacity. Selection, updates and creation of measures occur annually in reference to MCH capacity and priorities. VA SSDI prepares and presents to OFHS Leadership and MCH Programs recent trends and findings regarding selected performance measures and related measures annually, and this presentation is shared widely among MCH stakeholders.
MCH Needs Assessment	VDH MCH implemented a mixed-methods approach for the Virginia Title V Five-Year Needs Assessment process, with a priority to maximize the input of internal and external partners, and engagement of families and consumers in a meaningful way. The products produced from the needs assessment are found online, including Virginia MCH LiveStories, which serves as a significant resource to inform stakeholders about the health status of the Virginia MCH population, and results from the population-based and action-focused qualitative portion of the assessment.
Data Reporting	MCH Epidemiology works with the Population Health Data Lead to create a more efficient system for data visualization, extraction and management. VA SSDI continues to maintain and update the MCH Dashboard, which includes common MCH indicators at the state, health district, and locality level. The dashboards on the public-facing VDH Data Portal are used by health districts in the community health assessment (CHA) process and by the public and academia for general direction. The team has plans to expand the current information available on the public facing portal to have race/ethnicity stratifications and include indicators from the Minimum-Core Dataset. The team participates in regular project meetings with OIM staff to manage plans and ensure consistency of indicators presented on the public-facing MCH Dashboard and tables used by division staff. As the COVID-19 pandemic emerged in Virginia, VA SSDI worked to create an internal MCH COVID-19 dashboard to show diagnoses among pregnancy status, including visualization by locality, race/ethnicity and age, and including numbers by healthcare worker status. There is also a dashboard for children and adolescents age 0 to 21, which can be filtered by age groups. VA SSDI created a dashboard that overlays state birth outcomes with the AMCHP Concentrated Disadvantage Life Course Metric to assess MCH needs within the state and identify potential “hot spots” for VDH’s MCH reach. This project was presented at the 2020 AMCHP Annual Conference, titled “Mapping Concentrated Disadvantage in Virginia for Guiding Program Initiatives and Decision-Making.”

Other MCH Data Capacity Efforts

As mentioned above, the peer group style of the DPHD and cross-office and agency collaborations allows the MCH Epidemiology Unit to access data and information systems to support MCH epidemiological activities.

Virginia House Bill 1467 (2017) required the Board of Health to adopt regulations to include Neonatal Abstinence Syndrome (NAS) on the list of reportable diseases. Medical facilities report NAS into the VDH online Confidential Morbidity Report portal (Epi-1). The MCH Epidemiology Supervisor and IVP Epidemiologist have direct access to this data and share responsibility for reporting of NAS hospital discharges (Opioid Addiction Dashboard) and medical facility reported cases (Physician Reported NAS Cases). The Opioid Addiction Dashboard is a product of the agency's Opioid Addiction Surveillance and Data Workgroup, where the MCH Epidemiology Supervisor and the IVP Epidemiologist are members of this cross-office group.

The DPHD maintains multiple public-facing dashboards that provide data on common indicators at the state, region, district and locality level. These dashboards include MCH, Health Behavior, and Injury and Violence.

The Virginia Pregnancy Risk Assessment Monitoring Systems (VA PRAMS), Behavioral Risk Factor Surveillance System (BRFSS), Virginia Youth Survey (Youth Risk Behavior Survey), and the Virginia Cancer Registry (VCR) are housed within the DPHD. DPHD epidemiologists, including the MCH Epidemiology Unit, actively participate on steering committees regarding these sources and collaborate for access and analysis. Virginia Senate Bill 1406 (2021) established the legalization of marijuana in the state as of July 1, 2021. Our population health surveys are making provisions to add marijuana-related supplements/questions to the surveys, with PRAMS set to start the marijuana supplement October 2021 and BRFSS in 2022.

Virginia House Bill 2111 (2021) established the Maternal Health Data and Quality Measures Task Force for the purpose of evaluating maternal health data collection to guide policies in the Commonwealth to improve maternal care, quality, and outcomes for all birthing people in the Commonwealth. The provisions of the bill require the Task Force to monitor and evaluate relevant stakeholder data related to race, ethnicity, demographic and clinical outcomes to examine quality of care. The MCH Epidemiologist Lead will serve as a subject matter expert/member on this Task Force.

Unite Us: Unite Virginia is a coordinated care network of health and social care providers. Partners in the network are connected through a shared technology platform, Unite Us, which enables them to send and receive electronic referrals, address people's social needs, and improve health across communities. Unite Virginia is built in partnership with the Office of the Virginia Secretary of Health and Human Resources, the Virginia Department of Health and the Virginia Department of Social Services, Optima Health, Virginia Hospital & Healthcare Association, Partnering for a Healthy Virginia, and Kaiser Permanente. The actions taken in the Unite Us platform generate data about referral outcomes and population characteristics.

VHHA Maternal Health Dashboard: VDH and the Virginia Neonatal Perinatal Collaborative (VNPC) partnered to provide all birthing hospitals in Virginia access to the Maternal Health Outcomes Dashboard Analytics platform created by the Virginia Hospital & Healthcare Association (VHHA). The Maternal Health Outcomes Dashboard provides a comprehensive look at factors that drive maternal health outcomes, allowing the ability to investigate/visualize birth outcomes, severe maternal morbidities (SMM), chronic disease, and more stratified by race, zip code, payer type, and social determinants of health.

III.E.2.b.iv. MCH Emergency Planning and Preparedness

COMMONWEALTH OF VIRGINIA EMERGENCY RESPONSE:

The Governors' Executive Order Number 42, signed on 9/3/2019, updated the Commonwealth of Virginia Emergency Operations Plan, naming Virginia Department of Emergency Medicine (VDEM) as the state agency responsible for the activation and maintenance of the Plan, which provides for state government's response to emergencies and disasters wherein assistance is needed by affected state, tribal, and local governments in order to save lives, protect public health, safety, and property, restore essential services, and enable and assist with economic recovery.

Virginia Department of Emergency Management (VDEM) is the state agency that works with local government, state and federal agencies and voluntary organizations to provide resources and expertise through the five mission areas of emergency management: Prevention, Protection, Mitigation, Response and Recovery.

VDEM is responsible for maintaining the Emergency Operations Plan (COVEOP). The COVEOP is continually reviewed and periodically updated as required to incorporate federal policy changes, gubernatorial directives, legislative changes, and operational changes based on lessons learned from exercises and actual events. The COVEOP is reviewed and adopted in its entirety by the governor at least every four years.

The COVEOP lists Virginia Department of Health (VDH) as one of seven supporting agencies, and is assigned to seven emergency support functions (ESF) when activated.
The Virginia Department of Health's mission is to protect the health and promote the well-being of all people in Virginia. To accomplish this mission, VDH must ensure its operations are performed with minimal disruption during all-hazards emergencies or other situations that disrupt normal operations.

The COVEOP identifies five Emergency Support Function (ESF) areas in which Access and functional needs (AFN) are addressed. Those ESF areas are: maintaining independence, communication, transportation, supervision, and medical care. The assistance needs of individuals may occur as a result of a number of conditions, both temporary and permanent, that limit their ability to take action or access services. No diagnosis or specific evaluation is required to determine an individual has an access or functional need. Individuals with access and functional needs may include individuals from diverse cultures, races, and national origins; people with limited English proficiency; those who do not read; and those who have physical, sensory, behavioral, mental health, intellectual, developmental, and cognitive disabilities including individuals who live in the community and individuals who are institutionalized; women who are in late or high-risk pregnancy; and individuals who have acute and chronic medical conditions.

OFFICE OF FAMILY HEALTH SERVICES EMERGENCY RESPONSE PLAN:

Within VDH, however, there are mission essential functions (MEFs) that must continue with minimal disruption during all-hazards emergencies or other situations that disrupt normal operations. The Office of Family Health Services (OFHS) implemented a continuity plan (COOP) to ensure that OFHS is capable of conducting its MEFs under all threats and conditions, while mutually responding to the Agency requirements as a supporting agency. Three OFHS MEFs were identified:

- The Virginia Newborn Screening Program
- Food and Nutrition Programs – Women, Infants and Children (WIC)
- Food and Nutrition Programs – Child and Adult Food Program (CACFP)
  The OFHS COOP Plan establishes a line of succession for key leadership posi

All new VDH employees are required to complete Federal Emergency Management Agency (FEMA) National Incident Management System (NIMS) basic level training courses (IS-700 and ICS100 levels), and all existing employees are expected to participate in periodic training, updates. Additionally, tabletop, functional, or full-scale exercises are conducted annually in accordance with the Governor's Executive Order Number 42.

Title V Leadership participates in the annual COOP update with VDH Leadership. Title V Leadership is not involved in higher level Agency planning, as this is usually incident specific. In the event that a Declaration of Emergency is called and an Incident Command Structure is established, all Title V staff are eligible for assignment as indicated by need.

VIRGINIA MCH KEY PARTNERSHIPS & COLLABORATIONS

Name of Group	MCH Team Representation	Purpose
Children's Health Insurance Program Advisory Board (CHIPAC)	Director, Division of Child & Family Health (DCFH)	Child and adolescent health, oral health, health coverage
EHDI Advisory Board		
Newborn Screening Advisory Committee		
Virginia Interagency Coordinating Council (VICC)	Early Childhood Health (ECH) Consultant	Early Intervention with state representatives from early childhood programs, screening and referrals
Early Impact Virginia	ECH Team	Infant mortality, child health, maternal health, prenatal care (home visiting programs)
Virginia School Nurse Association	School Health Nurse Consultant	Child and adolescent health, Bright Futures guidelines
Annual Meeting of Virginia Chapter of the American Academy of Pediatrics (VA-AAP)	School Health Nurse Consultant Adolescent Health Coordinator	Child and adolescent health, Bright Futures guidelines
March of Dimes Committee (MOD)	Maternal Infant Health (MIH) Consultant	Maternal and child health
5 Star Breastfeeding Program	• Director, DCFH • MIH Consultant	Maternal and child health
Contraceptive Access Workgroup	Reproductive Health Unit Supervisor	Unintended pregnancy, birth spacing
Department of Education (DOE) Virginia Preschool Initiative +	Director, DCFH	School readiness for 4-year olds in high-risk communities
Virginia Neonatal Perinatal Collaborative (VNPC)	• Director, DCFH • MCH/Title V Director	Maternal and infant health, and preterm birth
Safe Sleep Initiative	MIH Consultant	Infant mortality (IM) and safe sleep
Head Start Collaborative	ECH Team	Early Childhood health; developmental screening
Advisory Board and Head Start State Health Advisory Committee	ECH Consultant	
Early Childhood Mental Health Advisory Board	ECH; MIECHV Project Director	Early Childhood mental health; Social, Emotional and Behavioral Health Issues related to developmental screening
Infant Toddler Specialist Network Advisory Board	ECH	Early Childhood health
Maternal Mortality Review	MIH Coordinator	to study and understand causes of Maternal mortality and identify potential preventative measures to implement to prevent future deaths
Child Fatality Review		

Virginia Food Security Leadership Team	Director, Division of Prevention & Health Promotion Director, DCFH	Targeted policy review and shared decision efforts to increase food security: VDH, DSS, DOE, Virginia Poverty Law Center, Virginia Federation of Food Banks, Governor's Office
National Academy for State Health Policy (NASHP) MCH Policy Innovations Program (PIP) Project	• Director, DCFH • Reproductive Health Unit Supervisor • Adolescent Health Coordinator	DMAS-Led Project in Petersburg: Emphasis on 90 days postpartum, decreasing maternal mortality and morbidity through teen engagement and access to care.
AMCHP Healthy Beginnings with Urban Baby Beginnings	Title V Team	
City MatCH Learning Collaborative – Alignment for Action Learning	Director, DCFH Blue Ridge Health District	Project Aim: Align state and local level action to make advancements towards MCH priority areas
PEW Charitable Trust: Calling All Sectors	Director, DCFH MCH Director EPI Director	Project Aim: Align state and local level action to make advancements towards MCH priority areas, specifically focused on aligning health systems and CBOs on a specific goal

VIRGINIA MCH COLLABORATES WITH OTHER STATE/FEDERAL AGENCIES /PROGRAMS

- All 35 Local Health Districts
- WIC
- Healthy Start
- Newborn and Early Childhood Screenings
- Blood Disorders Programs (sickle cell, hemophilia)
- Maternal, Infant and Early Childhood Home Visiting (MIECHV)
- Department of Medical Assistance Services (DMAS)
- Department of Behavioral Health and Developmental Services (DBHDS)
- Department of Education (DOE)
    - Department of Deaf and Hard of Hearing
- Department of Social Services (DSS)
- Department for the Blind and Vision Impaired (DBVI)

III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

Virginia Department of Medical Assistance Services (DMAS) administers the state's Medicaid and CHIP programs, playing an essential role in the Commonwealth's health care system by offering lifesaving coverage. One in four (599,640) children ages 0-19, and 38% of children with special healthcare needs are covered by Medicaid or Family Access to Medical Insurance Security (FAMIS), Virginia's CHIP program.

Virginia's Medicaid program covers approximately 1,870,000 individuals and is delivered to individuals through two models: fee-for-service (10% of enrollees) and managed care (90% of enrollees).

MEDICAID AND FAMIS PROGRAMS FOR CHILDREN AND PREGNANT INDIVIDUALS:

- FAMIS Plus, or children's Medicaid - Coverage to low-income children (with family income 0-143% of the federal poverty limit) from birth up until age 19
- FAMIS, Virginia's CHIP program - Coverage for uninsured children whose families are above the income cutoff for Medicaid but below 205% FPL, who cannot afford commercial coverage
- Medicaid for Pregnant Women - Comprehensive coverage for pregnant women up to 148% FPL
- FAMIS MOMS (CHIP for pregnant women) - Comprehensive coverage for uninsured pregnant women between 148 and 205% FPL
- Medicaid Waivers:
    - **Developmental Disability Waivers (DDW):** Virginia has three waivers for individuals with a developmental disability: 1. Building independence for individuals 18 and older; 2. Family & individual support; 3. Community living. Virginia Medicaid administers DD Waivers jointly with the Virginia Department of Behavioral Health and Developmental Services. There is a waiting list, and slots are assigned based on urgency of need.
    - **Commonwealth Coordinated Care (CCC) Plus Waiver:** The CCC Plus Waiver serves all ages and does not have a waiting list. The waiver provides care in the home and community rather than in a nursing facility or other specialized care medical facility. The CCC Plus Waiver provides supports and service options for successful living, private duty nursing, personal care respite, assistive technology and environmental modifications. DMAS oversees the Medicaid Long-term Services and Supports Screening Process in Virginia to evaluate what services may be available to an individual, including services through the CCC Plus waiver.

BABYCARE PROGRAM:

Virginia's BabyCare Program plays an essential role in providing health care to children and pregnant women. The program provides behavioral risk screening, case management services, and expanded prenatal services for pregnant women in order to: (1) Reduce infant mortality and morbidity; (2) Ensure provision of comprehensive services to eligible pregnant women and infants up to age two; and, (3) Enable pregnant women and caretakers of infants to receive wrap-around services that improve their well-being. Pregnant women not enrolled in Managed Care are eligible for BabyCare during pregnancy and through the end of the month of the 60th post-partum day, and infants are eligible up to age two. Each of the contracted health plans have similar programs and services for high-risk moms and infants up to age two. Specifically, case management services are available to high-risk pregnant women and children up to age two. "High Risk" needs can include any elements identified in the psychosocial, medical or nutritional domains of the screening tool administered by an RN or BSW/MSW. The BabyCare Program is administered across the state in all of Virginia's Local Health Departments, rural health clinics and FQHCs.

MEDICAID EXPANSION UPDATES THAT IMPACT TITLE V POPULATION:

- **MEDICAID EXPANSION:** In January 2019, new Virginia Medicaid expansion eligibility rules went into effect, resulting in a decrease of the overall uninsured rate from 12.3% to 11% between 2018 and 2019. The reduction was more dramatic for adults ages 18-64 with incomes below 138% FPL, with the uninsured rate dropping from 28.1% to 23%.
- **MEDICAID DENTAL BENEFITS EXPANSION:** Effective July 1, 2021, Virginia's nationally recognized ***SFC*** program

will continue to provide dental benefits to children age 20 and below, and pregnant women but will now add coverage to adults in Medicaid. Dental coverage for adults enrolled in Medicaid will focus on overall oral health, prevention and restoration and will be similar to the coverage currently available to pregnant women. There are no additional costs or co-payments for children, pregnant women or adults.

- **PRENATAL AND POSTPARTUM COVERAGE EXPANSIONS:**
  - Starting 7/1/2021, Virginia offers new FAMIS Prenatal Coverage, a comprehensive coverage program for pregnant individuals who meet all other eligibility criteria, regardless of immigration status. Applicants do not need to provide immigration documents or have a Social Security number to qualify for FAMIS Prenatal. Applicants must still meet income and state residency requirements.
  - In November 2020, Virginia's General Assembly and Governor enacted legislation directing DMAS to extend coverage to 12 months postpartum for FAMIS MOMS and other pregnant populations who otherwise would not qualify for a full-benefit eligibility category beyond 60 days postpartum. Virginia submitted a Section 1115 waiver amendment application requesting this change to the federal government on March 31, 2021. Waiver negotiations are in progress; Virginia will implement the extended postpartum coverage upon federal approval. By ensuring coverage during the critical 12 months postpartum, Virginia aims to reduce maternal and infant morbidity and mortality, improve health outcomes, and advance health equity.

MEDICAID COVID RESPONSE:

In 2020, Virginia Medicaid responded to the COVID-19 pandemic state of emergency declaration with a comprehensive set of policies, including temporary changes providing flexibility in eligibility rules. This resulted in an increase in Medicaid coverage for an additional 228,528 Virginians, including 72,286 children. Additional COVID-related benefits and temporary emergency flexibilities for Medicaid recipients positively impacted the MCH community. These included:

1. Suspension of co-pays for Medicaid or FAMIS-covered services for the duration of the public health emergency
2. Outreach to high risk members to review critical needs
3. Expanded telehealth options
4. Routine prescriptions supplied at 90-day intervals
5. Safeguard for coverage lapse due to processing delay

In September 2019, Virginia Medicaid was awarded $4.6 million from Centers for Medicare and Medicaid Services (CMS) Section 1003 Substance Use Disorder (SUD) Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act Grant. The grant's goal is to increase provider capacity for addiction and recovery treatment, and has designated Medicaid members who are pregnant and parenting as a priority population. Grant activities included providing training to providers on best practices for treating pregnant and postpartum individuals for substance use disorders. The grant also supported Preferred Office-Based Opioid Treatment programs that target pregnant and parenting individuals, such as OB-Motivate through the Virginia Commonwealth University.

VDH TITLE V/DMAS COLLABORATIONS:

VDH Department of Family Health Services, and specifically Title V and CYSHCN Programs, have a strong and collaborative partnership with DMAS, prioritizing and aligning shared goals and joint policy-level decision making.

Current collaborations include:

1. **Doula Reimbursement/Doula Certification:** DMAS is currently establishing a process for Doula enrollment and reimbursement, in collaboration with VDH's work regarding establishing doula certification.
2. **BabyCare:** Five health districts have robust BabyCare programs through which Title V funding supports their efforts.
3. **National Academy for State Health Policy (NASHP): Maternal and Child Health Policy Innovation Program** – DMAS applied for, and was awarded this funding, and subsequently invited Title V to participate in the following: Cohort 1 (2019/2020) Program focused on substance abuse and mental health; Cohort 2 (starting March 2021)

Program focus includes maternal mortality for Medicaid eligible population.

4. **Care Connection and CCC Plus Managed Care (Care Coordination)**-Training and education provided for Care Connection Care Coordination and MCO Care Coordinators on programs and roles to improve collaboration and the delivery system for children and youth with specialized health care needs.

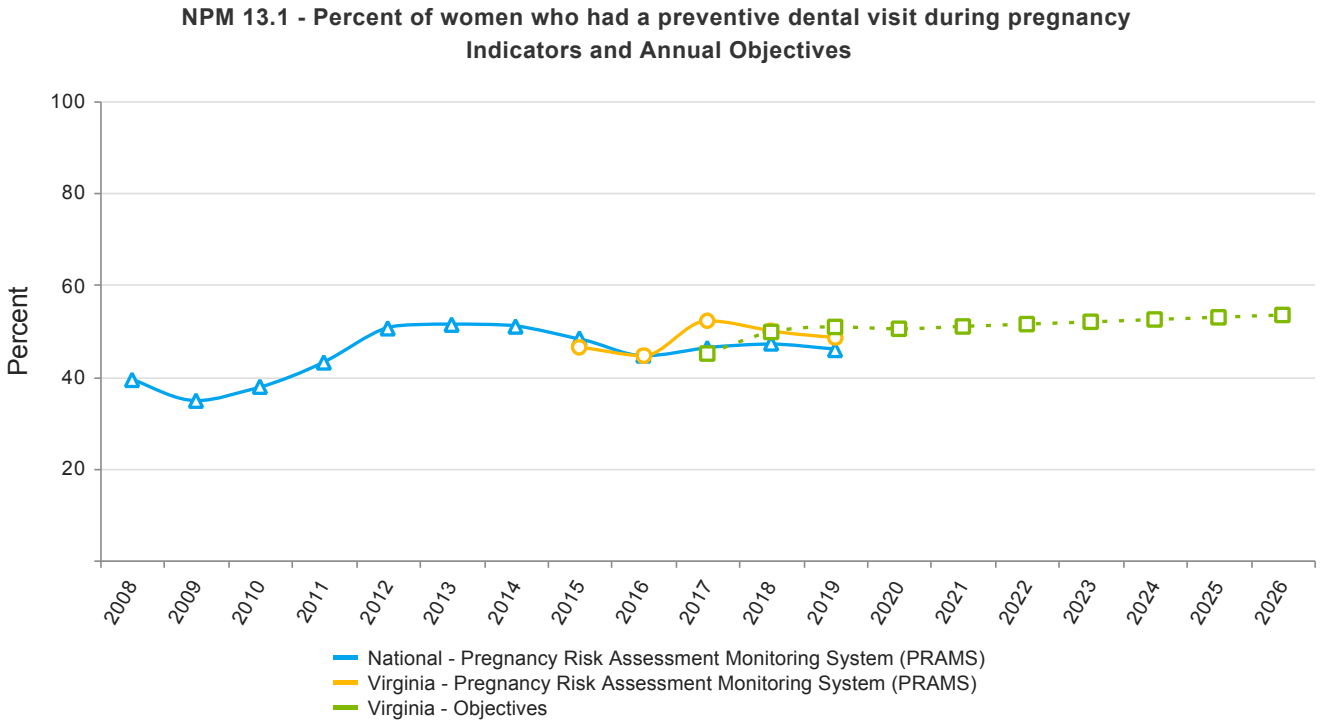
III.E.2.c State Action Plan Narrative by Domain

Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2018_2019	7.3 %	NPM 13.1
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	15.0 %	NPM 13.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	90.3 %	NPM 13.1

National Performance Measures



Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2017	**2018**	**2019**	**2020**
Annual Objective	45	49.7	50.8	50.4
Annual Indicator	46.5	44.7	49.9	48.4
Numerator	44,225	42,882	46,558	43,840
Denominator	95,088	95,839	93,304	90,596
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2016	2018	2019

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		45	49.7	50.8	50.4
Annual Indicator	43.6				
Numerator					
Denominator					
Data Source	PRAMS				
Data Source Year	2010-2011				
Provisional or Final ?	Provisional				

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.9	51.4	51.9	52.4	52.9	53.4

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			6	6
Annual Indicator		3	4	8
Numerator				
Denominator				
Data Source		VDH Oral Health Program documentation	VDH Oral Health Program documentation	VDH Oral Health Program documentation
Data Source Year		2018	2019	2020
Provisional or Final ?		Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	6.0	6.0	6.0	7.0	7.0	8.0

State Performance Measures

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	25.3	27.1
Numerator		
Denominator		
Data Source	VA PRAMS	VA PRAMS
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	23.8	23.3	22.8	22.3	21.8	21.3

State Outcome Measures

SOM 2 - Maternal Mortality Disparity: Black/White Maternal Mortality Ratio

Measure Status:	Active

State Provided Data			
	2018	2019	2020
Annual Objective			2.8
Annual Indicator	1.9	2.2	2.7
Numerator	52.6	32.4	38.2
Denominator	27.7	14.5	14.1
Data Source	National Vital Statistics System	National Vital Statistics System	National Vital Statistics System
Data Source Year	2013-2017	2014-2018	2015-2019
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	2.4	2.1	1.8	1.5	1.2	1.0

State Action Plan Table

State Action Plan Table (Virginia) - Women/Maternal Health - Entry 1	
Priority Need	
Oral Health: Maintain and expand access to oral health services across MCH populations.	
NPM	
NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy	
Objectives	
By June 30, 2025, increase the percent of women who had a dental visit during pregnancy from 50.8% (PRAMS 2018) to 52.9%	
Strategies	
Maintain and expand existing MCH-focused dental education programs to improve oral health for individuals across the lifespan, to include advising on oral health integration in primary care settings, education for home visitors, school-aged oral health education, and emerging needs of adolescents	
Sustain network of 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	
ESMs	**Status**
ESM 13.1.1 - Number of Regional Oral Health Collaborative Projects that implemented work plans to increase dental visits among pregnant women	Active
NOMs	
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	

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

Priority Need

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

SPM

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

Objectives

Eliminate the disparity between black maternal mortality rate (38.2 per 100,000 live births) and white maternal mortality (14.1 per 100,000 live births) by June 30, 2025 Decrease Black/White maternal mortality ratio from 2.7 to 0.0 by June 30, 2025

Strategies

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

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

Coordinate, strengthen and expand the impact of bi-monthly MMRT meetings

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

Priority Need

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

SPM

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

Objectives

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

Strategies

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

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

Identify training needs and provide ongoing training for Resource Mothers staff

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

Priority Need

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

SOM

SOM 2 - Maternal Mortality Disparity: Black/White Maternal Mortality Ratio

Objectives

Eliminate the disparity between black maternal mortality rate (38.2 per 100,000 live births) and white maternal mortality (14.1 per 100,000 live births) by June 30, 2025Decrease Black/White maternal mortality ratio from 2.7 to 0.0 by June 30, 2025 Decrease Black/White maternal mortality ratio from 2.7 to 0.0 by June 30, 2025

Strategies

Conduct epidemiological surveillance using MMRT Surveillance Database

Complete 2015-2017 maternal mortality data review for in-depth analysis

WOMEN/MATERNAL HEALTH DOMAIN
SUMMARY/OVERVIEW
FY20 ANNUAL REPORT

2016-2020 MCH Priority Needs Addressed in this Domain
Women's/Maternal Health: Support the physical and emotional well-being of women and their children
Oral Health: Increase access to oral health services for pregnant women and children

NOTE: The FY20 Annual Report represents the final year of priorities, strategies and activities aligned with the 2016-2020 needs assessment and state action plan for the Women/Maternal Health Domain.

DOMAIN CONTRIBUTORS:
Maternal and Infant Health (MIH) Coordinator – Division of Child and Family Health
Reproductive Health Unit – Division of Child and Family Health
Division of Death Prevention – Office of the Chief Medical Examiner (OCME)
Dental Health Program – Division of Prevention and Health Promotion

DOMAIN OVERVIEW

MATERNAL AND INFANT HEALTH (MIH) COORDINATOR: The MIH Coordinator serves as subject matter expert housed at VDH's Central Office who partners closely with an array of state and local partners, including the Virginia Neonatal Perinatal Collaborative (VNPC), the Maternal Mortality Review Team, and the recently-formed maternal mental health workgroup and Pathway to Coordinated Care for Infants and Families (PCC) workgroup.

- **Virginia Neonatal Perinatal Collaborative (VNPC):** As of February 2020, the Virginia Neonatal Perinatal Collaborative (VNPC) moved to Virginia Commonwealth University through a contract with VDH. VDH continues to provide contract administration, epidemiological support, and is represented on all VNPC committees. VNPC selected three initial quality improvement (QI) projects to focus on based on the Alliance for Innovation on Maternal Health (AIM) patient safety bundles : (1) reduce the use of inpatient intravenous antibiotics at hospital nurseries/NICUs; (2) decrease the rate of severe maternal morbidity attributable to obstetric hemorrhage; and in FY21, (3) care coordination from delivery to the post-partum visit and then transition to annual women's health, also known as the fourth trimester, where Virginia will be one of three states to pilot this bundle. Virginia's statewide perinatal quality collaborative is committed to including each of the 54 birth hospitals across the Commonwealth in these quality improvement projects.

REPRODUCTIVE HEALTH: This units led by the Reproductive Health Unit Supervisor, and includes the following programs and funding streams:

- Title X Family Planning (Title X): Clinical family planning programs consistent with Title X requirements and Quality Family Planning Services as defined by the CDC
- Contraceptive Access Initiative (TANF, Title V): Clinical contraceptive care for low-income patients without insurance
- Doula Certification Program and Task Force (Unfunded): State Program offering doulas the opportunity to earn state certification and to work together to promote doula services across the Commonwealth
- State Funding for Certain Abortions (General Funds): Abortion services for Medicaid members in cases of rape, incest, or incapacitating fetal anomaly
- Adolescent Health Program (Sexual Risk Avoidance Education, Title V): Positive youth development programs that build protective factors among participants that will make them less likely to initiate sexual activity

- Resource Mothers (TANF, Title V): Adolescent health program providing support services to pregnant and parenting teens and their families (Of note, the Adolescent Health Program and Resource Mothers Program are detailed in the Adolescent Health Domain)
- This unit works closely with the 35 LHDs to provide over $3.5 million in annual funds to support their local maternal and infant health programs and initiatives, providing quarterly recorded meetings via webinar platform for technical assistance and allow LHDs to share lessons learned across LHDs and programs.

MATERNAL MORTALITY REVIEW TEAM: The MMRT is a multidisciplinary group with representatives from academic institutions, behavioral health agencies, hospital associations, state chapters of professional associations, state medical societies, and violence prevention agencies. The MMRT collects data on and reviews the deaths of all Virginia residents who were pregnant within a year of their deaths regardless of the outcome of the pregnancy or the cause of death. These deaths are termed "pregnancy-associated deaths". The MMRT is dedicated to the identification of all pregnancy-associated deaths in the Commonwealth and the development of recommendations for interventions in order to reduce preventable deaths. Each case is reviewed by the MMRT to determine the community-related, patient-related, healthcare facility-related and/or healthcare provider-related factors that contributed to the woman's death. The MMRT also assesses and recommends needed changes in the care received that may have led to better outcomes. Consensus decision-making is used to determine whether the death was preventable and/or related to the pregnancy.

DENTAL HEALTH PROGRAM: The DHP performs many duties including the provision of the following: Educational activities and resources to a wide variety of partner groups to promote proper oral hygiene and support prevention services and access to dental care; direct clinical preventive services and assistance with establishing a dental home; quality assurance review to assure a competent public health oral health workforce; and, surveillance and evaluation activities to monitor and track dental disease rate and trends as part of program assessment for effectiveness and planning.

STATE ACTION PLAN UPDATES

M/WH DOMAIN PRIORITY 2016-2020	Women's/Maternal Health: Support the physical and emotional well-being of women and their children			
STRATEGY	Develop and mobilize strong interagency, multisector, and community partnerships to address disparities in maternal and infant mortality rates			
OBJECTIVE	Eliminate the racial and ethnic disparities in Virginia's maternal mortality rates. By December 2025, decrease the disparity in black-white maternal mortality disparity ratio from 2.1 (2017) to 1.23 (2025).			
OUTCOME MEASURE	(2021-2025) SOM 2: Maternal Mortality Disparity: Black/White Maternal Mortality Ratio			
2016-2020 SUMMARY				
Data Source: National Vital Statistics System (NVSS) – NOM 3				
2016	**2017**	**2018**	**2019**	**2020**
		1.9	2.2	2.7
GOAL FOR 2021-2025 SAP:	By December 2025, decrease the disparity in black-white maternal mortality disparity ratio from 2.1 (2017) to 1.23 (2025).			

Maternal Mortality Review Team: Activities of the Maternal Mortality Programs included the coordination and facilitation of the bi-monthly Maternal Mortality Review Team meetings. These activities included case selection for each meeting, requesting records from health, social and community based agencies that were used in the review, review of those

records, and determination of inclusion or exclusion in the review, as well as scanning the record for additional information that could be collected from other providers for use. Due to COVID-19 restrictions, the MMRT successfully implemented virtual review team meetings. After each review team meeting, the data was entered into the MMRIA system by the Maternal Mortality Programs Manager and Maternal Mortality Research Associate. The Programs Manager also maintained and reviewed the recommendations from each review meeting for the applicability and appropriateness based on the review topic and current data trends.

Additionally, in an effort to disseminate the findings and recommendations of the MMRT, Dr. Melanie Rouse (Maternal Mortality Programs Manager) participated in several dissemination activities. These activities included the following:

- Dr. Rouse was invited to submit a written statement to the U.S. Commission on Civil Rights briefing regarding "Maternal Health Disparities", September 2020.
- Dr. Rouse was an invited speaker at the following events:
    - Virginia Neonatal Perinatal Collaborative Perinatal Mortality Summit regarding maternal mortality and racial disparities in Virginia, February 2020.
    - Virginia Neonatal Perinatal Collaborative Monthly Webinar regarding the Maternal Mortality Review Team process and recommendations, March 2020.

MMRT Data Capacity: Using data from Maternal Mortality Surveillance Program, the OCME provided data to the Division of Population Health Data (DPHD) related to maternal health and health disparities for use in data briefs and other materials when requested. The Maternal Mortality Surveillance Program is the hallmark data program for maternal mortality, which not only includes data collection, but also data analysis and subject matter expert input. The OCME also serves as a subject matter expert and will review data briefs and other materials as requested by the DPHD once developed and before dissemination of materials.

Additionally, the Maternal Mortality Programs Manager collaborated with the Virginia Neonatal Perinatal Collaborative Director of Operations to develop a shared vision plan which aims to improve maternal and infant health across the Commonwealth through data-driven, evidence based collaborative initiatives. The Programs Manager also engages in monthly VNPC-led Maternal & Infant Sister Agency Workgroup meetings to (1) identify shared goals, priorities and strategies, (2) eliminate silos across state sister agency maternal and infant leads, and (3) meaningfully collaborate on shared deliverables of interest to improve maternal and infant health outcomes in Virginia.

Doula Certification Program: During the 2020 General Assembly Session, Virginia legislators tasked VDH with establishing a Doula Certification Program in order to make doula series more accessible to all people, but specifically to Black women, who experience the highest maternal mortality rate of any population in Virginia. In order to accomplish this, VDH's Reproductive Health Unit convened stakeholders to develop state regulations that will guide the program. Stakeholders included doulas, clinicians, advocates and representatives from the Department of Medical Assistance Services (DMAS). Similarly, Virginia legislators tasked DMAS with establishing a benefit for community-based doulas. VDH and DMAS work in concert so that when the doula certification program is launched in FY2022, certified doulas will then be able to apply to become a Medicaid provider. Medicaid coverage for doulas will open access to low-income women and directly address the racial maternal mortality disparity in Virginia. An official Doula Task Force convened in FY21 to provide the opportunity for doulas, providers, clients, and payers to provide continuous feedback to the Doula Certification Program throughout program implementation.

Maternal Health Collaborative (VDH, VNPC, VHHAF): Kick-off for this Collaborative was January 2020. However, due to COVID, the emphasis for this collaborative for its first 18 months was to build buy-in across Virginia's hospital systems. Beginning in July 2021, and through the use of cross-sector collaborations, The Collaborative's aim, based on data, analytics and analysis, is for hospital systems to partner with community based organizations to improve health outcomes of Black maternal populations. Each hospital system CBO goals and objectives will be unique to their own community. This is funded by a mix of general funds, Title V and Pew Charitable Trust Calling All Sectors Grant.
The opportunity to partner with both VNPCH and VHHAF provides strong, strategic alignment. The Virginia Hospital and

Health Care Association (VHHAF) aims to improve maternal health quality, care and access across the state of Virginia. As a principal convener of hospitals and healthcare systems statewide, VHHAF is uniquely positioned to support our state in building a collaborative-community based framework that minimizes rework, siloes and duplication, and optimizes financial resources to ultimately improve care for birthing people, and the overall community.

M/WH DOMAIN PRIORITY 2016-2020	Women's Maternal Health: Support the emotional well-being of women and children			
STRATEGIES	1. Increase capacity of youth-serving agencies to implement Aim 4 Teen Moms (AIM4TM), an evidence-based pregnancy prevention program designed for parenting teens. 2. Work with community stakeholders to remove policy, financial, and training barriers to LARC utilization.			
OBJECTIVE	By June 30, 2020, reduce the rate of unintended pregnancies for all women of child-bearing ages (ages 15-44) from 49.5% (PRAMS 2016) to 47%.			
PERFORMANCE MEASURE	SPM 4 – Unintended pregnancy: Proportion of females ages 15-44 using Tier 1 (most effective) contraceptive methods			
2016-2020 SUMMARY				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
2016	**2017**	**2018**	**2019**	**2020**
	35.5%	31.0%	65.1%	70.1%
GOAL FOR 2021-2025 SAP:	Reduce the rate of mistimed pregnancies from 25.3% (PRAMS 2018) to 21.8% by 2025.			

VDH Reproductive Health: VDH's Reproductive Health Unit includes several programs dedicated to the assurance, access and provision of quality, comprehensive family planning services. These include: Contraceptive Access Network (formerly known as the Long-Acting Reversible Contraceptives (LARC) Stakeholder Workgroup), the Virginia Contraceptive Access Initiative (formerly known at the Virginia LARC Initiative), the Title X Family Planning Program, Resource Mothers, and the Doula Certification Program and Task Force.
VDH Reproductive Health Unit utilizes PRAMS data to promote contraceptive access in Virginia, and the CDC featured Virginia's efforts on its webpage as a "data to Action" success story. https://www.cdc.gov/prams/state-success-stories/virginia-contraception.html

Title X Family Planning Program: This program provides comprehensive family planning services at approximately 140 clinical sites across the Commonwealth, including 34 local health districts and 3 federally qualified health centers. As the nation's only federally funded family planning program, Title X provides structure, funding, and technical support to clinics providing family planning services according to CDC's Quality Family Planning Services guidelines. VDH is Virginia's sole Title X grantee. The Title X Family Planning Program is not directly supported by Title V funds, but Title X complements Title V by supporting comprehensive family planning services beyond those provided by Virginia Contraceptive Access Initiative.

Contraceptive Access Network – This group of agencies work to reduce unintended pregnancies among women of childbearing age and increase access to comprehensive, quality family planning services. This group was originally developed to address infant mortality, recognizing the role of contraceptive access on maternal and infant healthy. The group is facilitated by VDH, meets twice a year, and includes over 70 members from a variety of community-based health centers, governmental organizations, hospital systems, payers and community members. This group collaborated

successfully advocate for the Virginia LARC Initiative.

Virginia Contraceptive Access Initiative – In 2018, VA PRAMS data showed that 49% of pregnancies resulting in a live birth in Virginia were unintended and had increased from 46% in 2014. High rates of unintended pregnancy present an economic burden to the state of Virginia and may be associated with negative maternal and child health outcomes. To address this concern, the Virginia LARC Initiative began in 2018 as a two-year pilot program funded through federal TANF funds allocated by the Virginia General Assembly. The LARC Initiative allowed VDH to contract with eighteen health providers to offer LARC insertions and removals to eligible patients. During the two-year pilot period (October 2018 – July 2020), the LARC Initiative provided approximately 3,986 no-cost visits to eligible patients. In July 2020, the Virginia Assembly expanded the scope of the program to cover all-FDA approved methods of contraception, and thus the program's name changed to the Virginia Contraceptive Access Initiative. As of June 30, 2021, the expanded program has provided over 5,000 no-cost visits to eligible patients, representing a significant increase in patients served.

M/WH DOMAIN PRIORITY 2016-2020	Oral Health: Increase access to oral health services for pregnant women and children			
STRATEGIES	1. Integrate targeted adolescent oral health messaging into existing MCH-focused dental education programs to improve oral health for individuals across the lifespan 2. 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 3. Convene statewide groups focused on targeted oral health issues and facilitate collaboration and work plan development, and provide leadership and oversight to guide initiatives			
OBJECTIVE	By June 30, 2020, increase the percent of women who had a dental visit during pregnancy from 46.5% (PRAMS 2015) to 51.95)			
PERFORMANCE MEASURE	NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy			
2016 -2020 Summary				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
2016	**2017**	**2018**	**2019**	**2020**
	46.5	44.7	49.9	48.4
GOAL FOR 2021-2025 SAP: Moved to Cross-Cutting/Systems Building Domain	By June 30, 2025, increase the percent of women who had a dental visit during pregnancy from 50.8% (PRAMS 2018) to 52.9%.			

The Dental Health Program (DHP) has many internal partners including other VDH MCH programs and the statewide oral health coalition now known as Virginia Health Catalyst (VHC). VHC is a non-profit organization that serves as the only statewide oral health coalition in the Commonwealth. It is a diverse group working to spark change so that all Virginians have equitable access to comprehensive health care that includes oral health, and to bring excellent oral health to all Virginians through policy change, public awareness and innovative programs. The VHC works closely with VDH to implement grant objectives and has in-depth knowledge of the Virginia Oral Health Plan and the Virginia Oral Health Report Card, and other foundations that prioritize oral health activities statewide. VHC has access to a diverse network of key, statewide stakeholders, and the unique ability to share oral health information with both key partners and the public. VHC

staff understand the need to continue promotion of oral health at the local level, support local initiatives to affect meaningful change, and to evaluate efforts to ensure ongoing, comprehensive support for structural sustainability.

Program activities aimed at increasing oral health care for pregnant women, infants, children and individuals with special healthcare needs (ISHCN) within the DHP are the Bright Smiles for Babies Fluoride Varnish Program, Dental Preventive Services Program, and Perinatal and Infant Oral Health Program.

The Perinatal, Infant, and Adolescent Oral Health Program aims to improve access to oral health care for pregnant women, infants and adolescents who are most at risk for disease through integration of dental services and information into the primary care delivery system. Additionally, this program allows for expansion of the existing Virginia Oral Health Surveillance System to include data collection, analysis, and reporting of indicators regarding pregnant women and infants. In 2019, this program began focus on HPV prevention and oral cancer education, and vaping concerns for the adolescent population.

Specific activities in FY20 (October 1, 2019 – September 30, 2020) include:

STRATEGY 1: Integrate targeted adolescent oral health messaging into existing MCH-focused dental education programs to improve oral health for individuals across the lifespan	
Recruit and hire an experienced oral health educator to focus on maternal, infant and adolescent oral health	Completed
Continue to provide education and trainings aimed at perinatal and infant oral health including education for home visitors and other family support workers	Ongoing
Review existing school-aged Oral Health Curriculum and revise as needed based on emerging issues (HPV, Vaping) and current standards of Learning (SOL) requirements	Completed
Using current information obtained through literature reviews regarding the need for oral health education for adolescents on emerging issues, assess the individual needs of schools in each of the 5 Health Planning Districts	Ongoing
Plan and implement educational initiatives and trainings including development of educational material and social media content related to adolescent oral health	Ongoing
Evaluate initiatives and trainings to ensure that goals are met	Ongoing
STRATEGY 2: 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	
Continue to conduct regional oral health assessments	Completed
Determine community-led strategies to improve oral health in their regions	Ongoing
Support development and implementation of project work plans to support regionally identified projects	Completed
Disseminate information to state level partners and other regional alliance members to inform statewide activities and planning	Completed
Disseminate micro grants to support alliance efforts	Completed
STRATEGY 3: Convene statewide groups focused on targeted oral health issues and facilitate collaboration and work plan development, and provide leadership and oversight to guide initiatives	
Identify the appropriate statewide organizational and community partners to participate in a water equity workgroup	Completed
Convene a Water equality workgroup and host meetings at different localities across the state	Ongoing
Develop and implement a workplan to support identified goals around water equity in Virginia	Ongoing
Continue convening the EDH workgroup, including providing oversight regarding program direction, participating in discussions related to allocation and management of resources, and sharing responsibility for the identification and maximization of community ownership to sustain the EDH workgroup's projects beyond the grant year	Ongoing
Identify existing groups working on HPV in Virginia and approach these groups about Virginia Health Catalyst participating as a collaborative member.	Ongoing
Ensure oral health initiatives are integrated into the workplans and projects conducted by existing HPV workgroups, with specific focus on dental visits and oral cancer education and screenings for children under 17, pregnant women, and their families	Ongoing
Convene the Virginia Oral Health Summit focused on community engagement to provide trauma-informed care, oral health and systemic health, and health equity to providers	Completed

EMERGING ISSUES

Reproductive Health: The COVID-19 pandemic brought unprecedented challenges to Virginians, but it also challenged health systems to consider alternate approaches to providing care. Health providers were forced to consider telehealth

options when they may not have considered them before, and CMS relaxed federal policies to allow for Medicaid reimbursement of telehealth visits. While telehealth services are not easy to navigate for all, telehealth can increase access to some populations, including young people and people with transportation barriers.

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

Dental Health Program: Families are worried about going to the doctor or dentist office because of possible exposure to COVID-19. The dental office is especially concerning because many of the regular procedures produce aerosols, which can spread the virus. Many patients already had fears about going to the dentist; COVID has added more concerns to an already stressful experience. Delayed dental care allows existing conditions to worsen and new issues to begin creating more extensive and pervasive disease. As patients begin to re-enter dental care, providers lack the ability to keep up with the demand for those requiring greater amounts of care.

CHALLENGES/BARRIERS

Reproductive Health: The COVID-19 pandemic challenged Resource Mothers staff and clients in unprecedented ways. When a state moratorium on in-person home visits was issued for safety reasons, community health workers needed to consider alternate ways of delivering services to clients. During FY20, VDH purchased licenses for doxy.me, a HIPAA-compliant video platform, to use during virtual encounters, and all Resource Mothers staff were given access. During this project period, Resource Mothers staff learned that doxy.me was a difficult platform to use in areas of the Commonwealth with poor internet access. Families without access to broadband and without unlimited cellular data were largely unable to use this platform. As a result, VDH switched to Zoom for Health Professionals, another HIPAA-compliant platform, during the FY21 funding period. VDH predicts that Zoom for Health Professionals will be easier for clients and staff to navigate in areas with limited connectivity.

Maternal Mortality Review Team: As the focus on maternal mortality and infant/child mortality have increased, review teams across the U.S. have found significant racial and ethnic disparities in mortality ratios between Black and White populations. This has led to an increase in focus on the social/environmental determinants that contribute to these deaths, including systemic racism, personally mediated racism and discrimination. As such, the Maternal Mortality Projects Manager also facilitated a training for the MMRT that included training on the fatality review process, as well as health equity and implicit bias.

Dental Health Program:

- The Virginia Governor's budget for 2020 release in mid-December 2019 did not include funding dedicated to adding a comprehensive adult dental benefit in Medicaid.
    - *Partners worked to educate communities and state legislators about the importance of adding a comprehensive adult dental benefit in Medicaid. With support from around the state, the comprehensive benefit was added to the final 2022 budget.*
- VDH and partners shifted roles and priorities because of COVD-19. Many partners pivoted their activities to support the crisis response, and did not have the capacity or capabilities to work on dental projects.
    - *VDH and Catalyst team members continued to work towards project goals and support partners vial*

teleworking. Both VDH and Catalyst continued to be dedicated to supporting partners through the COVID-19 crisis. VDH and Catalyst team members also continued to reevaluate programs, educate themselves regarding the COVID-19 crisis and impact on all stakeholders, and discuss alternatives for the future.

- The widespread use of new technologies for education, meetings and information gathering is a growing edge with multiple roadblocks including individual computer skills, internet access, overwhelmed networks, and limited or no access to technology.
    - *VDH staff members are working toward expanding their technical knowledge and computer skills regarding online platforms for meetings and education.*
- Families are worried about going to the dentist because of possible exposure to COVID-19. The dental office is especially concerning because many of the regular procedures produce aerosols, which can spread the virus.
    - *VDH worked with the Governor's office and partners on an educational campaign promoting the need for dental care and how dental offices have adapted care to ensure safety for all during services.*

WOMEN/MATERNAL HEALTH DOMAIN
SUMMARY/OVERVIEW
FY22 APPLICATION YEAR

2021-2025 MCH Priority Needs Addressed in this Domain
Maternal and Infant Mortality Disparity
MCH Data Capacity
Reproductive Justice and Support
Oral Health

IDENTIFIED NPMs/SPMs FOR STATE ACTION PLAN 2021-2025	
NOM 3 Maternal Mortality	Maternal mortality is a sentinel indicator of health and health care quality worldwide. In 2019, Virginia's governor announced a goal to eliminate the racial disparity in the maternal mortality rate in Virginia by 2025. The maternal mortality rate was 18.5 per 100,000 live births, with a rate of 14.1 per 100,000 among White women and 38.2 per 100,000 among Black women (2015-2019). The Black/White Maternal Mortality Ratio was 2.7 (SOM 2)
SPM 4 Pregnancy intention: Mistimed or unwanted pregnancy	The percentage of women reporting that they wanted to become pregnant later or never was 27.1% (2019 VA PRAMS). The concept of unintended pregnancy helps in understanding the fertility of populations and the unmet need for contraception and family planning (CDC 2019). In Virginia, 44.4% of pregnancies were described by women as unintended.
NPM 13.1 Preventive dental visit during pregnancy	Data from the Pregnancy risk Assessment Monitoring System (PRAMS) showed that 48.4% of moms had a preventive dental visit during pregnancy (2019). Preventive dental care in pregnancy is recommended by the American College of Obstetricians and Gynecologists (ACOG) to improve lifelong oral hygiene habits and dietary behavior for women and their families.

During FY22, the following programmatic strategies and activities have been identified as methods to advance and improve outcomes.

IDENTIFIED STATE PRIORITY	Maternal and Infant Mortality Disparity
FY22 STRATEGY	• Work with stakeholders to increase access to doula services among women of color • Coordinate, strengthen and expand the impact of b-monthly MMRT meetings • Maintain Title V representation on the Virginia Neonatal Perinatal Collaborative's Steering and Executive Committees, and develop a shared visioning and planning document specific to the VDH-VNPC relationship

Doula Services: In order to advance the Doula Certification Program, VDH convened the Virginia Doula Task Force in FY21, with the ultimate goal to launch the program in FY22. This task force, which meets quarterly, guides the Doula Certification and Medicaid Reimbursement. The regulatory process for the certification of doulas is not finalized; however, it is anticipated to be finalized at the end of FY2021. That would, in turn, provide DMAS the necessary information to complete the benefit for community doula providers. Once completed by DMAS, the benefit would require CMS approval prior to full implementation.

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

Maternal Health Collaborative (VDH, VNPC, VHHAF): Through the use of cross-sector collaborations, Virginia Hospital and Health Care Association (VHHAF) aims to improve maternal health quality, care and access across the state of Virginia. As a principal convener of hospitals and healthcare systems statewide, VHHAF is uniquely positioned to support our state in building a collaborative-community based framework that minimizes rework, siloes and duplication, and optimizes financial resources to ultimately improve care for birthing people, and the overall community. The Collaborative's aim, based on data, analytics and analysis, is for hospital systems to partner with community based organizations to improve health outcomes of Black maternal populations through the provision of mini grants. Each hospital system CBO goals and objectives will be unique to their own community. This is funded by a mix of general funds, Title V and Pew Charitable Trust Calling All Sectors Grant.

Virginia Neonatal Perinatal Collaborative (VNPC): The vision of the VNPC is to ensure that every mother has the best possible perinatal care, and that every infant cared for in Virginia has the best possible start to life. The mission of the VNPC is to ensure an evidence-based, data-driven collaborative process that involves care providers for women, infants and families, as well as state and local leaders. The VNPC believes that working together now will create a stronger, healthier Virginia in the future, and is committed to including each of the 54 birth hospitals across the Commonwealth in the three initial quality improvement (QI) projects to focus on based on the Alliance for Innovation on Maternal Health (AIM) patient safety bundles:

- Reduce the use of inpatient intravenous antibiotics at hospital nurseries/NICU
- Decrease the rate of severe maternal morbidity attributable to obstetric hemorrhage
- Care coordination from delivery to the post-partum visit and then transition to annual women's health, also known as the fourth trimester, where Virginia was one of three states to pilot this bundle which started in FY21. In FY22, implementation and data collection will begin in hospitals that choose to participate.

VNPC Sister Agency State Partners: VNPC facilitates monthly meetings across state agencies, VDH, DMAS, DBHDS, OCME, VDSS), for common legislative initiatives, funding opportunities, agency updates and information sharing.

VNPC Strategic Planning: VNPC is utilizing The Spark Mill, a Richmond-based organization, to conduct strategic planning throughout FY20 to ensure unified goals and directives for the Collaborative.

IDENTIFIED STATE PRIORITY	MCH Data Capacity
FY22 STRATEGY	• Conduct epidemiological surveillance using MMRT Surveillance Database • Complete 2015-2017 maternal mortality data review for in-depth analysis

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

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

IDENTIFIED STATE PRIORITY	Reproductive Justice and Support
FY22 STRATEGY	• Work with stakeholders to remove policy, financial, and training barriers to contraceptive access • Explore opportunities for providing support to families seeking fertility services and families experiencing pregnancy loss • Identify training needs and provide ongoing training for Resource Mothers staff

Stakeholder collaboration: During FY22, VDH's Reproductive Health Unit intends to continue its work supporting the Contraceptive Access Network and the Contraceptive Access Initiative. The Contraceptive Access Initiative has grown tremendously since its inception – the program budget is now $4 million annually and all FDA-approved methods of contraception are covered. Title V funds will continue to be used to support staff time administering the program, facilitating network meetings, and monitoring statewide data related to contraceptive utilization and access. VDH aims to facilitate two contraceptive Access Network meetings during the upcoming fiscal year, and to enable the Contraceptive Access Initiative

to support at least 7,000 contraceptive visits for eligible patients.

Pregnancy loss support: VDH intends to launch a Pregnancy Loss Support program in FY22. VDH plans to partner with community-based agencies to offer support services, including grief counseling, to families experiencing pregnancy loss. VDH will released a Request for Proposals in the summer of 2020, with the goal of establishing 2-3 official partnerships with local agencies.

Resource Mothers training: Title V funds will also continue to support professional development opportunities for Resource Mothers staff. As new staff join the Resource Mothers Team, Growing Great Kids and AIM4TM trainings must be made available on a rolling basis. VDH aims to offer at least one AIM4TM training in either the online or in-person format this year.

IDENTIFIED STATE PRIORITY	Oral Health
NOTE: Dental Health Programmatic work cross-cuts three MCH Domains: Women and Maternal Health, Child Health, and Adolescent Health. Shared strategies address needs across the lifespan.	
FY22 STRATEGIES:	1. 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 2. 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 3. Convene statewide groups focused on targeted oral health issues and facilitate collaboration and work plan development, and provide leadership and oversight to guide initiatives

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

New programming specifically aimed at advancing the oral health of adolescents began in FY20. Activities included updating the School-aged Oral Health Curriculum to include emerging topics for adolescents including vaping, and HPV exposure and vaccination and developing trainings and educational material related to these new topics of focus to highlight the importance of vape cessation and HPV prevention to combat oral cancer, as well as early detection of this disease in youth and young adults. Staff will continue this work and identify new partnerships to expand the reach of programming 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. Staff will also continue to provide pertinent MCH related information to partners as a member of the Early Dental Home Workgroup and Project Immunize Virginia. The Early Dental Home Workgroup consists of partners from dentistry, early childhood education, and perinatal and pediatric health, as well as state agencies that offer

social and health support services. The workgroup identifies promising practices and techniques to increase the number of young kids and pregnant women who access dental care. Project Immunize Virginia (PIV) is a team of energetic and innovative health professionals, business, and community members that believe every community in the Commonwealth can be free of vaccine-preventable disease by increasing immunizations across the lifespan. PIV achieves this by promoting partnerships and using effective strategies among its member organizations throughout the Commonwealth.

Strategy: Sustain network of 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.

VDH will continue to partner with the VHC to foster regional efforts and initiatives throughout the Commonwealth. Catalyst will work with the alliances to support development and implementation of regionally-identified projects, including projects from partners in far Southwest Virginia, through a micro-grant program; leverage Catalyst's Clinical Advisory Board (CAB) and expert consultants to provide clinical guidance and education to the micro grantees;
assist micro grantees with developing an evaluation component for their projects; share regionally-specific data; enable information-sharing among state and local partners and regional alliance members to inform the plans and implementation of local and statewide activities; ensure alignment between regional and statewide initiatives, as applicable; and develop and disseminate communications to spur replication of promising practices, share data and
surveillance information, and elevate issues related to oral health access and integration.

Strategy: Convene statewide groups focused on targeted oral health issues and facilitate collaboration and work plan development, and provide leadership and oversight to guide initiatives

VDH will continue to partner with VHC to convene statewide groups to advance health equity, care coordination, and systems-change approaches that increase access to integrated, comprehensive care that includes oral health care for children under 17, pregnant women and their families.

VHC will convene a statewide workgroup focused on the future of oral health care delivery in Virginia following the COVID-19 pandemic and considering other environmental changes, trends in healthcare, and policy forecasts. The VHC will continue to engage a wide variety of partners to assemble participants including the Department of Medical Assistance Services, an MCO, maternal health providers, dental providers, and other community partners, while also leveraging the Catalyst's Clinical Advisory Board (CAB) to provide expertise on the statewide future-focused workgroup. The VHC will also engage other clinical expertise, as needed, to offer additional technical assistance and guidance to the workgroup. HRSA Oral Health Workforce Grant funds will be leveraged to continue to implement a pilot program aimed at putting the workgroups ideas into action through a contract with a safety-net site to carry out future-focused projects including developing teledentistry capabilities to improve access to care.

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

VHC will also continue convening the Early Dental Home (EDH) workgroup and collaborate with existing groups working on HPV to ensure oral health is integrated into their approach and goals. Additionally, the VHC will expand community engagement and provide trauma-informed care, oral health and systemic health, and health equity education to providers at

the Virginia Oral Health Summit. Annually, the Summit reaches nearly 250 providers, public health stakeholders and caregivers, who attend to learn skills to improve the health and wellbeing of the individuals they serve. At this year's Summit, Catalyst seeks to highlight the role of health equity and oral health in the COVID-19 pandemic, teledentistry (and telehealth more broadly), health policy at the state and federal level, and innovative community programs, so that attendees can work collectively to increase equitable access to quality health care, with a focus on oral health.

VHC will, for the second time, partner with a consulting team and Virginia Center for Inclusive Communities to provide twelve free racial equity trainings to partners across Virginia. These trainings will be virtual to allow partners from across Virginia to participate. The trainings will be offered in three bundles, and each bundle will be offered twice (six total bundles offered).

LEGISLATIVE MANDATE

Task Force on Maternal Health Data and Quality Measures: HB2111 requires the establishment of a Task Force on Maternal Health Data and Quality Measures for the purpose of evaluating maternal health data collection to guide policies in the Commonwealth to improve maternal care, quality, and outcomes for all birthing people in the Commonwealth. The provisions of the bill require the Task Force to monitor and evaluate relevant stakeholder data related to race, ethnicity, demographic and clinical outcomes to examine quality of care. The MCH Epidemiologist Lead will serve as a subject matter expert/member on this Task Force.

Perinatal/Infant Health

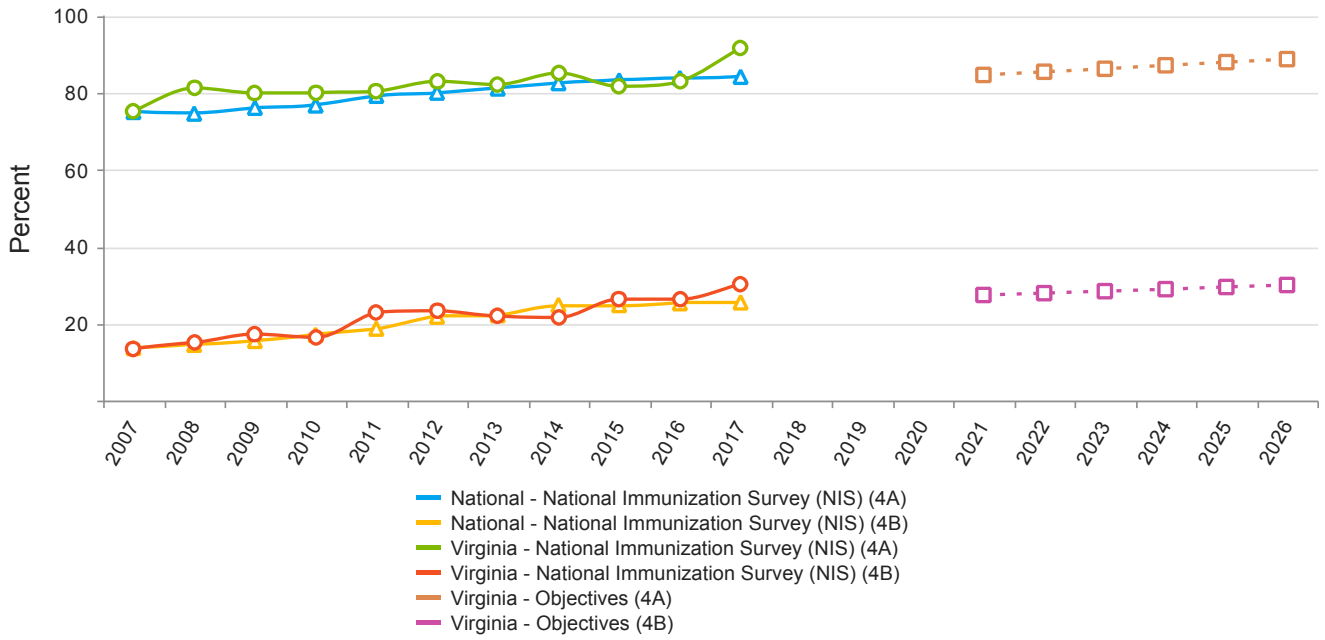
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	5.6	NPM 4 NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	1.9	NPM 4 NPM 5
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	103.2	NPM 4 NPM 5

National Performance Measures

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

Indicators and Annual Objectives



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2019	**2020**
Annual Objective		
Annual Indicator	82.9	91.7
Numerator	73,338	84,128
Denominator	88,459	91,769
Data Source	NIS	NIS
Data Source Year	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	84.6	85.4	86.2	87.1	87.9	88.7

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

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2019	**2020**
Annual Objective		
Annual Indicator	26.4	30.4
Numerator	22,710	27,265
Denominator	85,942	89,656
Data Source	NIS	NIS
Data Source Year	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	27.5	28.0	28.5	29.0	29.6	30.1

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

State Outcome Measures

SOM 1 - Infant Mortality Disparity: Black/White Infant Mortality Ratio

Measure Status:	Active

State Provided Data			
	2018	2019	2020
Annual Objective			1.8
Annual Indicator	2.2	2	2.3
Numerator	9.6	9.7	10.6
Denominator	4.4	4.9	4.7
Data Source	VDH Division of Health Statistics	VDH Division of Health Statistics	VDH Division of Health Statistics
Data Source Year	2017	2018	2019
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	2.1	1.9	1.7	1.5	1.2	1.0

State Action Plan Table

State Action Plan Table (Virginia) - Perinatal/Infant Health - Entry 1	
Priority Need	
MCH Data Capacity: Maintain and expand state MCH data capacity, to include ongoing needs assessment activities, program evaluation, and modernized data visualization and integration.	
NPM	
NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	
Objectives	
1. Increase the number of infants ever breastfed from 82.9% (NIS 2016) to 87.9% by 2025; 2. Increase the number of infants breastfed exclusively through 6 months from 26.4% (NIS 2016) to 29.6% by 2025.	
Strategies	
Complete evaluation of Five-Star Breastfeeding-Friendly Hospital Recognition Program.	
ESMs	**Status**
ESM 4.1 - Development of a coordinated action plan of gap-filling activities for breastfeeding programming across VDH divisions	Active
NOMs	
NOM 9.1 - Infant mortality rate per 1,000 live births	
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	

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

Priority Need

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

SOM

SOM 1 - Infant Mortality Disparity: Black/White Infant Mortality Ratio

Objectives

Eliminate the disparity between Black infant mortality (9.3 per 1,000 live births) and White infant mortality (5.0 per 1,000 live births) by June 30, 2025 (Virginia Vital Statistics System 2018). Decrease the Black/White infant mortality ratio (SOM 1) from 2.0 to 0.0 by June 30, 2025

Strategies

Coordinate and expand the Five-Star Breastfeeding Friendly Hospital Program

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

Sustain state maternal mortality and child fatality review programs

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

Priority Need

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

SOM

SOM 1 - Infant Mortality Disparity: Black/White Infant Mortality Ratio

Objectives

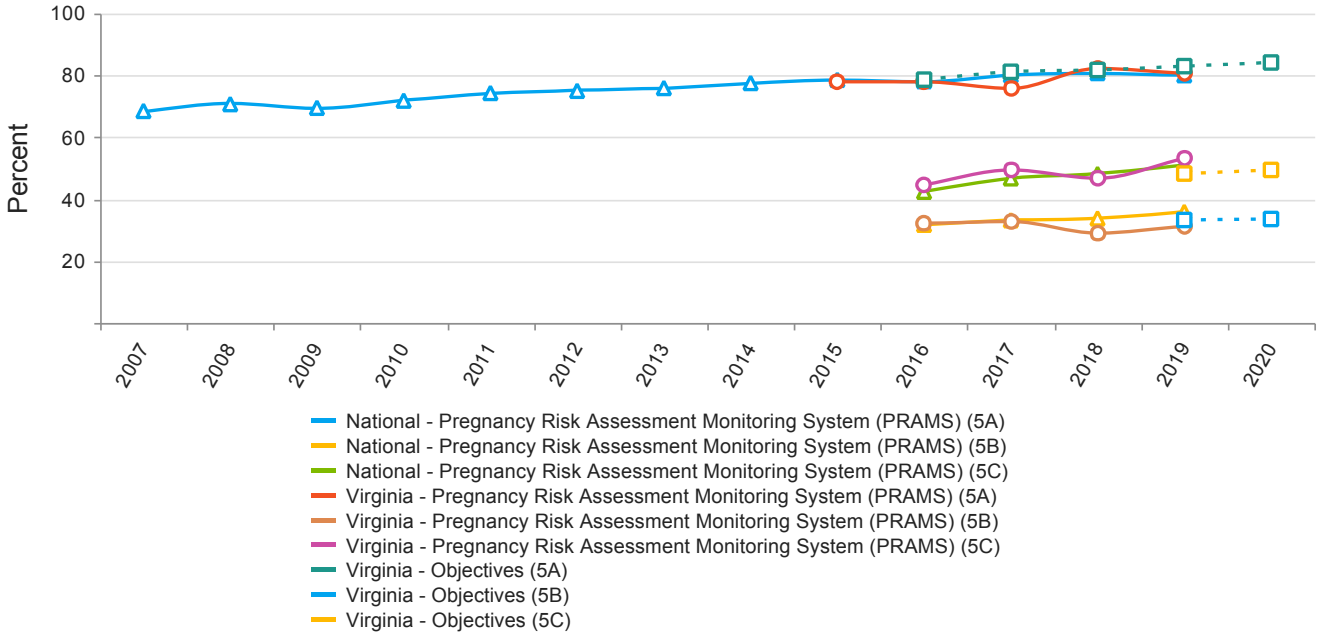
Eliminate the disparity between Black infant mortality (9.3 per 1,000 live births) and White infant mortality (5.0 per 1,000 live births) by June 30, 2025 (Virginia Vital Statistics System 2018). Decrease the Black/White infant mortality ratio (SOM 1) from 2.0 to 0.0 by June 30, 2025

Strategies

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

2016-2020: National Performance Measures

2016-2020: NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding Indicators and Annual Objectives



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

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2017	**2018**	**2019**	**2020**
Annual Objective	81	81.6	82.8	84
Annual Indicator	78.0	78.0	82.0	80.7
Numerator	73,007	73,211	75,207	71,462
Denominator	93,567	93,856	91,692	88,597
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2016	2018	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	78.5	81	81.6	82.8	84
Annual Indicator			75.9	82	
Numerator					
Denominator					
Data Source			VA PRAMS	VA PRAMS	
Data Source Year			2017	2018	
Provisional or Final ?	Final		Final	Final	

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

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2018	**2019**	**2020**
Annual Objective		33.3	33.6
Annual Indicator	32.0	28.8	31.4
Numerator	28,740	25,307	26,629
Denominator	89,922	87,734	84,895
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2016	2018	2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			33.3	33.6
Annual Indicator	73.3	75.7	73.8	
Numerator				
Denominator				
Data Source	VA PRAMS	VA PRAMS	VA PRAMS	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Final	Final	

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

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2018	**2019**	**2020**
Annual Objective		48.2	49.4
Annual Indicator	44.6	46.9	53.4
Numerator	39,580	40,840	45,255
Denominator	88,829	87,067	84,743
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2016	2018	2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			48.2	49.4
Annual Indicator	79.6	84.7	83.1	
Numerator				
Denominator				
Data Source	VA PRAMS	VA PRAMS	VA PRAMS	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Final	Final	

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

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

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective	150	200	250	300
Annual Indicator	1,373	2,756	2,628	2,287
Numerator				
Denominator				
Data Source	VDH-OFHS Communications Specialist	VDH-OFHS Communications	VDH-OFHS Communications	VDH-OFHS Communications
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

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

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective		10,000	10,000	10,000
Annual Indicator	9,924	20,216	22,658	6,462
Numerator				
Denominator				
Data Source	Maternal/Infant Health Program - LHD Reports	Maternal/Infant Health Program - LHD Reports	Maternal/Infant Health Program - LHD Reports	Maternal/Infant Health Program - LHD Reports
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

2016-2020: ESM 5.4 - Number of providers (home-visitors, doctors, nurses, health educators, etc.) educated about Safe Sleep environments and resources provided at www.safesleepva.com

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			500	500
Annual Indicator		562	823	4
Numerator				
Denominator				
Data Source		VDH Maternal and Infant Health Program documents	VDH Maternal and Infant Health Program documents	VDH Maternal and Infant Health Program documents
Data Source Year		2019	2019	2020
Provisional or Final ?		Final	Final	Final

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

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			35	35
Annual Indicator			35	0
Numerator				
Denominator				
Data Source			VDH Maternal and Infant Health Program documents/a	VDH Maternal and Infant Health Program documents
Data Source Year			2019	2020
Provisional or Final ?			Final	Provisional

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

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			375	400
Annual Indicator			243	247
Numerator				
Denominator				
Data Source			VDH Home visiting programs	VDH Home visiting programs
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

PERINATAL/INFANT HEALTH DOMAIN
SUMMARY/OVERVIEW
FY20 ANNUAL REPORT

2016 - 2020 MCH Priority Needs Addressed in this Domain
Women's/Maternal Health: Support the physical and emotional well-being of women and their children
Safe Sleep: Increase safe sleep practices for infants

NOTE: The FY20 Annual Report represents the final year of priorities, strategies, and activities aligned with the 2016-2020 needs assessment and state action plan for the Perinatal/Infant Health Domain.

DOMAIN CONTRIBUTORS:
Maternal and Infant Health (MIH) Coordinator – Division of Child and Family Health
Early Childhood Health Unit – Division of Child and Family Health
Local Health Districts
Division of Death Prevention – Office of the Chief Medical Examiner (OCME)

DOMAIN OVERVIEW

MATERNAL AND INFANT HEALTH (MIH) COORDINATOR: The MIH Coordinator serves as subject matter expert housed at VDH's Central Office who partners closely with an array of state and local partners, including the Virginia Neonatal Perinatal Collaborative (VNPC), the Maternal Mortality Review Team, and the recently-formed maternal mental health workgroup and Pathway to Coordinated Care for Infants and Families (PCC) workgroup.

EARLY CHILDHOOD HEALTH UNIT: The purpose of this Unit is to provide programmatic support to partners in the home visiting services field and early childhood developmental screening providers. Parental education and support along with maternal depression screenings, developmental screenings of children and appropriate referral connects are strategies used to ensure prenatal, maternal and early childhood health outcomes. This Unit oversees the Healthy Start/Loving Steps grant. The grant has two sites (Crater District and EVMS in Norfolk) that provide home visiting services to at-risk families. There is a focus on maternal health and prevention of infant and maternal mortality as well as several benchmarks required by HRSA. Also housed in this Unit is the Maternal Infant and Early Home Visiting (MIECHV) grant. This program has 18 evidence-based home visiting sites and 1 centralized intake center. The focus is to provide parental education and support to reduce infant mortality, child abuse/neglect and increase health outcomes for child and mother.

LOCAL HEALTH DISTRICTS: The Commonwealth is divided into 35 Local Health Districts (LHD). They are responsible for providing health services and support tailored to the specific community needs of their geographical area. The Early Childhood Health Unit partners with the LHDs for implementation of domain-related programs and initiatives.

VIRGINIA STATE CHILD FATALITY REVIEW TEAM: The Virginia State Child Fatality Review Team is unique when compared with child death review processes in other states. Virginia's Team does not review every child death every year; instead, focus on a certain cause, manner of death, or injury pattern is chosen. For example, in FY19, the state Child Fatality Review Team reviewed cases of drowning deaths to infants and children up to age 17 that occurred in Virginia during the two-year period between 2014-2016. The Team is tasked with developing recommendations for prevention, education, policy change, and improved child death investigation.
Membership of the multidisciplinary team is defined in State statute, and includes physicians and representatives from state

and local agencies who provide the services to families and children, or who may be involved in the investigation of child deaths. The Team also appoints special advisors whose areas of specialization provide additional insight to the Team. The Team is chaired by the Chief Medical Examiner and includes the following persons or their designees:

- Commissioner of Behavioral Health and Developmental Services
- Program Manager for Child Protective Services
- Virginia Department of Social Services
- Virginia Department of Education
- State Registrar of Vital Records
- Director of Criminal Justice Services

And one representative from each of the following is appointed:

- Local law enforcement agencies
- Local fire departments
- Local departments of social services
- Medical Society of Virginia IT Infrastructure Partnership Virginia College of Emergency Physicians
- Virginia Chapter, American Academy of Pediatrics
- Local emergency medical services providers
- Attorneys for the Commonwealth
- Community services boards

In addition, special advisors are appointed to the Team based upon their area of expertise, and include representatives from:

- Child advocacy
- Child psychiatry
- Forensic pathology
- Public health
- Juvenile justice
- Toxicology

STATE ACTION PLAN UPDATES

IDENTIFIED STATE PRIORITY	Maternal and Infant Mortality			
STRATEGY	Sustain state maternal mortality and child fatality review programs.			
OBJECTIVE	1. Eliminate the racial and ethnic disparities in Virginia's infant mortality rates 2. By December 2025, decrease the disparity in black-white infant mortality disparity ratio from 2.2 (2017) to 1.24 (2025)			
PERFORMANCE MEASURE	(2016-2020) SPM 4 - Unintended Pregnancy: Proportion of females ages 15-44 using Tier 1 (most effective) contraceptive methods (2021-2025) SOM 1 – Infant Mortality Disparity: Black/White Infant Mortality Ratio			
2016-2020 Summary				
Data Source: Virginia PRAMS				
2016	**2017**	**2018**	**2019**	**2020**
	35.5%	31.0%	65.1%	70.1%
Data Source: Virginia Vital Statistics System				
2016	**2017**	**2018**	**2019**	**2020**
2.4	2.3	2.2	2.0	2.3
GOAL FOR 2021-2025 SAP:	By December 2025, decrease the disparity in black-white infant mortality disparity ratio from 2.2 (2017) to 1.24 (2025)			

VIRGINIA STATE CHILD FATALITY REVIEW TEAM:

Coordination and facilitation of bi-monthly child fatality review team (CFRT) meetings: Activities include case selection for each meeting, requesting records from health, social and community based agencies that will be used in the review, review of those records, and determination of inclusion or exclusion in the review, as well as scanning the record for additional information that could be collected from other providers or agencies. After each review team meeting, data from review team meeting are entered into the CFRT database by the Family Violence Programs Manager and Family Violence Research Assistant. After each review meeting, the Programs Manager is also responsible for maintaining, compiling and reviewing the recommendations quarterly for applicability and appropriateness based on the review topic and current trends.

The OCME continued to engage the community through multidisciplinary workgroups, review team meetings, and other activities where appropriate, through the Child Fatality Review Team. In FY19, the state CFRT reviewed cases of drowning deaths to infants and children up to age 17 that occurred in Virginia during the two-year period between 2014-2016, and FY20 was spent releasing the report to appropriate stakeholders.

Conduct epidemiological surveillance: The OCME re-developed Infant and Child Fatality Surveillance Tools, which has enhanced the ability to collect comprehensive data. The Family Violence Research Assistant is responsible for collecting data using the tool and entering the data into the REDCap Surveillance Database. The Research Assistant is also working with the Programs Manager to identify data trends, conduct data analysis, including exploring geographic and demographic disparities, and evaluate the tool and the data for quality assurance purposes.

Project Patience: Project Patience Version 2.0 is an initiative advancing statewide delivery of prenatal and postpartum education on Child maltreatment and infant injury prevention to newborn and infant parents and caregivers prior to their maternity hospital discharge to home or setting after birth and/or as they access community level settings, inclusive of service receipt from libraries and health departments. Priority populations include mothers of NAS infants and pregnant women at risk for or with a history of addiction. Due to the demands on health systems, community programs, and families during our statewide COVID-19 response, the IVPP's Project Patience initiative continues to advance to Version 2.0, transitioning from in-person instruction to virtual for hospitals, libraries, health departments and other prevention programs; and is working to create a repository of references helpful with educating families. These resources include a ready-made no-cost injury prevention toolkit with facilitator instructions, Baby TV modules, VDH IVPP technical assistance, and parent resources. This evidence-informed toolkit of evidence-based materials contains the necessary preparations and minimum level benchmarks according to the American Academy of Pediatrics, the Centers for Disease Control and Prevention, and the American Public Health Association Injury and Violence Prevention Core Competencies. The curriculum includes modules in child passenger safety, drowning prevention, poisoning prevention, traumatic brain injury prevention, injury by children's products prevention, safe sleep strategies, and prevention of shaken baby syndrome. VDH IVPP staff also provide technical assistance in the advancement of Adverse Childhood Experiences trainings and Trauma-Informed Care to health systems and associated community partners. The goals are to engage, inform, and educate key stakeholders and to leverage infrastructure partnerships to address child maltreatment and injury prevention among newborn and infants, with an emphasis on those children at higher risk: substance exposed newborns.

IVPP met its annual objective by presenting the Project Patience curriculum to the Virginia Hospital and Healthcare Association overseeing a total of 14 maternity hospitals during the project period year. Technical assistance was provided to the Virginia Hospital and Healthcare Association in the adoption of the curriculum and for distribution to all of the hospitals. One county library system and one local health department was presented the Project Patience curriculum for adoption. One health system, encompassing two campuses, integrated Project Patience into practice. Due to Executive Order addressing the statewide amplified response to COVID-19, many hospitals, health departments, and libraries were unable to adopt a community class model during 2020. VDH IVPP used time, effort, and resources during the project year to tape training modules for facilitators, revise its website, and transition to a virtual model for launch in 2021 to meet the needs of content delivery by hospitals.

IDENTIFIED STATE PRIORITY	Safe sleep: Increase safe sleep practices for infants				
STRATEGY	• Provide staff support and technical assistance to 24 LHDs to promote safe sleep practices • Provide staff support and training to home visitors on promotion of safe sleep practices • Develop strong interagency, multisector, and community partnerships to inform strategic planning for addressing emerging issues impacting pregnant women and individuals parenting infants				
OBJECTIVE	By June 30, 2020, increase a) the percent of infants placed to sleep on their backs from 78% (PRAMS 2015) to 84%, and b) the percent of infants placed to sleep on a separate approved sleep surface from 59.9% (PRAMS 2015) to 62.9%				
PERFORMANCE MEASURE	NPM 5 – A) Percent of infants placed to sleep on their backs. B) Percent of infants placed to sleep on a separate approved sleep surface. C) Percent of infants placed to sleep without soft objects or loose bedding				
OUTCOME MEASURE	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				
2016-2020 Summary					
Data Source: PRAMS					
	2016	**2017**	**2018**	**2019**	**2020**
5A		78.0%	78.0%	82.0%	80.7%
5B			32.0%	28.8%	31.4%
5C			44.6%	46.9%	53.4%

Early Childhood Health Unit: FY20 activities to address Safe Sleep strategies include continued participation in Early Impact Virginia, which is a statewide collaboration of early childhood home visiting program and partners that serve families with children from pregnancy to age 5. Early Impact Virginia: Guides through coaching professional development, and technical assistance for high quality services; leads in resource development, innovation, efficiency, and advocacy to sustain and expand high quality services; collaborates and coordinates home-based services across public and private agencies for greater impact; and, facilitates research through data collection, analysis and evaluation for continuous improvement and growth. The Institute of Family Support Professionals, which is overseen by Early Impact Virginia, developed content and implemented three online modules. The three modules developed were: Infant Care - The ABCs of Safe Sleep for Infants, Child Development – Secrets of Baby Behavior, and Promoting Safe and Healthy Homes. A total of 247 home visitors enrolled in these online modules. In addition, 1746 early childhood staff nationally also enrolled in these modules. MIECHV home visitors have a safe sleep benchmark that is required by HRSA, and during this time period, 87.5% of home visitors addressed safe sleep with enrolled families. The Healthy Start home visitors also addressed safe sleep practices with 71% of enrolled families.

EMERGING ISSUES

OCME: Emerging issues include looking at the feasibility of re-implementing a Fetal and Infant Mortality Review Team to better understand circumstances around fetal and infant deaths.

CHALLENGES/BARRIERS

OCME: In FY20, challenges that delayed ongoing fatality review activities included the lack of gubernatorial appointed representatives in the team. In addition to the COVID-19 pandemic, this resulted in a delay in the case reviews. However, once appointees were made, meetings were restarted in Fall 2020 in an entirely virtual format, with high attendance and engaged members.

Early Childhood Health Unit: The onset of COVID-19 resulted in the suspension of in-person home visiting, which necessitated the shift to virtual service delivery. The challenge was to figure out how to provide services and resources to families during this time. This led to the development of the Rapid Response Virtual Home Visiting, through a collaborative effort across the nation. Early Impact Virginia played a principal role in organizing the Rapid Response Virtual Home Visiting collaborative.

Immunization Access: The onset of COVID-19 impacted the ability to manage well-care and scheduled immunizations for Virginia's children, from birth through adolescence. The full scope of this impact is not fully ascertained; however, it is recognized as a priority for school and daycare re-opening.

PERINATAL/INFANT HEALTH DOMAIN
FY22 APPLICATION YEAR

2021-2025 MCH Priority Needs Addressed in this Domain
Reproductive justice and support
MCH data capacity

IDENTIFIED NPMs/SPMs FOR STATE ACTION PLAN 2021-2025	
NPM 4 Breastfeeding	Research shows that breastfeeding provides many health benefits for moms and babies, including lower risk of type 2 diabetes and certain cancers for mom, and protection from illness for babies. Virginia PRAMS (2019) showed 88.5% of respondents ever breastfed, 25.0% for 1-10 weeks, and 55.0% were breastfeeding at the time of the survey. There were some differences observed in continuation by race, where by the time of the survey 57.1% of White moms were breastfeeding at the time of the survey, 50.3% of Hispanic moms, and 41.4% of Black moms.
NPM 7.2 Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19	Infant mortality is a sentinel measure of population health that reflects the underlying well-being of mothers and families, as well as the broader community and social environment that cultivate health and access to health-promoting resources. The infant mortality rate in Virginia is 5.9 per 1,000 live births (Virginia Vital Statistics System, 2019). A significant disparity exists in infant deaths between racial groups in Virginia, where non-Hispanic Black women had an infant mortality rate of 10.8, twice that of non-Hispanic White women (4.8 per 1,000 live births). Goal 2.3 of the Virginia Plan for Well-Being is to eliminate the racial disparity in Virginia's infant mortality rates. The Black/White Infant Mortality Ratio is 2.3 (SOM 1).

During FY22, the following programmatic strategies and activities have been identified as methods to advance and improve outcomes.

IDENTIFIED STATE PRIORITY	Maternal and Infant Mortality
FY22 STRATEGY	Coordinate and Expand the Five-Star Breastfeeding Friendly Hospital Program

The 5 Star Breastfeeding Program is housed and administered within VDH and has the intent of supporting hospitals in achieving 4 or 5 stars to build the capacity of Virginia birthing facilities to later seek Baby-Friendly USA Designation. Staff from the Division of Child and Family Health provide programmatic support for this program, and in collaboration in the

Division of Community Nutrition, the team is committed to identifying and addressing needs for both community-based breastfeeding support and hospital oriented quality improvement initiatives. In FY20-21, COVID posed challenges to both hospital facilities and the VDH as it relates to continuity of the program. In FY22, VDH will hire a specific MCH Breastfeeding Coordinator to evaluate and continue operations of this initiative, as well as to consult with health districts, internal Title V programs and community based organizations on other breastfeeding initiatives.

The Virginia Breastfeeding Advisory Committee (VBAC) works to improve the duration of breastfeeding and provides a statewide organizational vehicle for communication, collaboration, and coordination of services throughout Virginia. The VBAC is led by the Division of Community Nutrition's State Breastfeeding Coordinator. Meetings are held quarterly and are attended by various Title V programmatic staff. VBAC will support 5-Star Breastfeeding Programming by advocating, educating and providing SME review of applications.

IDENTIFIED STATE PRIORITY	Maternal and Infant Mortality
FY22 STRATEGY	Develop and mobilize strong interagency, multisector, and community partnerships to address disparities in maternal and infant mortality rates

COORDINATION AND FACILITATION OF BI-MONTHLY CHILD FATALITY REVIEW TEAM (CFRT) MEETINGS:
Activities include continuation of case selection for each meeting, requesting records from health, social and community based agencies that will be used in the review, review of those records, and determination of inclusion or exclusion in the review, as well as scanning the record for additional information that could be collected from other providers or agencies. After each review team meeting, data from review team meeting are entered into the CFRT database by the Family Violence Programs Manager and Family Violence Research Assistant. After each review meeting, the Programs Manager is also responsible for maintaining, compiling and reviewing the recommendations quarterly for applicability and appropriateness based on the review topic and current trends.

IDENTIFIED STATE PRIORITY	Maternal and Infant Mortality
FY22 STRATEGY	Develop, coordinate and implement an action plan for substance-exposed infants based on the 2020 Report to the General Assembly

In November 2016, the Virginia opioid addiction crisis was declared a public health emergency. In 2017, the Governor and General Assembly directed the Secretary of Health and Human Resources to convene a workgroup to study barriers to the identification and treatment of substance-exposed infants in the Commonwealth. Related to the workgroup's recommendations, the Code of Virginia (§ 32.1-73.12) was amended during the 2018 General Assembly session to identify the Virginia Department of Health (VDH) as the lead agency to develop, coordinate, and implement a plan for services for substance-exposed infants. The plan must:

1. Support a trauma-informed approach to the identification and treatment of substance-exposed infants and their caregivers and include options for improving screening and identification of substance-using pregnant women
2. Include the use of multidisciplinary approaches in intervention and service delivery during the prenatal period and following the birth of the substance-exposed child, and in referrals among providers serving substance-exposed infants, their families and caregivers.

Various state and local agencies, health systems, and community partners are involved in efforts to provide services and resources for substance-exposed infants and their families. However, VDH identified a lack of coordination and knowledge of these efforts and resources among partners and health systems. Many partner organizations know what is available

within their respective communities but this does not transcend to resources and services external to the community. In FY20, under the direction of the Maternal and Infant Health Coordinator, VDH convened four different "pillar" workgroups to develop a statewide strategic plan for family and infants impacted by substance exposure and maternal substance use. Due to the COVID-19 pandemic, the full workgroup was invited to a series of three meetings in April 2020 and given an opportunity to review and provide feedback to the full draft strategic plan. In August 2020, a final draft was provided via email to over 300 stakeholders across the Commonwealth to review a final time and provide suggested edits and feedback. VDH is required to report to the General Assembly annually regarding implementation of the plan and the 2020 report is included in the Appendix

In FY22, a coordination and dissemination outline will be developed, detailing how the strategic plan will be implemented and communicated across state agencies, health systems and stakeholder partner organizations. The goal of this coordinated approach is to ensure interagency collaboration and a comprehensive system of care to address the medical, mental health, and social needs of families impacted by substance use disorder across the Commonwealth. After dissemination of the strategic plan, a work plan will be developed to outline implementation of the plan. The future of this work is contingent upon determining the required resources needed to make this strategic plan come to fruition.

IDENTIFIED STATE PRIORITY	MCH Data Capacity
FY22 STRATEGY	Sustain and expand data capacity within the Office of the Chief Medical Examiner related to maternal, infant and child health

OCME EPIDEMIOLOGICAL SURVEILLANCE: The OCME re-developed Infant and Child Fatality Surveillance Tools, which has enhanced the ability to collect comprehensive data. The Family Violence Research Assistant is responsible for collecting data using the tool and entering the data into the REDCap Surveillance Database. The Research Assistant is also working with the Programs Manager to identify data trends, conduct data analysis, including exploring geographic and demographic disparities, and evaluate the tool and the data for quality assurance purposes.

Child Health

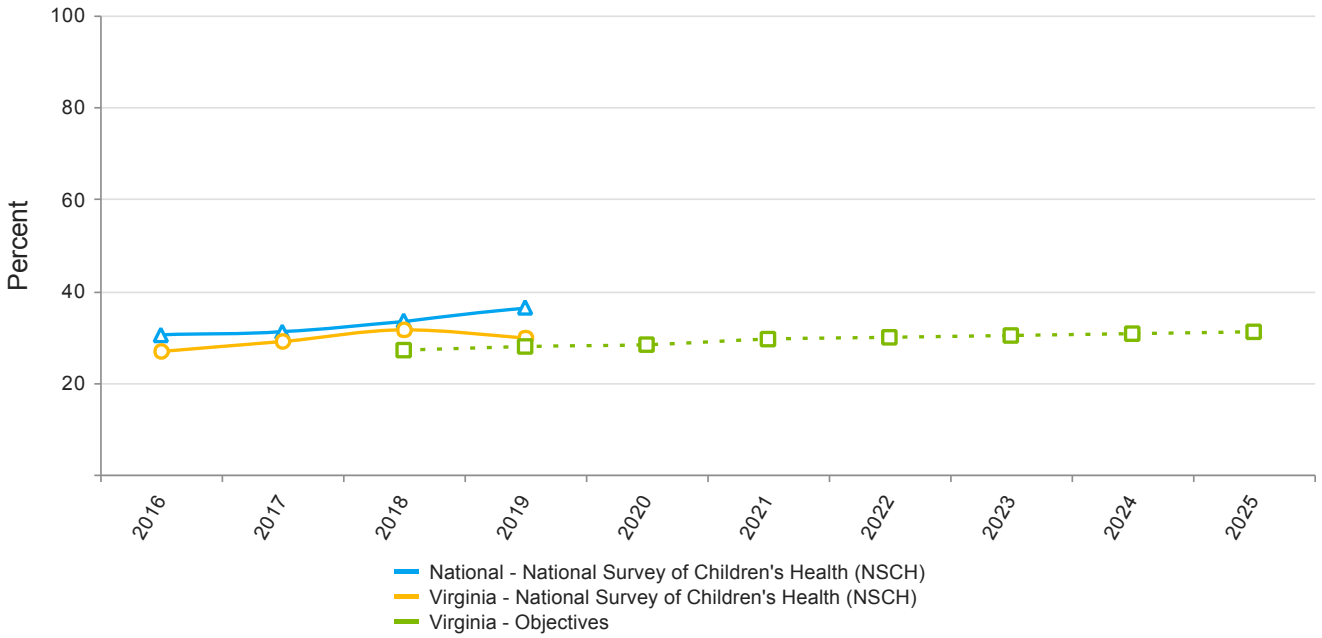
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available or Not Reportable	NPM 6
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2018_2019	7.3 %	NPM 13.2
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	NVSS-2019	15.1	NPM 7.1
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2019	29.0	NPM 7.1
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2017_2019	9.3	NPM 7.1
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2017_2019	11.9	NPM 7.1
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	15.0 %	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	90.3 %	NPM 6 NPM 13.2

National Performance Measures

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

Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			27.1	27.9	28.3
Annual Indicator		26.8	29.1	31.4	29.9
Numerator		67,562	59,469	54,036	67,406
Denominator		252,334	204,083	171,987	225,762
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	29.5	29.9	30.3	30.7	31.1	31.5

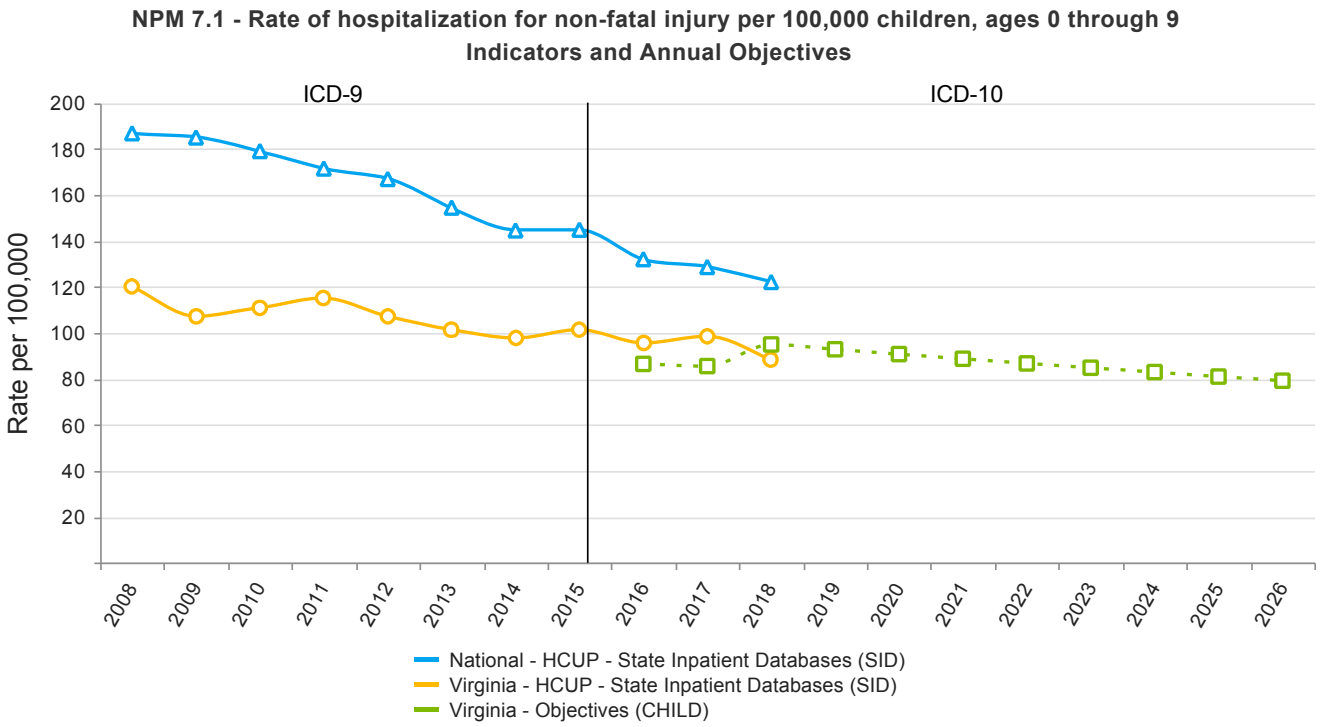
Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective	7	15	20	25
Annual Indicator	15	30	30	30
Numerator				
Denominator				
Data Source	VDH Division of Child and Family Health	VDH Division of Child and Family Health	VDH Division of Child and Family Health	VDH Division of Child and Family Health
Data Source Year	2016-2017	2017-2018	2018-2019	2019-2020
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	35.0	50.0	100.0	100.0	100.0	125.0



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

Federally Available Data					
Data Source: HCUP - State Inpatient Databases (SID)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	86.5	85.5	94.9	92.8	90.7
Annual Indicator	87.0	101.5	95.4	98.6	88.4
Numerator	899	785	982	1,013	906
Denominator	1,033,738	773,528	1,029,557	1,026,897	1,025,381
Data Source	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	88.7	86.7	84.8	82.9	81.0	79.2

Evidence-Based or –Informed Strategy Measures

ESM 7.1.1 - Number of maternity centers disseminated Virginia's injury prevention curriculum

Measure Status:	Active
State Provided Data	
	2020
Annual Objective	
Annual Indicator	14
Numerator	
Denominator	
Data Source	VDH - Injury and Violence Prevention Program
Data Source Year	2020
Provisional or Final ?	Final

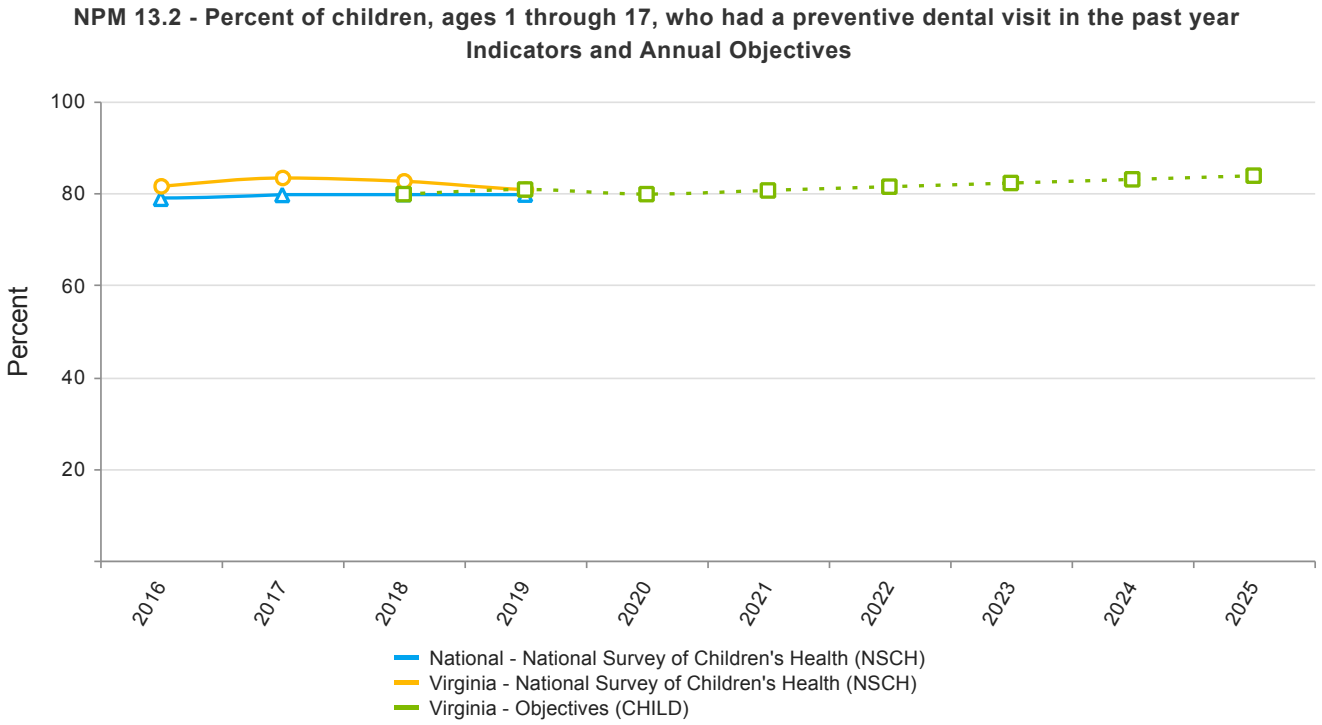
Annual Objectives					
	2022	**2023**	**2024**	**2025**	**2026**
Annual Objective	16.0	17.0	18.0	19.0	20.0

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

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			2,549	2,549
Annual Indicator		2,596	1,560	1,738
Numerator				
Denominator				
Data Source		VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program
Data Source Year		2018	2019	2020
Provisional or Final ?		Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	2,549.0	2,549.0	2,549.0	2,549.0	2,549.0	2,549.0



NPM 13.2 - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			93.2	94.3	79.7
Annual Indicator		81.4	83.1	82.4	80.5
Numerator		1,407,907	1,448,110	1,463,318	1,432,504
Denominator		1,729,004	1,741,839	1,775,616	1,778,464
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			79.7	80.7	79.7
Annual Indicator		75.7	78.4	78.9	77.6
Numerator					
Denominator					
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	80.5	81.3	82.1	82.9	83.7	84.5

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			6	6
Annual Indicator		3	4	8
Numerator				
Denominator				
Data Source		VDH Oral Health Program documentation	VDH Oral Health Program documentation	VDH Oral Health Program documentation
Data Source Year		2018	2019	2020
Provisional or Final ?		Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	6.0	6.0	6.0	7.0	7.0	8.0

State Action Plan Table

State Action Plan Table (Virginia) - Child Health - Entry 1	
Priority Need	
Mental Health: Promote mental health across MCH populations, to include reducing suicide and substance use.	
NPM	
NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9	
Objectives	
By June 30, 2025, decrease the rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 from 101.5 (HCUP - State Inpatient Databases (SID) 2015) to 81.0.	
Strategies	
Provide an injury prevention curriculum to maternity hospitals, local prevention partners, and libraries statewide.	
ESMs	**Status**
ESM 7.1.1 - Number of maternity centers disseminated Virginia's injury prevention curriculum	Active
ESM 7.1.2 - Number of child safety seats disseminated through the LISSDEP network	Active
NOMs	
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	

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

Priority Need

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

NPM

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

Objectives

By June 30, 2025, decrease the rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 from 101.5 (HCUP - State Inpatient Databases (SID) 2015) to 81.0.

Strategies

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

Work in tandem with interagency teams focused on the intersection between child health and transportation.

ESMs	Status
ESM 7.1.1 - Number of maternity centers disseminated Virginia's injury prevention curriculum	Active
ESM 7.1.2 - Number of child safety seats disseminated through the LISSDEP network	Active

NOMs

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

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

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

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

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

Priority Need

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

NPM

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

Objectives

By June 30, 2025, increase the percent of children (ages 10-71 months) receiving a developmental screening using a parent-completed screening tool from 29.1% (NSCH 2016-2017) to 31.1%.

Strategies

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

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

NOMs

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

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

State Action Plan Table (Virginia) - Child Health - Entry 4

Priority Need

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

NPM

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

Objectives

By June 30, 2025, increase the percent of children (ages 1 through 11) who had a preventive dental visit in the past year from 78.9% (NSCH 2017-2018) to 83.7%

Strategies

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

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

NOMs

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

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

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

CHILD HEALTH DOMAIN
SUMMARY/OVERVIEW
FY20 ANNUAL REPORT

2016-2020 MCH Priority Needs Addressed in this Domain
Early and continuous screening: support optimal physical, mental health and social emotional development for all children
Child adolescent injury: Reduce injuries, violence, and suicide among Title V populations
Oral Health: Increase access to oral health services for pregnant women and children

NOTE: The FY20 Annual Report represents the final year of priorities, strategies and activities aligned with the 2016-2020 needs assessment and state action plan for the Child Health Domain.

DOMAIN CONTRIBUTORS:
Injury & Violence Prevention Program - Division of Prevention and Health Promotion
Early Childhood – Division of Child and Family Health
Dental Health Program – Division of Prevention and Health Promotion

DOMAIN OVERVIEW

INJURY & VIOLENCE PREVENTION PROGRAM: The Injury and Violence Prevention Program (IVPP) supports promising and best practice activities statewide that address leading or emerging injury issues at the population health level. IVPP seeks to build solid infrastructure to improve the health of Virginians by increasing awareness, action, and technical assistance for and by local and state partners to assess the burden of injury, assure interventions and facilitate policy development. Per the socioecological model, the IVP works to implement multi-level interventions (EG individual, relationship, community, societal) across sectors to influence those potentially modifiable variables, improve protective factors, equip the workforce to address primary prevention, reduce barriers for access to safety devices, and influence policy changes through a health equity lens. IVPP staff seek family and consumer input and continues to utilize data on deaths and hospitalizations attributable to injury to inform programmatic activities. IVPP works to incorporate activities for addressing health equity by identify injury and violence prevention strategies and supporting policies and legislation to improve access to a trained workforce. The Injury and Violence Epidemiologist, partially funded by Title V, maintains the Injury and Violence Prevention Dashboard, which provides the public with data on deaths and hospitalizations attributable to injury. Systems allow for quick and easy access to basic injury data and enables users to customize data reports on various types of injury hospitalizations and deaths. Data are available for both intention and unintentional injuries, and some demographic and geographic information is included to allow for more detailed analysis. The Injury and Violence Epidemiologist routinely responds to data requests from constituents that could not be addressed through these systems.

EARLY CHILDHOOD: Effective screening and referral systems improve outcomes for children and strengthen communities. VDH is investing Title V Funds in six Developmental Screening Initiative (DSI) Hubs, each led by a local coordinating partner. DSI Hubs bring together screening and referral stakeholders to:

- Increase screening using a parent-administered evidence-based tool (ASQ, ASQ SE)
- Engage local partners to collaborate and coordinate local screening and referral processes
- Lead community awareness campaigns about healthy child development and the importance of developmental screening

DENTAL HEALTH PROGRAM: The DHP performs many duties including the provision of the following: Educational activities and resources to a wide variety of partner groups to promote proper oral hygiene and support prevention services and access to dental care; direct clinical preventive services and assistance with establishing a dental home; quality assurance review to assure a competent public health oral health workforce; and, surveillance and evaluation activities to monitor and track dental disease rate and trends as part of program assessment for effectiveness and planning.

STATE ACTION PLAN UPDATES

IDENTIFIED STATE PRIORITY	Child/Adolescent Injury: Reduce injuries, violence, and suicide among Title V populations
STRATEGIES	1. Provide an injury prevention curriculum to maternity hospitals. 2. Eliminate the financial barriers to safety devices by equipping income-eligible families with child safety seats through the Low Income Safety Seat Distribution and Education Program (LISSDEP) 3. Equip healthcare providers with primary prevention skills for reducing Neonatal Abstinence Syndrome (NAS) through the evidence-based model Project ECHO®
OBJECTIVE	By June 30, 2020, decrease the rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 from 101.5 (HCUP – State Inpatient Databases (SID) 2015) to 90.7.
PERFORMANCE MEASURE	NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9
EB/I STRATEGY MEASURE	ESM 7.1.1 – Proportion of maternity centers with prenatal courses including Virginia's injury prevention curriculum ESM 7.1.2 – Number of child safety seats disseminated through the LISSDEP network ESM 7.1.3 – Number of healthcare providers receiving Project ECHO content in reducing the impact of NAS
OUTCOME MEASURE	NOM 15 – Child Mortality rate, ages 1 through 9, per 100,000 NOM 16.1 – Adolescent mortality rates 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

2016-2020 Summary				
Data Source: HCUP - State Inpatient Databases (SID)-Child				
2016	**2017**	**2018**	**2019**	**2020**
87.0	101.5	95.4	98.6	88.4
GOAL FOR 2021-2025 SAP:	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.			

The Injury and Violence Prevention Program (IVPP) leverages Title V funds to expand statewide Low Income Safety Seat Distribution and Education Program (LISSDEP) activities and remove financial barriers for income eligible families and high risk populations statewide through a network of 149 distribution sites by providing no cost child safety seat devices, in addition to proper installation and usage education. The program provides transportation safety awareness as it relates to Virginia Child Passenger Safety Law (Code of Virginia, Chapter 10, Article 13). Title V-funded and non-funded IVPP staff continue to lead these programs.

Children continue to be a vulnerable population traveling and walking on roadways in Virginia, traveling nearly as much as adults on an average of 3.4 vehicle trips at 45-50 minutes each day. MV traffic related injuries remain to be a leading cause of death in Virginia for children 0-14 years of age. Those transporting children are often faced with increased number of registered vehicles with miles traveled, pedestrian traffic, and population size in communities. Through increased proper use of child restraint systems, child passenger safety (CPS) law enhancements, and strong existing infrastructure, the VDH CPS Program, in partnership with statewide transportation safety experts, continues to make progress in addressing the impact of motor vehicle traffic related injuries among children.

The proper use of child safety seats and booster seats is required for all children under the age of eight by Virginia Code 46.2-1095. Pursuant to VA code 46.2-1098, VDH coordinates the Low-Income Safety Seat Distribution and Education Program (LISSDEP) to provide safety seats through a network of 149 dissemination sites statewide to indigent families through revenue derived from fines collected from violations of the CPS law. LISSDEP helps to remove financial barriers and increase access to safety devices and proper education for reducing motor vehicle related injuries. Local health departments operating as LISSDEP distribution sites support program coordination and Child Passenger Safety education for indigent families that addressed the programmatic usage and installation of safety seats and safety seats.

During the project period, IVPP LISSDEP was unable to meet its annual objectives, however, was able to use non-MCH funded staff time to mitigate challenges and transition to virtual technical assistance. A total of 1,738 convertible safety seats and 226 booster seats, totaling 1,964 restraints were distributed. COVID-19 Statewide social distancing orders posed a barrier to completing activities, as this is a direct service, community level initiative. The vast majority of LISSDEP distribution sites suspended or greatly reduced the issuance of safety seats due to the necessity to redirect health department staff to provide essential tasks and abide by social distancing orders. A few sites adopted hands-on training and assessment suggestions provided for educating and issuing seats by utilizing simulator seats on a one-on-one basis, issuing seats during other required contact appointments, or by providing education in its entirety outside in parking lots with touchless training whenever possible.

Based on a hub and spoke model, Project ECHO® is a no-cost tele education platform that demonopolizes knowledge by exposing healthcare providers to a community of learners. The program provides continuing medical education units, opportunity to present de-identified cases, and access to a virtual community of tools and resources.

The IVPP has leveraged Title V funds to expand Project ECHO: Neonatal Abstinence Syndrome (NAS) prevention labs for the past three project periods, equipping organizations with maternal and pediatric healthcare providers with the skills to provide case management and harm reduction services for women at risk for, or with a history of, substance misuse, abuse, and addiction during childbearing age; all with the goal for prevention of Neonatal Abstinence Syndrome, in partnership with the University of Virginia (UVA) and as reported by UVA.

During the project period, 17 organizations/providers remained in the cohort from previous years, however, due to the amplified response to COVID-19 based on UVA's 2019 report, however, UVA was unable to meet its objective and grow outreach in the training 25 organizations within the cohort. VDH IVPP spent significant partially funded and non-Title V time and effort with UVA and the Title V team during the project period to evaluate its current model and revise its curriculum for launch when clinics were ready to receive instruction. IVPP worked with the Title V Director, UVA, the Virginia Perinatal Neonatal Collaborative (VPNC) and the Maternal Child Health Specialist at Virginia's Medicaid Authority, the Department of Medical Assistance Services, to create a number of ECHO sessions as the interventions to address the findings of their SBIRT and Maternal Mental Health Process Improvement Projects and to augment the VNPC Webinar series with content developed for a target audience of Maternal, Infant and Community Providers. VDH IVPP additionally worked with UVA to include specialized NAS content into its existing VDH IVPP Opioid Misuse Prevention ECHO member cohort, funded by the Centers for Disease Control and

Prevention (CDC). In FY21, this ECHO lab was absorbed into the VDH IVPP UVA Opioid Misuse Prevention Project ECHO as funded by the CDC Overdose Data to Action funding.

IDENTIFIED STATE PRIORITY	Early and continuous screening: Support optimal physical, mental health and social emotional development for all children
STRATEGIES	1. Through early childhood partnerships, support ongoing work force development through training, technical assistance, professional development and education with evidence-based tools for LHDs and their community partners 2. Provide messages for families and the community about the importance of ongoing screening, monitoring, referral, and followup of child development using social media 3. Strengthen the continuum of child health care infrastructure for screening, assessment, referral, and followup for developmental screening 4. Develop a strategic developmental screening work plan with community stakeholders in each of the six bugs to build a continuum of developmental and behavioral care to reduce barriers and gaps and promote equity for all young children and their families
OBJECTIVE	By June 30, 2020, increase the percent of children (ages 10-71 months) receiving a developmental screening using a parent-completed screening tool from 26.8% (NSCH 2016) to 28.1%
PERFORMANCE MEASURE	NPM 6: Percent of children ages 10 months through 71 months, receiving a developmental screening using a parent-completed screening tool
EB/I STRATEGY MEASURE	ESM 6.1 – Number of LHDs, community partners, and providers receiving developmental screening resources, training, and TA ESM 6.2 – Number of hits to the VDH web pages by individuals seeking information about the importance of regular developmental screening and Bright Futures ESM 6.3 – Completion of actionable plan for strengthening the comprehensive, complex developmental screening system of care for children 0-8
OUTCOME MEASURE	NOM 13: Percent of children meeting the criteria developed for school readiness Developmental: Developmental Measure: Federally Available Data (FAD) NOM 19: Percent of children, ages 0 through 17, in excellent or very good health

2016-2020 Summary				
Data Source: National Survey of Children's Health (NSCH)				
2016	**2017**	**2018**	**2019**	**2020**
	26.8%	29.1%	31.4%	29.9%
GOAL FOR 2021-2025 SAP:	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%.			

Local Smart Beginnings have brought public and private leaders together to collaborate on priorities for their youngest citizens since 2005. With steady investment from Virginia's governors and legislature over the last 15 years, Smart Beginnings has evolved from a network of 3 community coalitions working across 9 localities to 17 Smart Beginnings working across 93 of 133 localities. Building from this asset, the Virginia Early Childhood Foundation (VECF) will lead a transition creating a statewide network of Ready Regions that will cover all of Virginia and commit to assertive and consistent delivery of equitable early childhood opportunities – smart beginnings – for all families with young children in the Commonwealth. This latest evolution will allow Virginia's public-private network to continue to be responsive to those needs for the decade to come.

The purpose of the partnership for the Developmental Screening Initiative is to 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.

DSI Hub partners include:

- United Way of Southwest VA, Smart Beginnings
- Greater Roanoke Smart Beginnings
- United Way of Greater Charlottesville
- Smart Beginnings Greater Harrisonburg
- Smart Beginnings Southeast
- United Way South Hampton Roads

Over the past year, the six Developmental Screening Initiative (DSI) Hubs continued to make progress onboarding partners into the online ASQ platform, as well as collecting self-reported number of screens completed by/through other partners. This growth is evidenced by the increase in the number of screens documented over previous quarters. The six DSI Hubs reported a total of 2,015 screens conducted this quarter, more than doubling the 915 screens documented in the previous quarter. Of the total 2,015 screens, 373 were in the monitoring zone, and 180 either resulted in referral or were flagged for referral. Of 110 total partners across the six DSI Hubs, 85 are administering screens, 13 are not currently conducting screens but plan to, and 12 are not conducting screens. (Prior quarter counts: 102 total partners, 75 administering screens, 16 not conducting screens but planning to, and 11 not conducting screens. Data sharing agreements are in place through the Virginia Early Childhood Foundation (VECF) with 27 partners, with 20 partners pending.

The DSI Hubs report using a variety of messaging strategies and targeting a range of audiences. Some Hubs focused on outreach to parents, utilizing social media, email, and/or print (rack cards for example), as well as working with organizations/outlets that already cater to parents or specific populations, such as the Spanish speaking community, to raise awareness about optimal child development and promote the value of screening. Others focused messaging more on supporting strategic partners, to strengthen consistency of developmental milestone and screening knowledge, and support partnership engagement by providing training for providers on the digital platform. One DSI Hub is utilizing “Google Classroom" to aggregate standard messaging and procedures with regard to ASQ to make it easier for partners to navigate onboarding into the digital Enterprise system, deploying consistent screening and referral processes, and accessing and delivering consistent, accurate information about child development and the role of screening in child health.

IDENTIFIED STATE PRIORITY	Oral health: Increase access to oral health services for pregnant women and children
STRATEGIES	Continue to provide up to five health districts with direct service provider oral health trainings and dental provider trainings regarding ISHCN and very young children (a total of 10 trainings) and update the VDH online provider directory for dentists willing to treat individuals with special healthcare needs (ISHCN)
OBJECTIVE	By June 30, 2020, increase the percent of children (ages 1 through 11) who had a preventive dental visit in the past year from 77.8% (National Survey of Children's Health (NSCH) – NONCSHCN 2016) to 81.7%.
PERFORMANCE MEASURE	NPM 13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year
EB/I STRATEGY MEASURE	ESM 7.1.1 – Proportion of maternity centers with prenatal courses including Virginia's injury prevention curriculum ESM 7.1.2 – Number of child safety seats disseminated through the LISSDEP network ESM 7.1.3 – Number of healthcare providers receiving Project ECHO content in reducing the impact of NAS
OUTCOME MEASURE	NOM 15 – Child Mortality rate, ages 1 through 9, per 100,000 NOM 16.1 – Adolescent mortality rates 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

2016-2020 Summary				
Data Source: National Survey of Children's Health (NSCH) - Children				
2016	**2017**	**2018**	**2019**	**2020**
	75.7%	78.4%	78.9%	77.6%
GOAL FOR 2021-2025 SAP:	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%.			

The Dental Preventive Services Program aim is to prevent dental decay for children in most susceptible permanent teeth in the most vulnerable populations in Virginia. Low-income schoolchildren in targeted areas of the state receive dental services including oral health assessment, dental cleanings, dental sealants, fluoride varnish application, dental referral information, and oral health education.

Specific activities in FY20 (October 1, 2019 – September 30, 2020) include:

STRATEGY: Continue to provide up to five health districts with direct service provider oral health trainings and dental provider trainings regarding ISHCN and very young children (a total of 10 trainings) and update the VDH online provider directory for dentists willing to treat individuals with special healthcare needs (ISHCN)	
Establish contractual relationships with VDAF and VAOHC to plan and manage logistics to conduct trainings	Completed
Partner with contractors for project planning	Completed
Conduct oral health trainings regarding care for ISHCN and very young children	Completed
Evaluate trainings to ensure that goals are met	Completed
Update provider database that populates ISHCN Online Directory of Dental Providers	Ongoing

CHALLENGES/BARRIERS

LISSDEP Network site staff distributing child safety seats were deployed during the project year to manage COVID-19 prevention responsibilities within health departments. LISSDEP completed a needs assessment during the project year, and it was found that Network sites at all local health departments require financial support in the form of time and effort allocation so that deliverables can be met during epidemic deployment.

The partnership with The American Academy of Suicidology was integral in transitioning to an all virtual delivery model for the Recognizing and Responding to Suicide Risk: Essential Skills for Clinicians Training. While due to the Statewide social distancing restrictions no RRSR trainings took place during the Oct 2019 - Sept 2020 time period, time and effort was utilized during that time to research and review trainings that would be comparable to the accredited AAS RRSR training, and could be delivered in an all-virtual model. Some gatekeeper trainings transitioned well to the all virtual model (such as ASIST), however the transition to an all virtual RRSR training proved to be more difficult as RRSR is a two-day, 12 hour training which covers topics such as documentation, developing a treatment plan, and understanding the legal issues related to suicidality as well as significant client/counselor role playing for participants. Once AAS offered the RRSR training in an all-virtual model in late fall of 2020, the Virginia Department of Health began the planning and implementation of RRSR and dates were set for the following spring/summer 2021.

COVID severely restricted access to providers and families during most of 2020. The COVID-19 Pandemic continues to slow progress in some areas for DSI Hub partners. Hubs report that many screening partners continue to experience limited bandwidth and/or staffing issues that increase resistance to adoption of the ASQ on-line system; partners are not able to take on new tasks or learn these new ASQ processes. Hubs also report difficulties in engaging established partners and slower building of relationships with new partners due to the inability to meet in person. United Way of Greater Charlottesville reported challenges in reaching Spanish-speaking parents. United Way of Southwest Virginia mentioned the difficulty of reaching grandparents who are raising second-generation children using virtual tools to which they are unaccustomed; lack of access to technology is generally a complicating factor in rural areas, even more pertinent during COVID. Neighborhood and community events are still curtailed or non-existent. Nonetheless, Hubs continue to reach out to build expanded partnerships, and to advance DSI work as much as possible through virtual meeting and alternate outreach strategies. Partners continue to leverage existing initiatives (like the Preschool Development Grant) as routes to communicate with partners, and opportunities to advance DSI priorities. For example, SBGH, in collaboration with their Mixed Delivery Grant and Preschool Development Grant initiatives partners, will host a series of 6 Family Forums, over the next 12 months to build relationships with families and share information about developmental screening.

A second barrier is the lack of ability to quantitatively track progress on DSI goals and objectives. Virginia lacks a state centralized developmental screening site to track/monitor developmental screening. Agency IT barriers prevent the ability to utilize existing developmental screening software. The only available data is through the National Survey of Children's Health (NSCH), which serves as a proxy measure solely based on parent report.

MCH WORKFORCE DEVELOPMENT CAPACITY

Virginia ranks 37th lowest in the country for developmental screening care for children under age 5. The state has no centralized manner for collecting data, relying on parent report from a National Survey. Early identification and treatment of developmental delays can help children access the services and supports they need to reach their full potential. Routine screening for all children is an important gateway to ensure those identified with certain delays or needs receive early intervention or other appropriate services that can help them meet developmental milestones and enter school ready to learn. As many as one in four children under age 6 may be at moderate or high risk for developmental, behavioral, or social delays. Larger shares of young children of color are at risk for delays compared with their white peers. Young children living in poverty (100 percent of the federal poverty line, or FPL) are more than twice as likely to be at high risk of developmental delay as in families with incomes that are more than double. Partnering with referral groups, such as the Child Development Centers and Early Intervention Specialists, serves to build out infrastructure which in turn strengthens the continuum of

screening, assessment, referral, and follow-up for developmental screening. The child outcomes also include support for optimal mental health and social-emotional development of all children.
Actions taken by VDH to improve the capacity of the MCH workforce in program areas, are to strengthen the continuum of child health care infrastructure for screening, assessment, referral, and follow-up for developmental screening. One capacity building action item in the work plan to increase screenings is for screeners to adopt as part of normal practice, regardless of the point of entry, whether in child care or primary care, the algorithm for ongoing screening.
There is ongoing work with partners to support family strengthening of protective factors, comprehensive system building through collective impact and learning collaboratives, promoting the linkage of children and families to community-based resources to support optimal mental health and social-emotional development of all children and population-wide data collection. For example, professional development through training, technical assistance, and education with evidence-based tools for LHDs and their community partners is ongoing through ASQ3 and ASQSE2 training.

Another strategy is through our partnerships, encouraging lead agencies to adopt policies to promote developmental screenings in child care programs. Virginia is doing this through Child Care and Development Fund (CCDF) state plans. Virginia is promoting children's healthy development and learning by supporting child care licensing, quality improvements systems to help programs meet higher standards, and child care workers to attain more training and education and providing consumer education information to help parents make informed choices about child care services and to promote involvement by parents and family members in the development of their children in child care settings.

EMERGING ISSUES

The passage of the Affordable Care Act has expanded the role of primary care providers in promoting child and adolescent socio-emotional health and well-being. With additional emphasis on prevention and expanded coverage for services such as developmental screenings, behavioral assessments, and autism screening, primary care practitioners become increasingly involved in child mental health. This expansion provides opportunities for psychologists to be involved in service delivery in primary care setting with potential benefits such as improved health outcomes through early screening and diagnosis and associated reduced costs. Intra/Interagency involvement with this focus:

1. VDH COVID-19 FAQs workgroup representing child health
2. CDC VA Learn The Signs Act Early Team – Covid19 Response grant, VCU lead
3. Virginia Department of Education, Department of Behavioral Health and Developmental Services, and Department of Social Services Feasibility Study of Developing an Early Childhood Mental Health Consultation Program (HJR 51, 2020)
4. Virginia Commission on Youth, a bipartisan commission of the General Assembly, serve on the committee representing VDH, school age focus
5. Head Start State Collaborative Office Advisory Council, VDH representative on the council, early childhood focus
6. Early Childhood Mental Health Advisory Board, managed through DBHDS & VCU

CHILD HEALTH DOMAIN
FY22 APPLICATION YEAR

2021-2025 MCH Priority Needs Addressed in this Domain
Finances as a root cause
Mental Health
Strong systems of care for all children

IDENTIFIED NPMs/SPMs FOR STATE ACTION PLAN 2021-2025	
NPM 6 Developmental Screening	The percent of children, ages 9-35 months, ho received a developmental screening using a parent-completed screening tool in the past year is 29.9% (2018-2019) in Virginia, compared to the US at 36.4%. Early identification of developmental disorders is critical to child well-being and is an integral function of primary care.
NPM 7 Injury Hospitalization (ages 0-9 years)	Data from the Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases (SID) showed the rate of hospitalization for non-fatal injury among children was 88.4 per 100,000 in 2018. Among age groups, the annual indicator was 187.4 for children less than one year of age, 96.7 among children ages 1-4, and 62.6 among children ages 5-9. Reducing the burden of nonfatal injury can greatly improve the life course trajectory of infants and children, resulting in improving quality of life and cost savings.
NPM 13.2 Preventive dental visit (ages 1-11 years)	The NSCH showed that 63.0% of children age 1-5 years and 89.0% of children age 6-11 years had a preventive dental visit *2018-2019). Insufficient access to oral health care and effective preventive services affects children's health, education and ability to prosper.

During FY22, the following programmatic strategies and activities have been identified as methods to advance and improve outcomes.

IDENTIFIED STATE PRIORITY	Finances as a root cause
FY22 STRATEGY :	Work in tandem with interagency teams focused on the intersection between child health and transportation

VDH Injury and Violence Prevention Program (IVPP) will continue dissemination of child safety seats through the Low Income Safety Seat Distribution and Education Program (LISSDEP) network in FY22 in support of income eligible families. Families are provided a safety seat at no cost to participant that completes an educational session and training in proper installation and usage. Families must demonstrate proficiency in skills mastered. This work supports geographical and racial disparities statewide. Family voices will be actualized with the evaluation of trainings. This strategy is fully

implemented and is anticipated to be expanded to reach more families in FY22.

IVPP was able to complete a strategic communications plan around child safety seat distribution, with an emphasis on targeted populations of disparity and a needs/asset assessment and evaluation specific to the child safety seat distribution program in FY21, to include key accomplishments, identification of community-based organizations poised to serve as strategic partners, and assessment of 3-5 strategic needs. Assessment linked to safe sleep, WIC, tobacco, etc., network out access points, inclusive of LHDs, faith-based and VDH Office of Health Equity, and demonstrated equity consideration through Census analysis and program planning to meet enrollment needs. This work will inform equitable distribution of safety seats and time and effort support to regional LISSDEP coordinators within the health district regions in FY22. IVPP additionally developed a CPS training plan in FY22 that identified outreach opportunities to community based organizations, with an emphasis on disparate populations.

Activity	Expected Completion Date	Responsible Staff
Continue the dissemination of child safety seats through the LISSDEP network for income eligible families and identified within the IVPP communication and outreach plan	10/2021-9/2022	IVP Supervisor; Transportation Safety Coordinator; 3 non-MCH funded positions; contractor company

In FY22, VDH IVPP will continue its action planning within interagency forums to advance pedestrian safety and bicycling behavior safety.

IVPP non-MCH funded staff provided in kind contribution and work with interagency teams to address pedestrian safety. In-kind contribution includes participation with the Pedestrian Safety Task Force, PATHS (Promoting Active Transportation Safety and Health), Virginia Statewide Bike/Pedestrian Advisory Committee, Complete Streets Richmond, Plan RVA (Active Transportation), Share Virginia Roads Bicycle Pedestrian Technical Advisory Committee (Northern Region), and State Trails Advisory Committee. All listed committees and workgroups are intra-agency with representation from multiple state agencies, locality organizations, and other civic groups.

With jurisdictions in Virginia adopting Vision Zero and Complete Streets, the VDH IVP Program views urban planning and access to safe green space as a long-term strategy. Existing programs, such as Park RX and development of traffic gardens, can be adopted and expanded on to include local parks and create safe spaces for all to practice and learn safe active transportation. VDH IVPP will create one feasibility plan in pedestrian safety and bicycling behavior initiatives in the upcoming project year.

Activity	Expected Completion Date	Responsible Staff
Serve on interagency teams focused on the intersection between child health and transportation. Focus will be on IVP Program planning for increasing pedestrian safety and safe bicycling behavior.	10/2021-9/2022	IVP Supervisor; Transportation Safety Coordinator; 3 non-MCH funded positions; contractor company
Complete one feasibility plan for implementation of pedestrian and bicycling safety activities	10/2021-9/2022	IVP Supervisor; Transportation Safety Coord; 3 Non-MCH funded positions; Contractor company

IDENTIFIED STATE PRIORITY	Mental health
FY22 STRATEGY:	Provide an injury prevention curriculum to maternity hospitals, local prevention partners, schools, and libraries statewide, inclusive of the traumatic brain injury (TBI) prevention Virginia Concussion Initiative tool kit, ACEs, child abuse and neglect curriculum, and linkages of care resources

IVPP will continue the dissemination of Project Patience into FY22, an initiative supporting statewide delivery of prenatal and postpartum education on child maltreatment and infant injury prevention. IVPP staff provides technical assistance in maternity hospitals, libraries, prevention programs, health departments, and schools so that prevention programs can in turn train their community members in childhood injury and violence prevention. The initiative has undergone a transition this year due to COVID-19 Executive Orders gathering restrictions, and continues to be constructed as a fully virtual toolkit. Hospitals, local health departments, and prevention programs will have a full compendium of Baby TV materials in FY22, and schools will have a traumatic brain injury (TBI) virtual toolkit from the Virginia Concussion Initiative and George Mason University in supporting children with traumatic brain injuries and concussions.

The curriculum will also be disseminated to health systems completing Project ECHO education in partnership with Virginia Commonwealth University to reduce child abuse and neglect and to the Virginia Chapter of American Academy of Pediatrics. In addition, VDH IVPP will support work to increase utilization of resources/linkages of care for available public health services/available statewide benefits for families that promote healthy outcomes and reduction of injuries and violence in partnership with Families Forward. This work will come in the form of a toolkit and technical assistance for families and businesses, and will continue to promote UniteUs and Bridges2Resources.

This work supports geographical disparities statewide. Work will support families with an infant diagnosed with Neonatal Abstinence Syndrome, equipping women at risk for, or with a history of, substance misuse, abuse, and addiction during childbearing age; all with the goal for prevention of newborn and infant injury. Family voices will be actualized with the evaluation of materials. This strategy is fully implemented and is anticipated to be expanded to reach more families in FY22.

Activity	Expected Completion Date	Responsible Staff
Disseminate the injury prevention curriculum to all maternity hospitals, inclusive of materials for Baby TV channels	10/2021-9/2022	IVP Supervisor; Non-MCH Funded Position; Contractor company; VHHA
Provide maternity hospitals with continued technical assistance in implementing the injury prevention curriculum	10/2021-9/2022	IVP Supervisor; Non-MCH Funded Position
Disseminate the injury prevention curriculum to all local/regional libraries with child services programs	10/2021-9/2022	IVP Supervisor; Non-MCH Funded Position; LOVA
Disseminate the injury prevention curriculum to all local prevention partners, inclusive of local health departments, and WIC offices	10/2021-9/2022	IVP Supervisor; Non-MCH Funded Position; VDH CHS
Disseminate the injury prevention TBI toolkit curriculum to all applicable public schools.	10/2021-9/2022	IVP Supervisor; Non-MCH Funded Position; GMU
Disseminate general injury prevention communication campaigns to the public through web, social media, and broadcast methods	10/2021-9/2022	IVP Supervisor; Non-MCH Funded Position; Contractor company
Disseminate the injury prevention curriculum to health systems through the Virginia Commonwealth University and Virginia Chapter of American Academy of Pediatrics to its healthcare providers and members. Curriculum content will also include training in messaging the science of resilience post Adverse Childhood Experiences, Zero Suicide, Safe Environment for Every Kid in the prevention of child abuse and neglect, and linkages to resources in the prevention of injuries and violence	10/2021-9/2022	IVP Supervisor; Non-MCH Funded Position; Contractor company; Virginia Commonwealth University, Virginia Chapter AAP, Families Forward

IDENTIFIED STATE PRIORITY	Strong system of care for all children
FY22 STRATEGY	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

The goal of the Title V funding for DSI is to reach out to underserved communities, focusing on the screening, diagnosis, management, treatment, referral, and resources required to address developmental and mental health concerns in pediatrics. Training and developmental services prepare providers and extend access to Virginia counties who are severely underserved. VECF supports the work of six Smart Beginnings partners funded by VDH Title V to lead local ASQ screening and referral systems coordination. These local hubs build community capacity to 1) improve coordination of developmental screening services and supports across systems; 2) increase the number of developmental screens administered, followed by appropriate referrals; 3) engage families and providers through appropriate outreach and messaging.

A strategic analysis of the Smart Beginnings – Title V Developmental Screening Initiative is planned for September –

December, 2021 by the National Center for Children in Poverty (NCCP). Overall goal: Under this scope of work, NCCP will examine how the Developmental Screening Initiative (DSI) is being implemented in six Virginia communities. The analysis will focus on the strengths, weaknesses, and opportunities of DSI implementation strategies with a priority placed on racial and economic equity, explore the role the DSI plays related to other systems in the state, and examine its potential to deliver unique or "value-added" benefits in terms of screening and referral activities for young children, families, and communities. Information about these topics will be gathered through key informant individual and group interviews and review of available reports. NCCP will use this information to develop a strategic analysis report with recommendations for most effectively adapting and/or positioning the DSI model in currently engaged communities and to inform a possible statewide regional approach.

IDENTIFIED STATE PRIORITY	Oral Health
NOTE: Dental Health Programmatic work cross-cuts three MCH Domains: Women and Maternal Health, Child Health, and Adolescent Health. Shared strategies address needs across the lifespan.	
FY22 STRATEGIES:	1. 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 2. 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 3. Convene statewide groups focused on targeted oral health issues and facilitate collaboration and work plan development, and provide leadership and oversight to guide initiatives

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

New programming specifically aimed at advancing the oral health of adolescents began in FY20. Activities included updating the School-aged Oral Health Curriculum to include emerging topics for adolescents including vaping, and HPV exposure and vaccination and developing trainings and educational material related to these new topics of focus to highlight the importance of vape cessation and HPV prevention to combat oral cancer, as well as early detection of this disease in youth and young adults. Staff will continue this work and identify new partnerships to expand the reach of programming 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. Staff will also continue to provide pertinent MCH related information to partners as a member of the Early Dental Home Workgroup and Project Immunize Virginia. The Early Dental Home Workgroup consists of partners from dentistry, early childhood education, and perinatal and pediatric health, as well as state agencies that offer social and health support services. The workgroup identifies promising practices and techniques to increase the number of

young kids and pregnant women who access dental care. Project Immunize Virginia (PIV) is a team of energetic and innovative health professionals, business, and community members that believe every community in the Commonwealth can be free of vaccine-preventable disease by increasing immunizations across the lifespan. PIV achieves this by promoting partnerships and using effective strategies among its member organizations throughout the Commonwealth.

Strategy: Sustain network of 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.

VDH will continue to partner with the VHC to foster regional efforts and initiatives throughout the Commonwealth. Catalyst will work with the alliances to support development and implementation of regionally-identified projects, including projects from partners in far Southwest Virginia, through a micro-grant program; leverage Catalyst's Clinical Advisory Board (CAB) and expert consultants to provide clinical guidance and education to the micro grantees;
assist micro grantees with developing an evaluation component for their projects; share regionally-specific data; enable information-sharing among state and local partners and regional alliance members to inform the plans and implementation of local and statewide activities; ensure alignment between regional and statewide initiatives, as applicable; and develop and disseminate communications to spur replication of promising practices, share data and
surveillance information, and elevate issues related to oral health access and integration.

Strategy: Convene statewide groups focused on targeted oral health issues and facilitate collaboration and work plan development, and provide leadership and oversight to guide initiatives

VDH will continue to partner with VHC to convene statewide groups to advance health equity, care coordination, and systems-change approaches that increase access to integrated, comprehensive care that includes oral health care for children under 17, pregnant women and their families.

VHC will convene a statewide workgroup focused on the future of oral health care delivery in Virginia following the COVID-19 pandemic and considering other environmental changes, trends in healthcare, and policy forecasts. The VHC will continue to engage a wide variety of partners to assemble participants including the Department of Medical Assistance Services, an MCO, maternal health providers, dental providers, and other community partners, while also leveraging the Catalyst's Clinical Advisory Board (CAB) to provide expertise on the statewide future-focused workgroup. The VHC will also engage other clinical expertise, as needed, to offer additional technical assistance and guidance to the workgroup. HRSA Oral Health Workforce Grant funds will be leveraged to continue to implement a pilot program aimed at putting the workgroups ideas into action through a contract with a safety-net site to carry out future-focused projects including developing teledentistry capabilities to improve access to care.

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

VHC will also continue convening the Early Dental Home (EDH) workgroup and collaborate with existing groups working on HPV to ensure oral health is integrated into their approach and goals. Additionally, the VHC will expand community engagement and provide trauma-informed care, oral health and systemic health, and health equity education to providers at the Virginia Oral Health Summit. Annually, the Summit reaches nearly 250 providers, public health stakeholders and

caregivers, who attend to learn skills to improve the health and wellbeing of the individuals they serve. At this year's Summit, Catalyst seeks to highlight the role of health equity and oral health in the COVID-19 pandemic, teledentistry (and telehealth more broadly), health policy at the state and federal level, and innovative community programs, so that attendees can work collectively to increase equitable access to quality health care, with a focus on oral health.

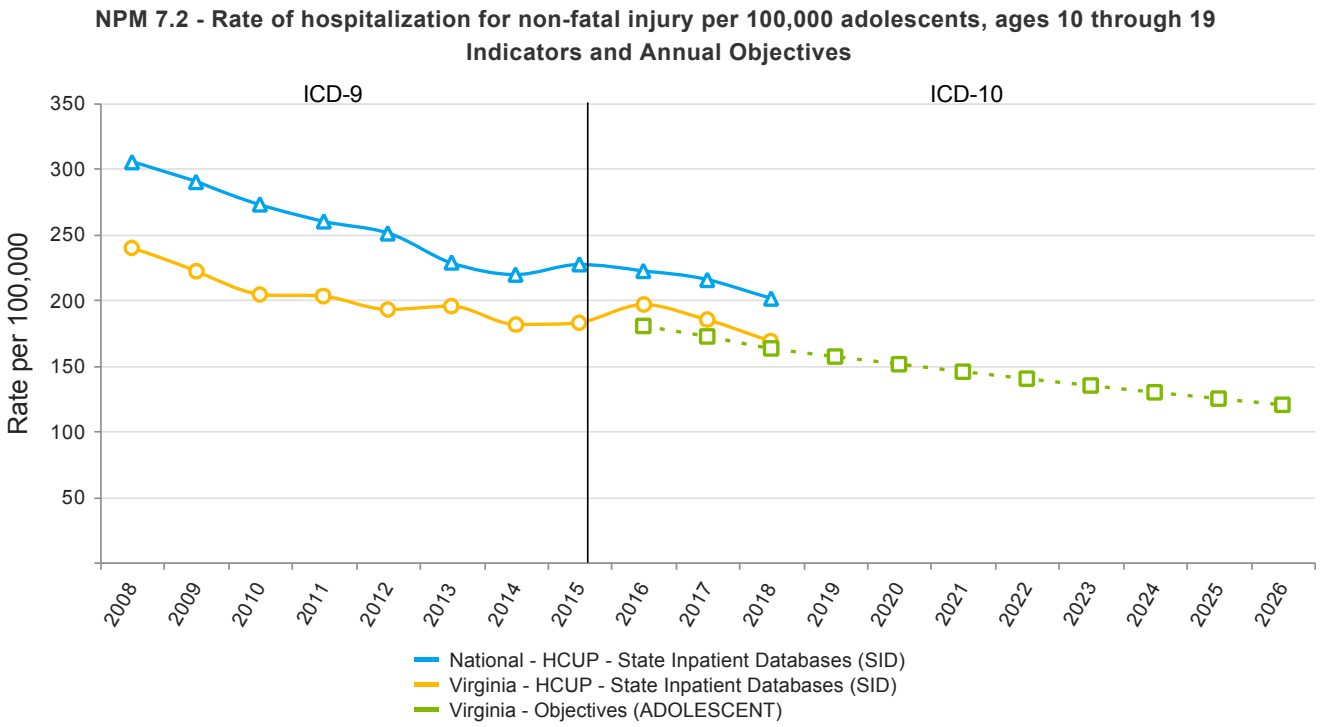
VHC will, for the second time, partner with a consulting team and Virginia Center for Inclusive Communities to provide twelve free racial equity trainings to partners across Virginia. These trainings will be virtual to allow partners from across Virginia to participate. The trainings will be offered in three bundles, and each bundle will be offered twice (six total bundles offered).

Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2018_2019	7.3 %	NPM 13.2
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	NVSS-2019	15.1	NPM 7.2
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2019	29.0	NPM 7.2
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2017_2019	9.3	NPM 7.2
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2017_2019	11.9	NPM 7.2
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	15.0 %	NPM 12 NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	90.3 %	NPM 13.2

National Performance Measures



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

Federally Available Data					
Data Source: HCUP - State Inpatient Databases (SID)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	180	172	162.9	156.8	151
Annual Indicator	172.4	182.6	196.3	184.5	168.1
Numerator	1,826	1,451	2,087	1,964	1,800
Denominator	1,059,470	794,656	1,062,972	1,064,407	1,070,646
Data Source	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	145.3	139.9	134.7	129.6	124.8	120.1

Evidence-Based or –Informed Strategy Measures

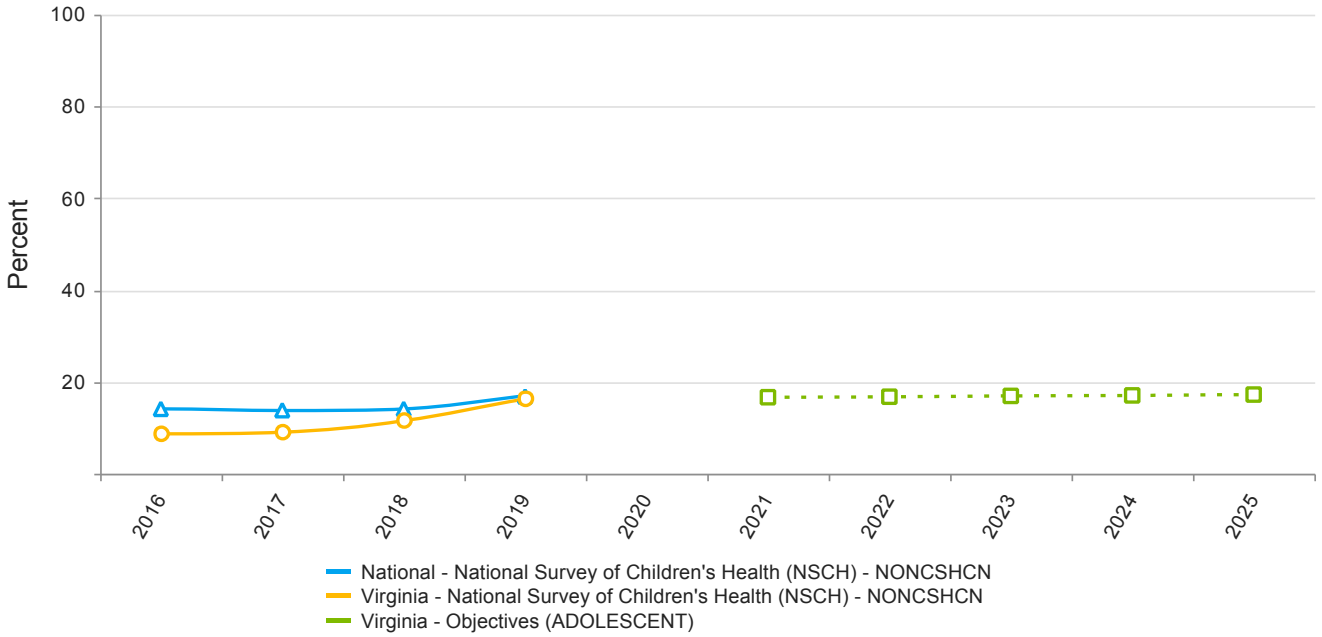
ESM 7.2.1 - Number of gatekeepers trained in the prevention of suicide among youth

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			10	20
Annual Indicator		102	195	237
Numerator				
Denominator				
Data Source		VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program
Data Source Year		2018	2019	2020
Provisional or Final ?		Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	250.0	300.0	350.0	400.0	450.0	500.0

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
Indicators and Annual Objectives



NPM 12 - Adolescent Health - NONCSHCN

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - NONCSHCN		
	2019	**2020**
Annual Objective		
Annual Indicator	11.6	16.5
Numerator	56,684	71,210
Denominator	489,697	431,868
Data Source	NSCH-NONCSHCN	NSCH-NONCSHCN
Data Source Year	2017_2018	2018_2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	16.7	16.8	17.0	17.1	17.3	17.5

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		25	100	250	400
Annual Indicator	0	0	0	0	45
Numerator					
Denominator					
Data Source	Division of Child and Family Health	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Provisional	Final	Final

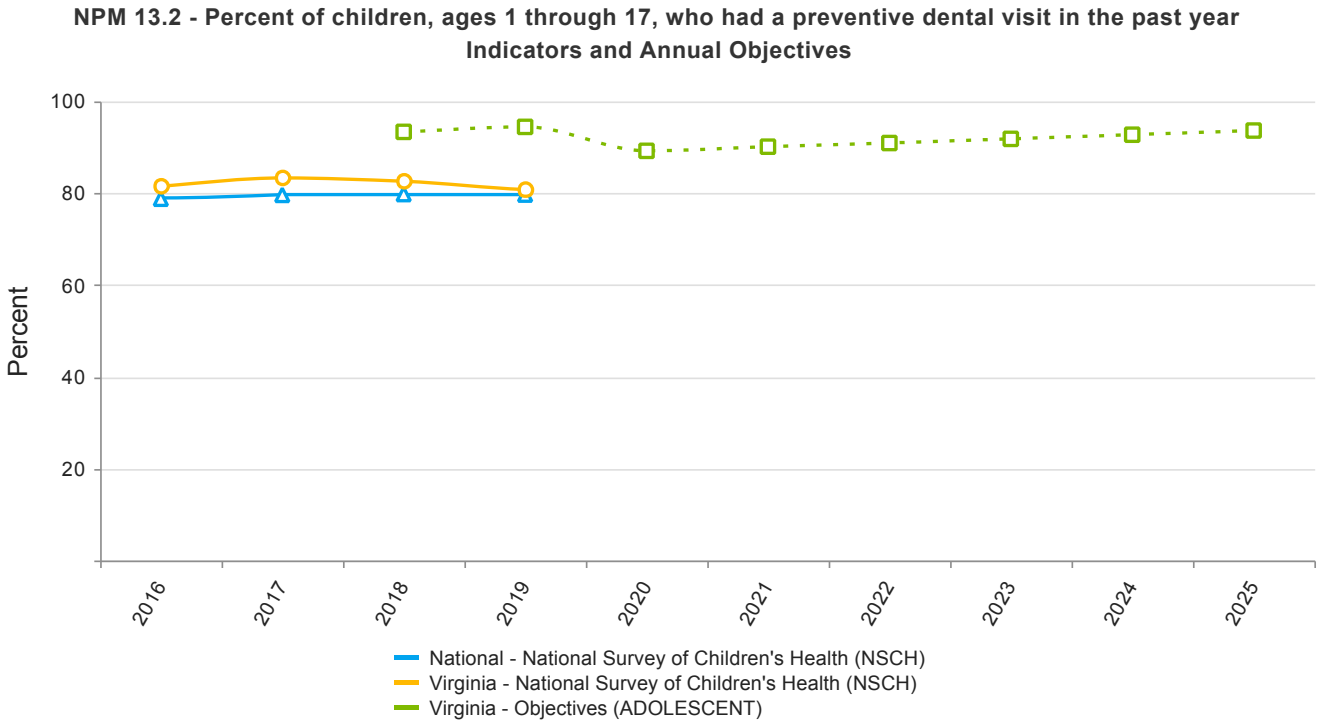
Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	40.0	45.0	50.0	55.0	60.0	65.0

ESM 12.2 - Percentage of Virginia school divisions reporting into the VDOE school health data system

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		68.2
Numerator		90
Denominator		132
Data Source		VDH and VDOE School Health Nurse Documentation
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	75.0	77.0	79.0	81.0	83.0	85.0



NPM 13.2 - Adolescent Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			93.2	94.3	89.1
Annual Indicator		81.4	83.1	82.4	80.5
Numerator		1,407,907	1,448,110	1,463,318	1,432,504
Denominator		1,729,004	1,741,839	1,775,616	1,778,464
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			93.2	94.3	89.1
Annual Indicator	90.9	90.9	90.5	88.2	86.6
Numerator					
Denominator					
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016	2016_2017	2017_2018	2018_2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	90.0	90.8	91.7	92.6	93.5	94.4

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			6	6
Annual Indicator		3	4	8
Numerator				
Denominator				
Data Source		VDH Oral Health Program documentation	VDH Oral Health Program documentation	VDH Oral Health Program documentation
Data Source Year		2018	2019	2020
Provisional or Final ?		Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	6.0	6.0	6.0	7.0	7.0	8.0

State Performance Measures

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	25.3	27.1
Numerator		
Denominator		
Data Source	VA PRAMS	VA PRAMS
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	23.8	23.3	22.8	22.3	21.8	21.3

State Action Plan Table

State Action Plan Table (Virginia) - Adolescent Health - Entry 1	
Priority Need	
Mental Health: Promote mental health across MCH populations, to include reducing suicide and substance use.	
NPM	
NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19	
Objectives	
By June 30, 2025, decrease the rate of hospitalization for non-fatal injury per 100,000 children ages 10 to 19 from 182.6 (HCUP - State Inpatient Databases (SID) 2015) to 124.79.	
Strategies	
Empower communities to address mental health issues that impact young people.	
Provide suicide prevention trainings to professionals interacting with youth and adolescents.	
Expand Suicide Prevention Interagency Group membership.	
ESMs	**Status**
ESM 7.2.1 - Number of gatekeepers trained in the prevention of suicide among youth	Active
NOMs	
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	

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

Priority Need

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

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Objectives

By June 30, 2025, increase the proportion of adolescents, ages 12 through 17, in Virginia who are engaged in transition services to adult health care from 11.6% (NSCH 2017-2018) to 14.2%.

Strategies

Maintain data capacity for school health immunization data.

Expand and empower school nurse workforce.

ESMs	Status
ESM 12.1 - Number of providers in Virginia who have completed the transition training module.	Active
ESM 12.2 - Percentage of Virginia school divisions reporting into the VDOE school health data system	Active

NOMs

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

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

Priority Need

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

NPM

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

Objectives

By June 30, 2025, increase the percent of children (ages 12 through 17) who had a preventive dental visit in the past year from 88.2% (NSCH 2017-2018) to 93.5%

Strategies

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

Sustain network of 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

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

NOMs

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

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

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

State Action Plan Table (Virginia) - Adolescent Health - Entry 4

Priority Need

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

SPM

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

Objectives

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

Strategies

Fund and Support evidence-based comprehensive sexual education in areas of the state with disproportionately high rates of teen pregnancy and low access to sexual health information.

ADOLESCENT HEALTH DOMAIN
SUMMARY/OVERVIEW
FY20 ANNUAL REPORT

2016- 2020 MCH Priority Needs Addressed in this Domain
Women's/Maternal Health: Support the physical and emotional well-being of women and their children
Child/Adolescent Injury: Reduce injuries, violence, and suicide among Title V populations
Oral Health: Increase access to oral health services for pregnant women and children

NOTE: The FY20 Annual Report represents the final year of priorities, strategies, and activities aligned with the 2016-2020 needs assessment and state action plan for the Adolescent Health Domain

DOMAIN CONTRIBUTORS:
Adolescent Health Program – Division of Child and Family Health Reproductive Unit
Injury & Violence Prevention Program – Division of Prevention and Health Promotion
School Health - Division of Child and Family Health

DOMAIN OVERVIEW

The focus and activity around the Virginia Title V adolescent population demonstrate strength and intention, recognizing the pivotal role that adolescence plays in the life course perspective approach. Adolescence has strong connections to the two life stages on either side. Clearly, protective and risk behaviors that develop during this influential period of life contributes to measurable consequences in adulthood. Virginia's Title V recognized the importance of allowing the youth population to have a voice in guiding the work in a number of topics related to this Domain, offering unique input into programmatic planning and implementation.

Key work in this Domain includes:

COMPREHENSIVE SEXUAL EDUCATION PROGRAM: VDH's Adolescent Health Program funds three grantees who implement *Get Real: Comprehensive Sexual Education that Works,* a LGBTQ+ inclusive, trauma-informed comprehensive sexuality education curriculum for middle and high school students. The grantees are located in Central Virginia, Hampton Roads and southwest Virginia. The *Get Real* program is funded exclusively through Title V.

YOUTH ADVISORS: VDH's Adolescent Health Program recently hired two Youth Advisors, young people who provide input and leadership on VDH initiatives that impact young people. These two part-time VDH employees provide input on existing VDH initiatives that impact young people and are in the process of developing a larger youth advisory structure.

POSITIVE YOUTH DEVELOPMENT: VDH's Adolescent Health Program funds positive youth development programs throughout the Commonwealth. The Reproductive Health Unit uses Title V State SRAE funds to support two evidence-based positive youth development programs: Teen Outreach Program (TOP) and Project AIM. Five sites throughout the state – four in southwest Virginia and one on the coast – receive these funds and use them to serve youth.

RESOURCE MOTHERS: Resource Mothers is an adolescent health program for pregnant and parenting teens. Resource Mothers uses two evidence based programs: Growing Great Kids and AIM4TM (AIM for Teen Moms). Funded through

federal TANF funds allocated by the Virginia General Assembly, Resource Mothers is offered at six local implementation sites, including four local health districts, one hospital system, and one community-based organization. Title V funds support curriculum-specific training sessions for Resource Mothers staff.

YOUTH SUICIDE PREVENTION: VDH Injury and Violence Prevention Program (IVPP) focuses on efforts to address youth suicide through training youth-serving professionals and organizations to comprehensively screen for suicide risk and refer affected youth to immediate care. IVPP coordinates gatekeeper trainings in partnership with James Madison University. IVPP also facilitates the Prevention Interagency Advisory Group (SPIAG) and is currently drafting the *Commonwealth of Virginia Suicide Across the Lifespan Prevention Plan*.

SCHOOL HEALTH: The VDH School Health Nurse Consultant partners and collaborates closely with the Virginia Department of Education (DOE) School Nurse Consultant to serve elementary to high school aged children enrolled in public, private and parochial schools in the Commonwealth. The program aims to provide technical assistance and professional development training opportunities to school systems, particularly to school-based medical professionals and families, and also to develop and update certain guidelines relevant to mandated services noted in the Code of Virginia.

STATE ACTION PLAN UPDATES

IDENTIFIED STATE PRIORITY	Women's/Maternal Health: Support the physical and emotional well being of women and their children			
STRATEGIES	1. Fund and support evidence-based comprehensive sexual education in areas of the state with disproportionately high rates of teen pregnancy and low access to sexual health information 2. Increase capacity of youth serving agencies to implement AIM 4 Teen Moms (AIM4TM), an evidence-based pregnancy prevention program designed for parenting teens 3. Work with community stakeholders to remove policy, financial, and training barriers to LARC utilization			
OBJECTIVE	By June 30, 2020, reduce the rate of unintended pregnancies for all women of child-bearing age (age 15-44) from 49.5 (PRAMS 2016) to 47%			
PERFORMANCE MEASURE	(2016-2020) SPM 4 - Unintended Pregnancy: Proportion of females ages 15-44 using Tier 1 (most effective) contraceptive methods			
2016-2020 SUMMARY				
Data Source: Virginia PRAMS				
2016	**2017**	**2018**	**2019**	**2020**
	35.5%	31.0%	65.1%	70.1%
GOAL FOR 2021-2025	Reduce the rate of mistimed pregnancies from 25.3% (PRAMS 2018) to 21.8% by 2025.			

The Reproductive Health Unit funds teen pregnancy prevention programs that are implemented in schools. In many schools, these programs are used to meet the state's optional Family Life Education standards. The Adolescent Health Coordinator keeps the Virginia Department of Education (VDOE) apprised on where programs are being implemented and what curricula grantees are using. VDOE, who is responsible for revising the standards on a regular basis, enlists the help of VDH to provide the public health perspective during this revision process

The Adolescent Health Coordinator has worked with James Madison University's Appalachian Replication Project (ARP), which is part of JMU's SexEdVA Initiative. This is funded by the Teen Pregnancy Prevention Program in the Office of Population Affairs. The aim of ARP is to increase access to evidence-based teen pregnancy prevention programs in

Southwest Virginia. The Adolescent Health Coordinator has connected JMU's ARP program with a number of local health departments and schools in th region that have expressed an interest in expanding access to comprehensive sex ed in their communities. In turn, JMU's ARP program has been able to provide funding and programs in communities in need of comprehensive sex education, which advances the goals of VDH's Adolescent Health Program.

IDENTIFIED STATE PRIORITY	Child/Adolescent Injury: Reduce injuries, violence, and suicide among Title V populations.			
STRATEGY	Provide suicide prevention trainings to professionals interacting with youth and adolescents			
OBJECTIVE	By June 30, 2020, decrease the rate of hospitalization for non-fatal injury per 100,000 children ages 10 to 19 from 172.4 to 171.1 (SID-Adolescent)			
PERFORMANCE MEASURE	NPM 7.2: Rate of hospitalization for nonfatal injury per 100,000 adolescents, ages 10 through 19			
EB/I STRATEGY MEASURE	ESM 7.2.1: Number of gatekeepers trained in the prevention of suicide among youth			
OUTCOME MEASURE	NOM 15: Adolescent mortality rate ages 10 through 19, per 100,000 NOM 16.1: Adolescent mortality rate ages 10 through 10, 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			
2016-2020 SUMMARY				
Data Source: HCUP - State Inpatient Databases (SID)-Adolescent				
2016	**2017**	**2018**	**2019**	**2020**
172.4	182.6	196.3	184.5	168.1
GOAL FOR 2021-2025 SAP:	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.			

By leveraging Maternal and Child Health funds with Substance Abuse and Mental Health Services Administration (SAMHSA) Youth Suicide Prevention Program funds, IVPP Youth Suicide Prevention Program partnered with James Madison University and the American Association of Suicidology to meet its annual objective.

MCH Grant Year October 2019 through September 2020				
MHFA – Mental Health First Aid ASIST – Applied Suicide Intervention Skills Training RRSR – Recognizing & Responding to Suicide Risk SafeTalk – Suicide Prevention Course				
2019/2020 dates	**Training**	**Location**	**# Participants**	**Host Institution**
Oct. 8	MHFA	Petersburg	24	Virginia State U.
Oct. 28-29	ASIST	Lynchburg	27	Lynchburg University and Central VA Community College
Nov. 4-5	ASIST	Harrisonburg	29	James Madison University
Dec. 5-6	ASIST	Radford	25	Radford Univ.
Jan. 6-7, 2020	ASIST	Fredericksburg	27	Univ. of Mary Washington
Jan. 9-10	ASIST	Winchester	29	Shenandoah Univ.
Feb. 13-14	ASIST	Harrisonburg	28	EMU/JMU
March 9-10	ASIST	Middletown	24	Lord Fairfax CC
Mar. 27	MHFA	Petersburg	CANCELLED	Virginia State U.
Apil 1-2	ASIST	Lynchburg	CANCELLED	Liberty University
April 9-10	ASIST	Charlottesville	CANCELLED	UVA
May 14-15	RRSR	Chester	CANCELLED	Promoted to campus and community clinicians
May 19-20	RRSR	Fairfax	CANCELLED	Promoted to campus and community clinicians
June 4-5	RRSR	Roanoke	CANCELLED	Promoted to campus and community clinicians
10-Aug	safeTALK	Bluefield	10	Bluefield College
Aug. 10	safeTALK	Bluefield	14	Bluefield College
		TOTAL	**237**	

During the project period, the Campus Suicide Prevention Center of Virginia trained 237 gatekeepers. A detailed breakdown is included in the table below. In addition to the table, the Center purchased 300 CAMS licenses for distribution. As of September 2020, 264 licenses had been purchased by providers with 150 having started the modules. As CAMS is an online, self-paced training, specific location completion date cannot be provided.

IDENTIFIED STATE PRIORITY	Oral Health: Increase access to oral health services for pregnant women and children			
STRATEGY	1. Integrate targeted adolescent oral health messaging into existing MCH-focused dental education programs to improve oral health for individuals across the lifespan 2. 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 3. Convene statewide groups focused on targeted oral health issues and facilitate collaboration and work plan development, and provide leadership and oversight to guide initiatives			
OBJECTIVE	By June 30, 2020, increase the percent of children (ages 12 through 17) who had a preventive dental visit in the past year from 90.9% (NSCH) – NONCSHCN 2016) to 95.5%			
PERFORMANCE MEASURE	NPM 13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year			
EB/I STRATEGY MEASURE	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)			
OUTCOME MEASURE	NOM 14: Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year NOM 19: Percent of children, ages 0 through 17, in excellent or very good health NOM 17.2: Percent of children with special healthcare needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system			
2016-2020 SUMMARY				
Data Source: National Survey of Children's Health (NSCH) -Adolescent				
2016	**2017**	**2018**	**2019**	**2020**
	90.9%	90.5%	88.2%	86.6%
GOAL FOR 2021-2025 SAP:	By June 30, 2025, increase the percent of adolescents (ages 12 through 17) who had a preventive dental visit in the past year from 88.2% (NSCH 2017-2018) to 93.5%.			

PLEASE REFER TO ORAL HEALTH REPORTS IN WOMEN/MATERNAL HEALTH AND CHILD HEALTH FOR CROSS-DOMAIN ACTIVITIES THAT IMPACT ADOLESCENT HEALTH DOMAIN.

ADDITIONAL DOMAIN-RELATED ACTIVITIES

VDH SCHOOL HEALTH PROGRAM:

The Mission of the Virginia Department of Health is to protect the health and promote the well-being of all people in Virginia. Immunization rates have fallen dramatically since the pandemic and VDH school health program will continue to focus on increasing immunization rates for our school age population. The current data suggest only 88.1% of public school students are adequately immunized.

On March 13, 2020 schools closed in Virginia due to COVID-19 and it was clear from the beginning of the pandemic, our unserved school population would be greatly impacted by school buildings being closed. School nurses across the Commonwealth, with support from the Virginia Department of Health (VDH) and the Virginia Department of Education (VDOE), identified students and developed plans to implement programs to address the social determinants of health (food insecurity, virtual learning disadvantages, mental health, abuse, and homelessness). Many school nurses assumed

responsibilities outside of their usual job duties and found innovative solutions to difficult situations by expanding existing partnerships with local health departments. School nurses provided access to care by staffing local health departments as contact tracers, COVID testers and many joined the Medical Reserve Corps (MRC). Professional development opportunities were made available to all Virginia school nurses and contact hours were awarded to those who completed the MRC vaccinator training and approved contact tracing courses. The Virginia Department of Health (VDH) partnered with the Virginia Department of Education (VDOE) and the Virginia Association of School Nurses (VASN) to provide educational opportunities, training, best practices and guidance necessary for school nurses/school health staff to meet the medical and social emotional needs of their students and school staff.

Due to the pandemic, well child visits to healthcare providers and local health departments decreased. Vaccination rates decreased across all ages during the COVID-19 pandemic. Initially, the CDC recommended prioritizing vaccines for children under 24 months of age. As a result, vaccines typically given to children older than 24 months and adults saw the steepest decline. Vaccines entered in the Virginia Immunization Information System (VIIS) in May 2020 were 23% lower compared to previous years. In June, Virginia saw community pediatricians increased their outreach efforts to parents. The Virginia Department of Health (VDH) developed guidance for school based drive thru immunization clinics. School nurses were encouraged to partner with local health departments and community organizations. A collaboration between the Medical Reserve Corps (MRC) and VDH school health streamlined the training requirements for school nurses. School nurses around the Commonwealth joined the MRC to become volunteer vaccinators. As volunteer vaccinators, school nurses were able to provide school required immunizations to their students. Once the COVID vaccine became available, school nurses joined the volunteer vaccinator program and vaccinated their community. The partnership between the MRC and school nurses expanded to include assisting schools with COVID mitigation measures and health screenings. The MRC's Infection Prevention Ambassador Program was tasked with stopping the spread of COVID in the school setting and previously trained MRC volunteers assisted school nurses with hearing and vision screenings and referrals.

In the beginning of the 2020 summer, families were encouraged to make well child visit appointments with their pediatrician, healthcare provider or local health department to avoid the "back to school rush". Many children had not received medical care since the pandemic and were not up to date on school required immunizations. This trend was particularly alarming because unmet health needs create barriers to learning and academic success. The VDH, with input from the VDOE and community stakeholders, redesigned the 2014 School Entrance Health Form (MCH 213G) to include the updated ACIP immunization requirements and for the first time, the form was made available in Spanish. In partnership with the Virginia Department of Education, the newly revised School Entrance Health Form was provided to local school divisions. In addition, a Superintendent's memo addressing the importance of maintaining health requirements for school enrollment was sent to all school administrators in Virginia. This was particularly important because routine childhood immunizations and well care visits had dropped significantly during the pandemic.

The 2020 Virginia General Assembly passed HB1090. This legislation amended the minimum vaccination requirements for attendance at a public or private elementary, middle or secondary school to include Rotavirus, Hepatitis A, HPV for both male and females, and MenACWY for 7th and 12th grade students. VDH continued to encourage school nurses to bridge the gap and increase access to adolescent vaccines by hosting school based immunization clinics with the focus being the 7th grade adolescent vaccinations of HPV, Tdap, and MenACWY. Local school divisions were encouraged to partner with their local health departments to provide immunization clinics to their school community. VDH school health developed a helpful hints for school based immunization clinics resource document/brochure explaining immunization clinic needs, training requirements, staffing requirements, consents, and communication materials for families. The drive thru immunization clinics have been well received by families and many school divisions have established year around school based vaccination clinics throughout the 2020-2021 school year.

The VDH school health program and the VDH Immunization Division will continue to provide support, guidance, training and resources to school nurses, local school divisions and local health departments to increase adolescent vaccination rates in Virginia. Many school divisions have established school based vaccination clinics throughout the entire 2020-2021 school year and have offered families the ability to receive the COVID vaccine along with routine childhood vaccines during regular school hours in the school setting. Together, VDH and the American Academy of Pediatrics (AAP) presented immunization

updates (HB1090) and guidance for drive thru immunization clinics to school nurses during the Children's Hospital of Richmond (CHOR) Fall Conference (11/3/20) for School Nurses. VDH school health will continue to strengthen their partnership with the American Academy of Pediatrics (AAP) and Immunize VA Coalition.

VDH School Health Nurse Consultant, VDOE School Health Specialist, Manassas Park City Schools, University of Virginia School of Nursing, George Mason University School of Nursing, and Mason and Partners Clinic applied for a P4 Challenge Grant from HRSA to increase immunization rates in Manassas Park City Public Schools. Our healthcare reform efforts were recognize and Manassas Park City Schools received a grant for $10,000. Round 2 of the challenge is underway, our plan consist of decreasing conditional enrollment and increasing vaccination rates in Manassas Park City Public Schools. Implementation of the plan with documentation and data collection using interdisciplinary teams will be the next phase of the P4 challenge.

Professional development opportunities are available to school nurses during the Summer Institute for School Nursing 2021. The 2021 conference is a collaboration between VDOE, VDH and the Virginia Association of School Nurses (VASN). This all virtual conference will focusing on community/public health, care coordination and leadership and is titled "Coming out of the Pandemic: Envisioning a new normal". Currently over 507 school nurse have registered for the 3 day conference. School nurse are able to earn Continuing Nursing Education Credits through VASN. VDH, VDOE and the Children's Hospital of Richmond (CHOR) collaborated, earlier in the year, to provide 2 mini conferences for school nurse. Several of the topics for the two half day conferences (11/2020 and 2/2021) focused on health promotion and outreach including immunizations, vaccine hesitancy, drive thru immunization clinics and the upcoming changes to school required immunizations effective July 1, 2021.

The knowledge, skills and expertise of school nurses has been recognized by the VDH. Fifteen school nurses were awarded a scholarship from the VDH to become nationally certified. VDH partnered with VDOE and VASN to offer a scholarship opportunity, including study materials and review course, during the Summer Institute for School Nursing 2021. The participants, who successfully complete the review course and receive a passing score for the National Board Certified School Nurse exam, will receive full reimbursement for the cost ($360) of the exam.

CONSUMER FAMILY ENGAGEMENT/PARTNERSHIP

INJURY PREVENTION: IVP Program provides an opportunity for family and consumer input into LISSDEP. Staff continue to work with the Division of Population Health to construct an exit survey to evaluate programmatic education and technical support efforts. In the upcoming FY, the VDH Injury and Violence Prevention Program will continue family and consumer input expansion through its Project Patience and Youth Suicide Prevention initiatives.
FROM INJURY PREVENTION: The Coronavirus Disease 2019 (COVID-19) pandemic has impacted individuals, families, and communities on a worldwide and statewide scale since the beginning of the amplified response. In Virginia, as of the end of May 2020, almost three months since the first COVID-19 case was reported in Virginia, there were 41,401 positive cases, 4,442 hospitalizations, and 1,338 deaths statewide (vdh.virginia.gov) To mitigate the spread of COVID-19 throughout the Commonwealth and the United States, state and federal policymakers announced 'stay at home' orders and social distancing guidelines, which led to school closures and more families working and spending greater amounts of time together at home. The pandemic not only can force individuals and families to alter their way of living and working, but outbreaks can also increase stress and anxiety, due to fear and worry of one's health or health of loved ones, difficulty sleeping or concentrating, worsening of chronic or mental health conditions, loss of a job or other economic support, responding to COVID-19 as a healthcare worker, essential worker, or first responder, social isolation and loneliness, or loss of loved ones (https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/managing-stress-anxiety.html). Recent studies have indicated that, during the COVID-19 pandemic and other major natural disasters, there is increased risk of family and interpersonal violence, including child abuse and neglect and intimate partner violence, greater risk of childhood injury, suicide, drug overdose, and other substance abuse and mental health issues (IVPP analysis FY19 report quote).

It is critical to link families with young children with resources as it relates to childhood injury and violence prevention.

Hospitals, prevention, and public health programs are reduced in their capacity to hold community level meetings with families to provide these resources and education. As such, the VDH IVP Program is working to enhance its community level interventions with virtual options for hospitals, transportation safety, and prevention programs to utilize when training community members in injury prevention. These methods come in the form of VDH IVP Program virtual instruction, technical assistance, hard copy toolkits, video and website landing pages, and evaluation options. In addition, VDH IVP continues to remain connected to national IVP stakeholders to understand emerging topics in injury and violence prevention during the pandemic response and beyond.

CHALLENGES/BARRIERS

(1). The residual effects of the COVID-19 pandemic continue to impact youth programming, particularly for sub-grantees that partner with schools. Although many schools will return to in-person instruction in the Fall of 2021, many schools and students are drastically behind in core subjects like math and reading, which makes them more reluctant to partner with outside agencies for youth programming. Title V sub-grantees will continue to find alternative ways to serve young people in the event that some schools are unable to partner with them in Fall 2021.
(2). The COVID-19 pandemic brought unprecedented challenges to the Resource Mothers program and the families served. In-home services completely stopped out of safety concerns, and staff were challenged to explore alternate modalities for meeting with you, including phone calls, video calls, and porch visits. In-person trainings were not offered during the pandemic and the GGK and AIM4TM distributors took time to shift all trainings to online formats. As a result, VDH only offered one virtual training to nineteen community health workers on the AIM4TM program model during the FY20 reporting period.

ADOLESCENT HEALTH DOMAIN SUMMARY/OVERVIEW FY22 APPLICATION YEAR

2021-2025 MCH Priority Needs Addressed in this Domain
Reproductive justice and support
Mental health
Strong systems of care for all children

IDENTIFIED NPMs/SPMs FOR STATE ACTION PLAN 2021-2025	
SPM 4 Pregnancy intention: Mistimed or unwanted pregnancy (wanted to become pregnant later or never)	The teen pregnancy rate in VA is 18.1 per 1,000 females ages 15-19 years (Virginia Vital Statistics System, 2019). Differences exist among race/ethnicity and regions within the state. Hispanic/Latinx and non-Hispanic Black teens had the highest teen pregnancy rates in 2019 at 33.0 and 25.0, respectfully. The Eastern (23.6), Southwest (22.6) and Central (19.9) regions had rates higher than the state rate. The public savings in 2015 due to declines in the teen birth rate totaled $72 million (Power to Decide, 2020).
NPM 7.2 Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19	The HCUP-SID showed the rate of hospitalization for non-fatal injury among adolescents was 168.1 per 100,000 in 2018. The annual indicator was 87.4 among age 10-14 years and 246.7 among age 15-19 years. Among students who reported that they seriously considered attempting suicide, 82.0% reported having felt sad, empty, hopeless, angry, or anxious; 40.8% attempted suicide; 24.9% were physically hurt by someone they were dating or going out with; 36.2% were bullied on school property; 29.2% were bullied electronically; and only 54.2% had an adult they can talk to (Virginia Youth Survey, 2017). The adolescent suicide rate was 11.9 per 100,000 adolescents ages 15-19 (NOM 16.3).
NPM 12 Transition (ages 12-17 years)	The NSCH (2018-2019) showed that only 16.5% of adolescents received services necessary to make transitions to adult health care. Health care transition focuses on building independent health care skills – including self-advocacy, preparing for the adult model of care, and transferring to new providers.
NPM 13.2 Preventive dental visit (ages 12-17 years)	The NSCH (2018-2019) showed that 86.6% of adolescents had a preventive dental visit.

During FY22, the following programmatic strategies and activities have been identified as methods to advance and improve outcomes.

IDENTIFIED STATE PRIORITY	Reproductive Justice and Support
STRATEGY	Fund and support evidence-based comprehensive sexual education in areas of the state with disproportionately high rates of teen pregnancy and low access to sexual health information.

In July 2020, VDH began funding the implementation of *Get Real: Comprehensive Sexual Education That Works*, an evidence-based comprehensive sexuality education curriculum for middle and high school students. Three grantees receive funds: Virginia League for Planned Parenthood (central Virginia and Newport News), Planned Parenthood of the South Atlantic (Charlottesville, Roanoke and New River Valley), and Eastern Virginia Medical School (Norfolk). Each of these grantees implement *Get Real* in communities where the teen pregnancy rate is higher than the state averag3e.

FY21 was the first full year of the grant, and grantees faced a myriad of challenges reaching youth due to the COVID-19 pandemic. In FY22, grantees will focus on continuing to serve young people through the avenues they used in FY21, adjusting and possibly expanding their services:

- Planned Parenthood of the South Atlantic (PPSAT), will aim to serve the same number of youth, but will adjust their partnerships in Roanoke due to partner organizational capacity.
- Virginia League for Planned Parenthood (VLPP) will expand programming to the Northern Neck of Virginia.
- Eastern Virginia Medical School will pursue a mixture of community and school-based programming to mitigate challenges in partnering with the local school system.

In aggregate, VDH's *Get Real* program expects to serve 970 young people in FY22.

IDENTIFIED STATE PRIORITY	Mental Health
STRATEGIES	• Provide suicide prevention trainings to professionals interacting with youth and adolescents • Expand Suicide Prevention Interagency Group Membership • Empower communities to address mental health issues that impact young people

Injury and Violence Prevention Program (IVPP) Staff will identify new partners to participate in the Suicide Prevention Interagency Group (SPIAG). SPIAG serves as the primary mechanism for connecting and disseminating best practice suicide prevention information and data.

IVPP Staff will partner with the Department of Education support ongoing suicide prevention efforts through the continued development of school guidance on suicide prevention including detailed planning of resources related to prevention, intervention, and postvention in schools. Additionally,

IVPP Staff have started work on the Virginia Suicide Prevention Plan across the Lifespan which has resulted in a number of partnerships and identified areas for additional group. These steps have positioned staff working on suicide prevention funded projects to achieve the activities outlined below for the upcoming grant cycle. IVPP will continue its work to ensure a comprehensive suicide prevention program statewide by increasing the number of gatekeepers serving disparate populations.

ACTIVITY	EXPECTED COMPLETION DATE	RESPONSIBLE STAFF
Coordinate Suicide Intervention Skills Trainings at campuses, schools and disparate population gatekeeper organizations statewide	October 2021 – September 2022	James Madison University; Suicide and Violence Prevention Coordinator, Non-MCH funded staff
Contract with American Association of Suicidology to coordinate 3 "Recognizing and Responding to Suicide Risk" Trainings	October 2021 – September 2022	2 non-MCH funded staff
Expand the roster of SPIAG enrollment to include MCH Title V Partners	October 2021 – September 2022	Suicide and Violence Prevention Coordinator, Non-MCH funded staff

IDENTIFIED STATE PRIORITY	Strong Systems of Care for All Children
STRATEGY	Maintain data capacity for school health immunization status Expand and empower school nurse workforce

VDH School Health Program will focus on implementing measures to promote a safe environment. Providing routine school required immunizations will remain a priority. VDH School Health will partner with stakeholders to find creative ways to bridge access to vaccines and decrease conditional enrollment, and will encourage school divisions to partner with local health departments and community partners to establish community based routine immunization vaccination clinics.

The School Health Program will continue to provide professional development opportunities for school nurses across the Commonwealth, partnering with UVA School of Nursing, Old Dominion University Virginia Department of Education to identify and develop appropriate professional learning opportunities.

IDENTIFIED STATE PRIORITY	Oral Health
NOTE: Dental Health Programmatic work cross-cuts three MCH Domains: Women and Maternal Health, Child Health, and Adolescent Health. Shared strategies address needs across the lifespan.	
FY22 STRATEGIES:	1. 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 2. 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 3. Convene statewide groups focused on targeted oral health issues and facilitate collaboration and work plan development, and provide leadership and oversight to guide initiatives

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

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

Strategy: Sustain network of 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.

VDH will continue to partner with the VHC to foster regional efforts and initiatives throughout the Commonwealth. Catalyst

will work with the alliances to support development and implementation of regionally-identified projects, including projects from partners in far Southwest Virginia, through a micro-grant program; leverage Catalyst's Clinical Advisory Board (CAB) and expert consultants to provide clinical guidance and education to the micro grantees;
assist micro grantees with developing an evaluation component for their projects; share regionally-specific data; enable information-sharing among state and local partners and regional alliance members to inform the plans and implementation of local and statewide activities; ensure alignment between regional and statewide initiatives, as applicable; and develop and disseminate communications to spur replication of promising practices, share data and
surveillance information, and elevate issues related to oral health access and integration.

Strategy: Convene statewide groups focused on targeted oral health issues and facilitate collaboration and work plan development, and provide leadership and oversight to guide initiatives

VDH will continue to partner with VHC to convene statewide groups to advance health equity, care coordination, and systems-change approaches that increase access to integrated, comprehensive care that includes oral health care for children under 17, pregnant women and their families.

VHC will convene a statewide workgroup focused on the future of oral health care delivery in Virginia following the COVID-19 pandemic and considering other environmental changes, trends in healthcare, and policy forecasts. The VHC will continue to engage a wide variety of partners to assemble participants including the Department of Medical Assistance Services, an MCO, maternal health providers, dental providers, and other community partners, while also leveraging the Catalyst's Clinical Advisory Board (CAB) to provide expertise on the statewide future-focused workgroup. The VHC will also engage other clinical expertise, as needed, to offer additional technical assistance and guidance to the workgroup. HRSA Oral Health Workforce Grant funds will be leveraged to continue to implement a pilot program aimed at putting the workgroups ideas into action through a contract with a safety-net site to carry out future-focused projects including developing teledentistry capabilities to improve access to care.

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

VHC will also continue convening the Early Dental Home (EDH) workgroup and collaborate with existing groups working on HPV to ensure oral health is integrated into their approach and goals. Additionally, the VHC will expand community engagement and provide trauma-informed care, oral health and systemic health, and health equity education to providers at the Virginia Oral Health Summit. Annually, the Summit reaches nearly 250 providers, public health stakeholders and caregivers, who attend to learn skills to improve the health and wellbeing of the individuals they serve. At this year's Summit, Catalyst seeks to highlight the role of health equity and oral health in the COVID-19 pandemic, teledentistry (and telehealth more broadly), health policy at the state and federal level, and innovative community programs, so that attendees can work collectively to increase equitable access to quality health care, with a focus on oral health.

VHC will, for the second time, partner with a consulting team and Virginia Center for Inclusive Communities to provide twelve free racial equity trainings to partners across Virginia. These trainings will be virtual to allow partners from across Virginia to participate. The trainings will be offered in three bundles, and each bundle will be offered twice (six total bundles offered).

Children with Special Health Care Needs

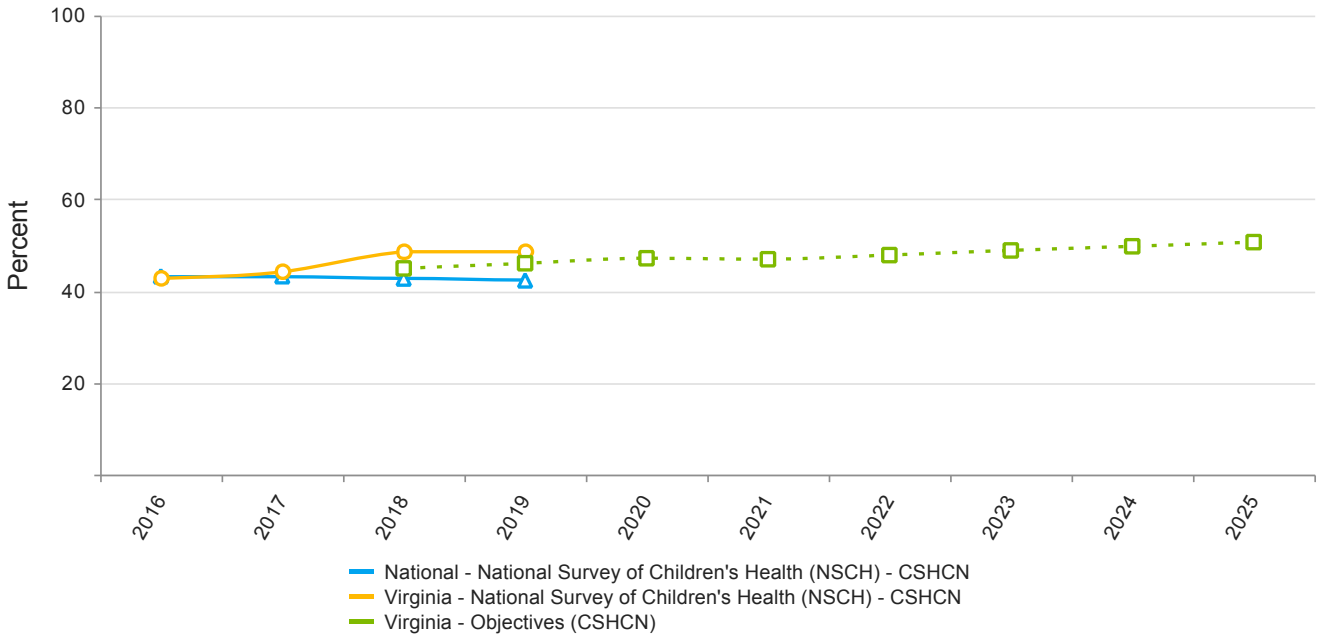
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	15.0 %	NPM 11 NPM 12 NPM 15
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	49.4 %	NPM 11 NPM 15
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	90.3 %	NPM 11 NPM 15
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	NIS-2016	76.1 %	NPM 15
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2019_2020	70.3 %	NPM 15
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2019	75.2 %	NPM 15
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2019	89.1 %	NPM 15
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2019	86.7 %	NPM 15
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	NSCH-2018_2019	1.7 %	NPM 11 NPM 15

National Performance Measures

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

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			44.9	46	47.1
Annual Indicator		42.7	44.2	48.4	48.6
Numerator		167,058	172,978	188,625	174,804
Denominator		391,428	391,467	389,683	360,019
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	46.9	47.8	48.8	49.7	50.6	51.5

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		25	100	250	400
Annual Indicator	0	0	0	0	37
Numerator					
Denominator					
Data Source	Division of Child and Family Health	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	40.0	45.0	50.0	55.0	60.0	65.0

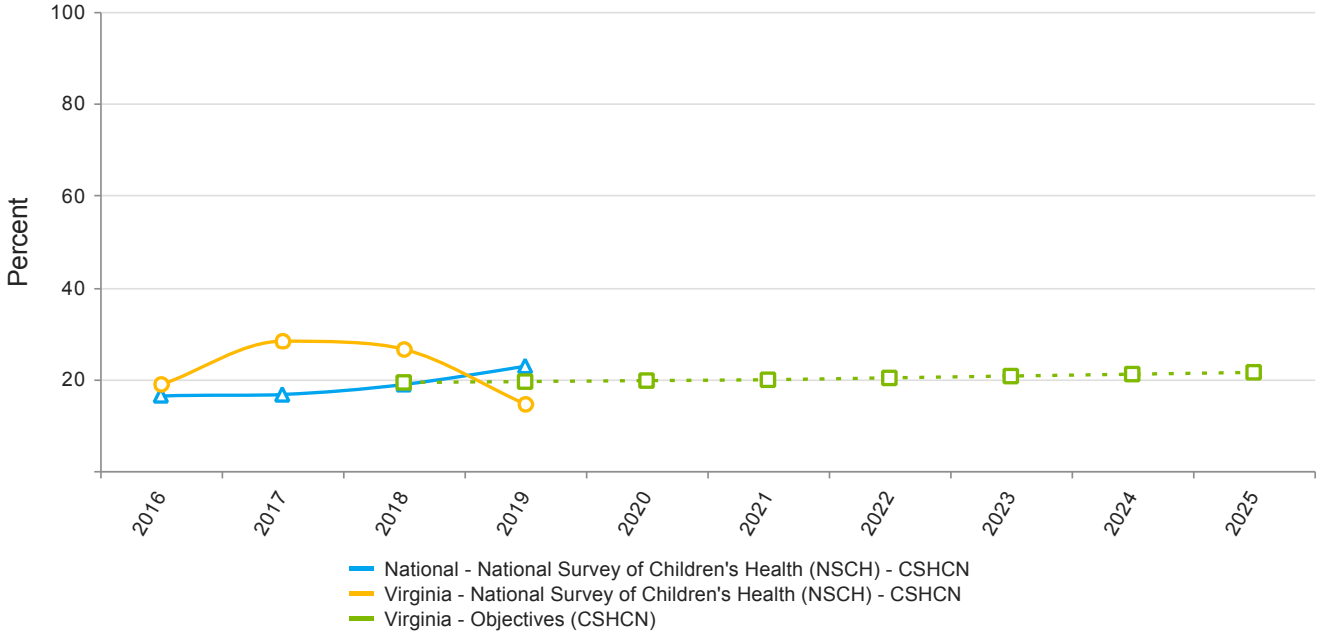
ESM 11.2 - Percentage of children served by the VA CYSHCN Program who report having a medical home

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		90	91.5	93	94.5
Annual Indicator	89.2	98.9	96.8	99	96
Numerator	4,061	4,391	4,239	4,788	5,490
Denominator	4,555	4,439	4,377	4,835	5,719
Data Source	Office of Family Health Services, VDH	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	96.0	97.5	98.0	99.5	99.5	99.5

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
Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			19.3	19.5	19.7
Annual Indicator		18.8	28.1	26.5	14.5
Numerator		31,194	48,657	47,355	22,590
Denominator		166,277	172,958	179,018	155,964
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	19.9	20.3	20.7	21.1	21.5	21.8

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		25	100	250	400
Annual Indicator	0	0	0	0	45
Numerator					
Denominator					
Data Source	Division of Child and Family Health	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Provisional	Final	Final

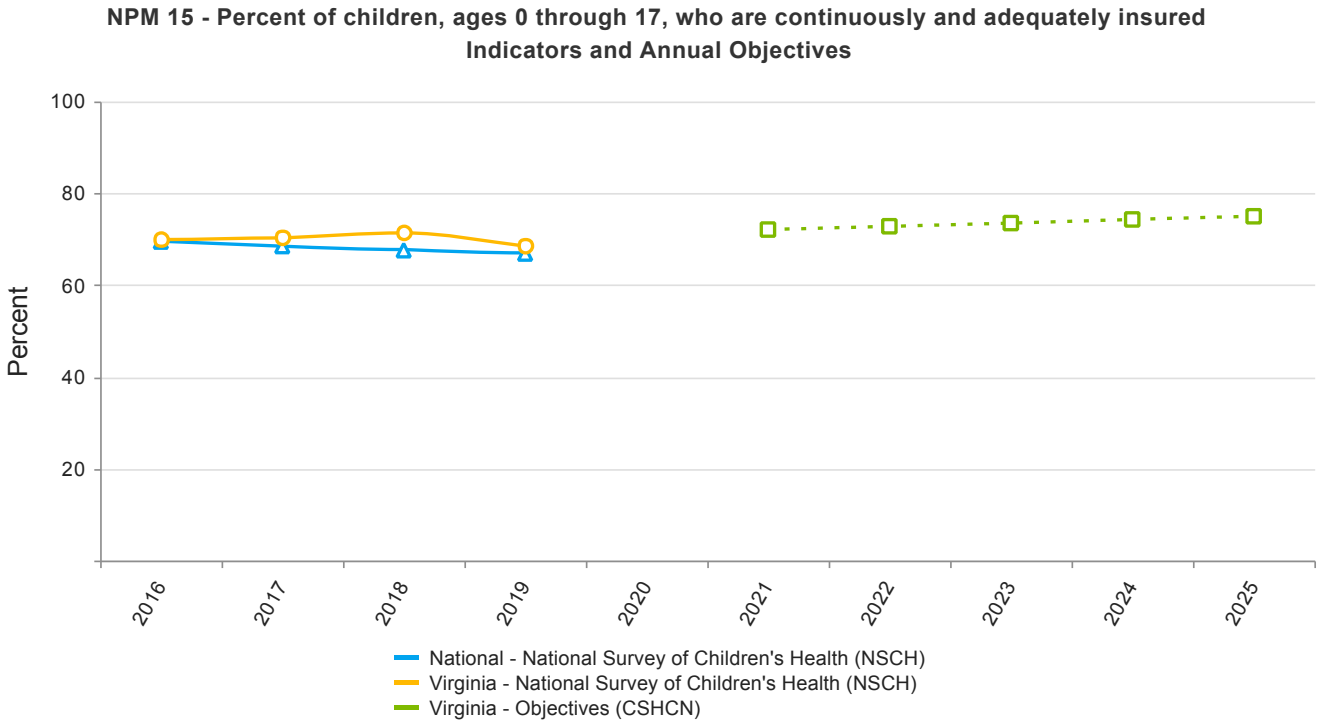
Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	40.0	45.0	50.0	55.0	60.0	65.0

ESM 12.2 - Percentage of Virginia school divisions reporting into the VDOE school health data system

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		68.2
Numerator		90
Denominator		132
Data Source		VDH and VDOE School Health Nurse Documentation
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	75.0	77.0	79.0	81.0	83.0	85.0



NPM 15 - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2019	**2020**
Annual Objective		
Annual Indicator	71.2	68.5
Numerator	1,323,014	1,274,181
Denominator	1,857,510	1,859,679
Data Source	NSCH	NSCH
Data Source Year	2017_2018	2018_2019

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	71.3	66.9
Numerator		
Denominator		
Data Source	NSCH	NSCH
Data Source Year	2017_2018	2018_2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	72.0	72.7	73.4	74.2	74.9	75.6

Evidence-Based or –Informed Strategy Measures

ESM 15.1 - Number of Managed Care Organizations (MCO) and Care Connection for Children (CCC) Care Coordinators that attend statewide meeting

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	40.0	40.0	40.0	40.0	40.0	40.0

ESM 15.2 - Number of Managed Care Organization (MCO) and Care Connection for Children (CCC) regions that commit to partnering with each other to reduce barriers

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	3.0	3.0	4.0	5.0	6.0	6.0

State Performance Measures

SPM 5 - Cross-Cutting (Family Leadership): Percentage of VDH CYSHCN programs (i.e. Care Connection for Children, Child Development Centers, Bleeding Disorders Program, Sickle Cell Program) actively incorporating family engagement annually

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		100
Numerator		4
Denominator		4
Data Source		CYSHCN Program Documentation
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

State Action Plan Table

State Action Plan Table (Virginia) - Children with Special Health Care Needs - Entry 1	
Priority Need	
Strong Systems of Care for All Children: Strengthen the continuum supporting physical/socio-emotional development (i.e. screening, assessment, referral, follow-up, coordinated community-based care).	
NPM	
NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	
Objectives	
By June 30, 2025, increase the percentage of children with special health care needs having a medical home from 48.4% (NSCH 2017-2018) to 53.2%.	
Strategies	
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).	
Through the CYSHCN network, facilitate access to comprehensive medical and support services that are collaborative, family-centered, culturally-competent, fiscally-responsible, community-based, coordinated and outcome-oriented to CYSCHN and their families (CYSHCN National Standard: Easy to Use Services and Supports / Care Coordination).	
ESMs	**Status**
ESM 11.1 - Number of providers in Virginia who have completed the medical home training module	Active
ESM 11.2 - Percentage of children served by the VA CYSHCN Program who report having a medical home	Active
NOMs	
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	

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

Priority Need

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

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Objectives

By June 30, 2025, increase the proportion of adolescents with special health care needs in Virginia who are engaged in transition services to adult health care from 26.5% (NSCH 2017-2018) to 29.2%.

Strategies

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).

ESMs	Status
ESM 12.1 - Number of providers in Virginia who have completed the transition training module.	Active
ESM 12.2 - Percentage of Virginia school divisions reporting into the VDOE school health data system	Active

NOMs

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

State Action Plan Table (Virginia) - Children with Special Health Care Needs - Entry 3

Priority Need

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

NPM

NPM 15 - Percent of children, ages 0 through 17, who are continuously and adequately insured

Objectives

By June 30, 2025, increase the proportion of children with special health care needs in Virginia who are continuously and adequately insured from 71.3% (NSCH 2017-2018) to 74.9%.

Strategies

Collaborate with Medicaid to strengthen the relationship between Title V-funded care coordinators and Medicaid-funded care coordinators.

ESMs	Status
ESM 15.1 - Number of Managed Care Organizations (MCO) and Care Connection for Children (CCC) Care Coordinators that attend statewide meeting	Active
ESM 15.2 - Number of Managed Care Organization (MCO) and Care Connection for Children (CCC) regions that commit to partnering with each other to reduce barriers	Active

NOMs

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

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

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

NOM 22.1 - Percent of children 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

State Action Plan Table (Virginia) - Children with Special Health Care Needs - Entry 4

Priority Need

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

SPM

SPM 5 - Cross-Cutting (Family Leadership): Percentage of VDH CYSHCN programs (i.e. Care Connection for Children, Child Development Centers, Bleeding Disorders Program, Sickle Cell Program) actively incorporating family engagement annually

Objectives

Support and document family engagement in 100% of CYSHCN programs (i.e., Care Connection for Children, Child Development Centers, Bleeding Disorders Program, Sickle Cell Program) annually.

Strategies

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)

CHILDREN WITH SPECIAL HEALTHCARE NEEDS DOMAIN
SUMMARY/OVERVIEW
FY20 ANNUAL REPORT

2016-2020 MCH Priority Needs Addressed in this Domain
Medical Home: Promote the importance of medical home among providers and families
Transition: Promote independence and transition of young adults with and without special healthcare needs

CYSHCN PROGRAM DESIGN AND OVERVIEW

CHILDREN WITH SPECIAL HEALTHCARE NEEDS PROGRAM: The VDH Children with Special Health Care Needs (CYSHCN) program is based on the vision that the Maternal and Child Health Bureau has for this population and it closely aligns with the overall system outcomes for CYSHCN (as described in the national standards). The Virginia State Plan for CYSHCN validates this because it is written into law as part of the Virginia Administrative Code (VAC). The entire plan can be found at: https://law.lis.virginia.gov/admincode/title12/agency5/chapter191/.

The scope and content is as follows (excerpt taken directly from the VAC):
"12VAC5-191-40. Scope and Content of the Children with Special Health Care Needs Program.

A. Mission. The Children with Special Health Care Needs Program promotes the optimal health and development of individuals living in the Commonwealth with special health care needs by working in partnership with families, service providers, and communities.

B. Scope. The scope of the Children with Special Health Care Needs Program includes the following:

1. Direct health care services.
2. Enabling services.
3. Population-based services.
4. Assessment of community health status and available resources.
5. Policy development to support and encourage better health.

C. Networks and Services. The Children with Special Health Care Needs Program administers the following networks and services:

1. Care Connection for Children.
2. Child Development Services.
3. Virginia Bleeding Disorders Program.
4. Genetics and Newborn Screening Services.
    a. Virginia Newborn Screening System.
    b. Virginia Congenital Anomalies Reporting and Education System.
5. Virginia Sickle Cell Awareness Program.
6. Pediatric Comprehensive Sickle Cell Clinic Network.

*7. Adult Comprehensive Sickle Cell Clinic Network.

Please note that the Adult Comprehensive Sickle Cell Clinic Network is a new program. The Virginia Department of Health is finalizing a Request for Proposals (RFP) and is planning to issue it during the late summer months of 2021. The goal is to have agreements in place by the end of calendar year 2021. This service was one of the Governor of Virginia's budget priorities and will be paid for with state general funds.

D. Target population. The target population to receive services from the networks and programs within the Children with Special Health Care Needs Program are the following:

1. Residents of the Commonwealth.
2. Individuals between the ages of birth and their 21st birthday except that the Virginia Bleeding Disorders Program and the Virginia Sickle Cell Awareness Program serve individuals of all ages, and the Adult Comprehensive Sickle Cell Clinic Network serves individuals 18 years of age and older.
3. Individuals diagnosed as having, or are at increased risk for having, a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Each network and program within the CYSHCN Program has its own specific eligibility criteria.

E. Goals. The Title V national performance measures, as required by the federal Government Performance and Results Act (GPRA-Pub. L. 103-62), are used to establish the program goals.

STATUTORY AUTHORITY

§§ 32.1-12 and 32.1-77 of the Code of Virginia."

As defined above in the code, the core CYSHCN programs include the Care Connection for Children, Sickle Cell, and Bleeding Disorders programs. The Child Development Center program is included; but it provides assessments of any child suspected of having a developmental and/or behavioral condition. Due to the size and complexity of the Virginia Newborn Screening System, it has its own manager and functions in partnership with the CYSHCN program (both programs fall under the Division of Child and Family Health along with Title V). Approximately 40% of the state's federal allocation serves this vulnerable population. To maximize federal funding and facilitate linkages to care, most CYSHCN efforts are provided in partnership with major health care systems and universities. **In FY20, the CYSHCN program served about 6,613 families**. This represents a decrease in service level from FY19 (7498) that is mostly due to COVID restrictions.

Care Connection for Children (CCC) The CCC program is a statewide network of six regional centers of excellence that provide care coordination services to reduce barriers that families face when trying to access care. **In FY20, the CCC program served 2851 families.**

Such services include, but are not limited to:

- Medical insurance benefit evaluation and referral (including Medicaid);
- Linkage to a primary care provider/medical home;
- Referrals to necessary resources and specialty services;
- Family-to-family support via parent coordinators;
- Support from the Virginia Department of Education's (DOE's) state educational consultants and;
- A pool of funds for uninsured or underinsured families with no other means for obtaining life-preserving medications and/or durable medical equipment.

Child Development Centers (CDCs) The CDC program serves families with children who are suspected of having behavioral or developmental disorders (e.g. autism, ADD/ADHD, learning disabilities, anxiety, PTSD, mood disorders). Five regional centers provide multidisciplinary assessments of each child, as well as diagnoses and short-term care coordination to link families to necessary services beyond the capabilities of most primary care providers. The program helps to respond to state and national shortages of developmental and behavioral pediatric service providers**. In FY20, the CDC program served 2,491 families, resulting in 5,247 diagnoses and 6,340 referrals for additional services.**

Virginia Bleeding Disorders Program (VBDP) The Virginia Bleeding Disorders Program is a legislatively enacted program established by the Commonwealth of Virginia through the Virginia Department of Health, Office of Family Health Services for the care and treatment of persons with hemophilia and other inherited bleeding disorders. Virginia recognizes

that the ongoing medical costs of treating such bleeding disorders often exceed the financial capacity of families, despite the existence of various types of medical and hospital insurance. **In FY20, the VBDP served 377 people.** In order to address the need, the Virginia Bleeding Disorders Program provides a "safety net" for persons with inherited bleeding disorders. The safety net includes:

- Coordinated, family oriented, multidisciplinary services for persons with congenital bleeding disorders;
- A Pool of funds to assist with the purchase of factor and/or supplies and;
- Insurance case management and premium assistance to help keep eligible clients insured.

Pediatric Comprehensive Sickle Cell Program The Pediatric Comprehensive Sickle Cell Clinic Network is a statewide group of clinics, located in major medical centers, that provide comprehensive medical and support services that are collaborative, family centered, culturally competent, community based and outcome oriented for newborns identified from newborn screening, children, and youth living with sickle cell disease. **In FY20, the clinics served 894 families.**

Virginia Sickle Cell Awareness Program (VASCAP) VASCAP provides access for adult sickle cell screening and follow-up education for individuals and families identified with sickle cell disease and other hemoglobinopathies. VASCAP collaborates with the Virginia Newborn Screening Program and the Pediatric Comprehensive Sickle Cell Centers to ensure early parent education, encourage confirmatory testing, and early entry into care for newborns and their families identified with sickle cell disease and other hemoglobinopathies. In FY 21, VDH received funding to establish an Adult Comprehensive Sickle Cell Clinic Network. VDH expects that the network will be fully functional in FY 22.

Adult Comprehensive Sickle Cell Program As described previously in this section, VDH received state general funds ($805,000) to establish an Adult Comprehensive Sickle Cell Clinic Network. The process of launching this network consisted of a change in state law, an allocation of funding from the Virginia General Assembly (as recommended and supported by the Governor), and the drafting/implementation of state regulations (https://law.lis.virginia.gov/admincode/title12/agency5/chapter191/section340/).

DOMAIN OVERVIEW

IDENTIFIED STATE PRIORITY	Medical Home: Promote the importance of medical home among providers and families
STRATEGY 1:	Partner with the VA Chapter of the American Academy of Pediatrics (AAP), community partners, and Virginia's CYSHCN Centers (CCC Centers, CDCs, VBDP sites, Sickle Cell Program sites) to develop a training module for health care providers and families to educate on a comprehensive care approach to provide a medical home for children (including those with special health care needs) as a component of the merging Virginia Medical Neighborhood Model
STRATEGY 2:	Assure youth with special health care needs receive coordinated, ongoing, comprehensive care within a medical home (CYSHCN National Standard: Medical Home)
STRATEGY 3:	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)
STRATEGY 4:	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 and Financing)
STRATEGY 5:	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)
OBJECTIVE	By June 30, 2020, increase the percentage of typical and children with special health care needs served by the VDH CYSHCN Program who can identify a primary care provider as a medical home from 89.2% to 91.5%
PERFORMANCE MEASURE	NPM 11: Percent of adolescents with and without special healthcare needs, ages 0 through 17, who have a medical home
ESMs	ESM 11.1 – Number of providers in Virginia who have completed the medical home training module ESM 11.2 – Percentage of CYSHCN served by the VA CYSHCN Program who report having a medical home
OUTCOME MEASURE	NOM 17.2 – Percentage of children, with special healthcare needs (CYSHCN), ages 0-17, who receive care in a well-functioning system NOM 18 – Percentage of children, ages 3-17, with a mental/behavioral condition who receive treatment and counseling NOM 19 – Percentage of children, ages 0-17, in excellent or very good health NOM 25 – Percentage of children, ages 0-17, who were not able to obtain needed healthcare in the last year

2016-2020 Summary

Data Source: National Survey of Children's Health (NSCH) - CSHCN

2016	**2017**	**2018**	**2019**	**2020**
	42.7%	44.2%	48.4%	48.6%

GOAL FOR 2021-2025 SAP:	By June 30, 2025, increase the percentage of children with special health care needs having a medical home from 48.4% (NSCH 2017-2018) to 53.2%.

PROGRESS UPDATE FOR STRATEGY 1: As a part of the VDH successfully renewed the contract with UVA Office of Continuing Medical Education for the online medical home and transition modules, reviewing and approving the demo and launched modules. Our communication plan consisted of notifying the Medical Neighborhood Collaborative and CYSHCN program partners (CCC, CDC, SCP, VBDP about the modules with a request that they help promote them. The modules are complementary to attend (due to financial support from Title V) and are housed within UVA's Promoting Healthy Communities at https://healthycommunity education.org/home.aspx. The Medical Home Modules consist of a track for professionals and a track for family members/community members. During FY2020 (7/1/2019-6/30/2020), there were 57 enrolled in the medical home modules (37 providers and 20 family/community members).

Activities for Strategy 1	Expected Completion Date	Responsible Staff
Renew Contract with UVA	7/1/19	CYSHCN Director
Monthly meetings with UVA to encourage accountability in producing module product and additional module work	Monthly	DCFH Director, CYSHCN Director
Communicate with Medical Neighborhood Collaborative regarding update on UVA module development. Hold Launch event	Fall 2019	CYSHCN Director & UVA
Throughout Fall 2019, monitor UVA's progress in developing a module homepage, assume demo is completed, ensure modules are launched	7/1/2019 – 12/31/2019	CYSHCN Director
Prepare communication plan with UVA and execute	1/31/2020	CHSCN Director, MCH/Title V Director
Develop evaluation plan to include pre/post-tests with UVA	6/30/2020	Blood Disorders Program Coordinator, Title V Family Delegate
Track module completion	Ongoing	VDH & UVA

PROGRESS UPDATE FOR STRATEGY 2: As a unit, the CYSHCN Team continued to require that all of its programs include work plan language promoting the importance of a medical home to all families served. These requirements go beyond promotion and require that centers connect families to a medical home if they do not have one. The CCC Program continued to work directly with primary care and specialty care providers to provide care coordination services for families and help link them to services as needed. The Program also continued to help obtain prior authorizations; explain health insurance/benefits to families/ link families to DME providers, especially for difficult-to-find items; and, most importantly, assist families overcome any barriers that make it difficult for the child with special needs to access services.

The CDC program continued to serve as a resource for providers and families to provide assessments of children suspected of having developmental and/or behavioral conditions. Upon diagnosis, the centers share results with families and providers (as approved by parents), and connect diagnosed CYSHCN to resources within their own community. In addition, VDH Central Office staff worked with state Medicaid and managed care organizations to improve reimbursement issues that have plagued the program. The VBDP and Pediatric Comprehensive Sickle Cell Centers continued to collaborate with medical homes to coordinate care in partnership with families.

Activities for Strategy 2	Expected Completion Date	Responsible Staff
Partner with family-identified medical home to coordinate care for CYSHCN served through CCCs, CDCs, SCPs, and bleeding disorders programs	Ongoing	CYSHCN Director
Partner with Family-identified medical homes to coordinate entry into specialty care for newborns with positive hemoglobinopathy screening	Ongoing	Blood Disorders Program Coordinator
All CYSHCN program will continue to promote and identify medical homes for families served	Ongoing	CYSHCN Director & Blood Disorders Program Coordinator
All programs will help to promote the medical home module to families once they have been created and they will be asked to promote the modules within their health system as a whole	January 2020 Ongoing	CYSHCN Director, Blood Disorders Program Coordinator, Center partners

PROGRESS UPDATE FOR STRATEGY 3: The CYSHCN program in Virginia partners very closely with major medical centers across the state. Contractual partners include: Children's Hospital of the King's Daughters in the Tidewater Region, the University of Virginia Health System in the Blue Ridge region, Carillion Health System in the Roanoke/southwest region, INOVA Health System and Children's National Medical Center in the northern region, and Virginia Commonwealth University Health System in the central region. This partnership benefits families tremendously because they are able to receive the services they need through one "open door". For example, children with sickle cell disease often need care from several specialty providers such as nephrologists, neurologists, and radiologists. The health systems VDH partners with readily refer children to specialties within their own health system and services are generally offered on the same campus. This same benefit exists for CYSHCN served through the CCC, CDC, Sickle Cell and Virginia Bleeding disorders programs.

COVID caused significant challenges for the VA CYSHCN programs during FY20. We were not able to make site visits due to travel restrictions and had to adapt. Our Child Development Clinic program likely suffered the most. Evaluations fell drastically due to the state of emergency issued by our Governor because our partners were limited when it came to evaluating children in person. In order to address this, center leadership communicated with each other regularly to share ideas on alternatives to in person evaluations of children suspected of having developmental and/or behavioral conditions. We held regular statewide calls with center leadership and actively engaged each other regarding overcoming obstacles/barriers. Some calls even focused solely on staff mental health as the stress of the situation weighed very heavily on everyone. In order to continue to be able to offer limited services, one of the licensed psychologists at our Tidewater center at Children's Hospital of the Kings Daughter's reached out to Pearson (owner of a validated assessment tool staff use) to see if their *Wechsler Intelligence Scale for Children* could be used in telehealth visits. She was granted permission to do this and then shared what she learned with our entire network. Initiatives like this allowed some of our centers to continue to operate (even though it was at limited capacity) to serve children. In fact, many of our partners stated that in some situations assessing children for developmental/behavioral conditions via telemedicine works better because they can view children in their natural environment which is often more comfortable for them and their family.

Our Sickle Cell Program continued to address issues of family support, health insurance and transportation barriers for patients getting to appointments by providing assistance in obtaining bus tickets, Medicaid cabs, gas vouchers, etc. The centers also refer patients to the appropriate community-based organizations, such as local sickle cell associations, Catholic Charities, food banks and other community resources. The VBDP program manager continued to work with the Virginia Hemophilia Foundation on education to families about ED/EMS and dental services. In addition, families continued to have access to Virginia Department of Education (DOE) consultants and social workers who often work at program sites and function as part of a comprehensive team that strives to meet the needs of CYSHCN. Services provided in this manner help ameliorate barriers and assure that providers work together to most effectively serve families.

Activities for Strategy 3	Expected Completion Date	Responsible Staff
Conduct subrecipient monitoring to ensure partners meet required service levels for providing care coordination and other similar services	Ongoing	CYSHCN Director & Blood Disorders Program Coordinator
Maintain infrastructure for centralized data system (CCC-SUN) for use by statewide CCC staff to track and document case management and care coordination services, insurance type, pool of funds, and I&Rs	Ongoing	CYSHCN Director
Collaborate with CCC Directors to encourage staff to become and maintain certifications as case managers	Ongoing	CYSHCN Director
Convene center director/consultant meetings to provide technical assistance and troubleshoot issues. Staff will make annual site visits and/or offer technical assistance via phone or email as well.	Ongoing	CYSHCN Director, Blood Disorders Program Coordinator, Center partners

PROGRESS UPDATE FOR STRATEGY 4: The CYSHCN programs continued to help families struggling with insurance issues by connecting them to public and private options as needed. The CCC program reported that 93% of CYSCHN served were insured in FY20 and the CDC program reported that 99% were insured. As for the VBDP, 97% of

patients had private or public insurance. The VBDP continued to employ a trained social worker who is very knowledgeable of health insurance options and worked very closely with families to find the most cost effective insurance solution that meets both family and client medical needs. One of the VBDP's most important partners in this process is Patient Services Incorporated (PSI). PSI continued to provide insurance case management and premium assistance to help eligible families so that they could maintain insurance coverage.

The sickle cell centers continued to employ social workers to help families address insurance needs and as with all VDH CYSHCN programs, families continued to be encouraged to apply for Medicaid (if it appears they are eligible). VDH continued to manage a Pool of Funds (POF) for the CCC and VBDP. The POF is the payer of last resort, and helps families purchase needed medications when no other viable options are present, including insurance. The Hearing Aid Loan Bank is located at one of the regional CCC centers and continues to provide gap-filling services to families of children with hearing loss.

Activities for Strategy 4	Expected Completion Date	Responsible Staff
Through CYSHCN programs, conduct medical insurance benefits evaluation and coordination to include identifying potential Medicaid-eligible families, providing assistance with applying, and providing ongoing education and support to access covered services	Ongoing	CYSHCN Director & Blood Disorders Program Coordinator
Work towards strengthening relationship with DMAS/MCOs and health systems by exploring opportunities for shared financing to sustain and expand services	Ongoing	CYSHCN Director
Administer a Care Connection for Children (CCC) pool of funds for payment of direct medical care services for the uninsured and underinsured clients	Ongoing	CYSHCN Director
Administer a bleeding disorders pool of funds for payment of direct medical care services for the uninsured and underinsured clients.	Ongoing	Blood Disorders Program Coordinator
Manage an insurance case management contract (PSI) to help assure people with bleeding disorders have ongoing access to insurance	Ongoing	Blood Disorders Program Coordinator
Support and encourage social work support at the VBDP and SCP centers across the state	Ongoing	Blood Disorders Program Coordinator

PROGRESS UPDATE FOR STRATEGY 5: Care Connection for Children (CCC) continued to employ parent coordinators as staff at two of our six centers. Another center has a contract with a parent organization to offer family support and the fourth center employees a resource coordinator who fills this role. Vacancies exist at the other two centers. Most of our employed staff have a child with a special health care need so they understand the unique challenges families face. In addition to providing general support to families, staff across the Commonwealth work to: Maintain center resource lists; Create newsletters; Lead educational activities and trainings and work closely with families on overcoming barriers to care.

Another one of our core programs, the Child Development Clinics (CDCs) continued to engage families. The CDCs provide assessments of children suspected of having developmental and/or behavior conditions. Families are an active part of the assessments and they receive documentation regarding diagnoses. In addition, center staff members refer them to clinical and non-clinical resources for assistance and share the results of their assessments with other providers serving the family (with permission from parents).

The VBDP continued to educate families on home therapy management for those who infuse at home and the SCP centers offered genetic counseling to aide in future reproductive decision making. The regional centers generally provide events for families, including social gatherings and overnight camps with educational and group activities focusing on transition and self-advocacy. However, this was not possible this year due to COVID. Social workers continued to send out pertinent

information to families as topics arise pertaining to medical advances in SCD. Families with newborns diagnosed with SCD were given a copy of *Hope and Destiny: A Patient's and Parent's Guide to Sickle Cell Anemia* and patients entering the transition phase were given a copy of *Hope and Destiny Jr* (as funding allows).

Activities for Strategy 5	Expected Completion Date	Responsible Staff
Maintain paid parent coordinators at each CCC center to provide support and resources to families served	Ongoing	CYSHCN Director
Assure CYSHCN centers identify and address family barriers, priorities, and concerns (EG sickle cell psychosocial assessments) while promoting family engagement in decision making at all levels of care planning and management (EG IEP/504 plans, home management of bleeding disorders)	Ongoing	CYSHCN Director, Blood Disorders Program Coordinator
Solicit, document, and respond to family feedback on satisfaction with services (eg, bleeding disorders family satisfaction survey every over year, CCC parent survey every 5 years)	Ongoing	CYSHCN Director, Blood Disorders Program Coordinator
Empower and equip populations impacted by sickle cell and bleeding disorders to manage complexities of disease through various community support and education activities/programs (eg youth transition camp, faith-based outreach)	Ongoing	Blood Disorders Program Coordinator

IDENTIFIED STATE PRIORITY	Transition: Promote independence and transition of young adults with and without special health care needs
STRATEGY 1:	Collaborate with VA-AAP, community partners, and Virginia's regional CYSHCN Centers (i.e., Care Coordination for Children centers, Child Development Centers, Virginia Bleeding Disorders Program sites, Sickle Cell Program Sites) to develop training modules for health care providers, school personnel, families, and adolescents to educate on best practices regarding the delivery of transition services, the provision of transition tools, the importance of the transition process, and self-advocacy, to achieve optimal health
STRATEGY 2:	Assure youth with special health care needs receive the services necessary to make transitions to all aspects of adult life (including adult heath care, work, and independence) through referrals to adult providers, utilizing transition tools when appropriate (CYSHCN National Standard: Transition to Adulthood)
STRATEGY 3:	Engage youth and families in program development and outreach for medical home and transition (Standard: Got Transition's Six Core Elements of Health Care Transition – Transition Completion & Youth and Family Engagement)
OBJECTIVE	By June 30, 2020, increase the proportion of children with and without special health care needs in Virginia who are engaged in transition services to adult health care from 44.9% (NSCH-CYSHCN 2010) to 47.1%
PERFORMANCE MEASURE	NPM 12: Percent of adolescents with and without special health care needs, age 12-17, who receive services necessary to make transitions to adult health care.
ESMs	ESM 12.1 – Number of providers in Virginia who have completed the transition training module ESM 12.2 – Percentage of Virginia schools reporting into the VDOE school health data system
OUTCOME MEASURE	NOM 17.2 – Percentage of children, with special healthcare needs (CYSHCN), ages 0-17, who receive care in a well-functioning system

2016-2020 Summary				
Data Source: National Survey of Children's Health (NSCH) - CSHCN				
2016	**2017**	**2018**	**2019**	**2020**
	18.8%	28.1%	26.5%	14.5%
GOAL FOR 2021-2025 SAP:		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%.		

PROGRESS UPDATE FOR STRATEGY 1: Activities and Progress updates for this strategy are the same as Strategy 1 in the Medical Home section. During state fiscal year 2020 (7/1/2019-6/30/2020), 86 people enrolled in the transition modules (45 providers and 41 family/community members).

PROGRESS UPDATE FOR STRATEGY 2: The CCC program continued to use its program specific transition tool. The tool helps families prepare their child with special needs to transition clinically, socially, educationally, and vocationally. All CYSHCN programs were notified of the completion of the transition modules and were asked to support VDH in promoting them to all of their partners and to families who receive services. The CDC program continued to work with in house Virginia Department of Education staff to refer older youth to their local school system for transition services when required (all youth served by this program are referred for clinical services as needed). The sickle centers continued to work on finding adult providers willing to receive transitioning sickle cell clients. VDH will be supporting these efforts in the future (as described previously in this document) with the establishment of a statewide Adult Comprehensive Sickle Cell Network. Last, the bleeding disorders program continued to transition patients to VCU for adult care or within their own community (if possible).

Activities for Strategy 2	Expected Completion Date	Responsible Staff
Through CCCs, facilitate transition from child to adult-oriented health care systems (e.g., transition planning tools, educational plans)	Ongoing	CYSHCN Director
Partner with the Comprehensive Sickle Cell Centers to ensure that all transition-age patients complete the American Society of Hematology transition readiness assessment tool or a similar tool/process	Ongoing	Blood Disorders Program Coordinator
Partner with funded hemophilia treatment centers to ensure the transition process from pediatric to adult treatment centers occurs (e.g., biannual transition calls between regional hemophilia treatment centers and the state's only comprehensive adult treatment center; development of transition plan of care)	Ongoing	Blood Disorders Program Coordinator
Encourage all CYSHCN program to promote the transition and medical home community/family modules and provider training modules	Ongoing	CYSHCN Director, Blood Disorders Program Coordinator

PROGRESS UPDATE FOR STRATEGY 3: During FY 20, VDH MCH staff members (CYSHCN Team, MCH Epidemiologist, and Adolescent Health Coordinator) partnered with our state family delegate to create a draft of a healthcare transition survey tool (note the attached tool). Initially, we planned to implement the tool in person (using kiosks) at a family related CYSHCN conference (I'm Determined Parent Summit). However, due to COVID the conference was moved to a virtual environment and there wasn't enough time to adapt and implement the survey. Our team regrouped, adolescent coordinators were hired and we utilized them to create a new plan to implement the survey. Our goal is to launch it in FY 22 and we will use the data to learn more about the transition needs of families.

Activities for Strategy 3	Expected Completion Date	Responsible Staff
Address youth/family engagement component of HCT assessment by ensuring onboarded youth advisors receive training about the 6 core elements	After staff hired	Adolescent Health Coordinator, CYSHCN Director, Blood Disorders Program Coordinator, MCH Director
Engage youth advisors and parents (including Family Delegate, VDH youth advisors, KASA, Family-to-Family, Virginia Board for People with Disabilities, etc) in program development	First Quarter of FY2020	Adolescent Health Coordinator, CYSHCN Director, Blood Disorders Program Coordinator, MCH Director
Task youth advisors with engaging state and community partners (eg go out and build partnerships with KASA, etc)	Ongoing	Adolescent Health Coordinator, CYSHCN Director, Blood Disorders Program Coordinator,
Address transition completion component of HCT assessment by developing and implementing HCT feedback survey for all CYSHCN program	Ongoing	Adolescent Health Coordinator, CYSHCN Director, Blood Disorders Program Coordinator,EPI Director
Following module launch event, brainstorm with Medical Neighborhood Team on promoting medical neighborhood concept (including medical home and transition policy, tracking and monitoring, readiness, planning and transfer of care)	Ongoing	CYSHCN Director, Blood Disorders Program Coordinator, MCH Director, UVA
Engage partners (e.g., Family Delegate, KASA), youth advisors, and families in encouraging others to complete modules	Ongoing	CYSHCN Director, Adolescent Health Coordinator, MCH Director

CYSHCN PROGRAM PUBLIC-PRIVATE PARTNERSHIP NETWORK

The CYSHCN Program partners closely with major public and private medical centers and universities across the state. These partnerships benefit families tremendously because they are able to receive the services they need through one "open door". For example, children with sickle cell disease often need care from several specialty providers such as nephrologists, neurologists, and radiologists. The health systems with whom we collaborate readily refer children to these specialties within their own health system and services are generally offered at the same campus/location. This similar benefit exists for CYSHCN served through our CCC, CDC, and bleeding disorder programs at health systems.

Additionally, the Virginia Administrative Code states that the Virginia Department of Education will collaborate with the four CYSHCN programs to provide consultation for families, providers, educators, and school administrators. CYSHCN Program staff partner with school systems and the educational consultants to ensure students receive services consistent with their level of need. As needed, the educational consultants make school visits, communicate with teachers, counselors, and school nurses to provide the information necessary to families, providers and school personnel to navigate develop of IEP/504 plans.

CHILD DEVELOPMENT CENTERS (CDC)

- Southwest Virginia Child Development Clinic, Gate City, VA: http://www.vdh.virginia.gov/lenowisco/childdevelopment-clinic/
- Shenandoah Valley Child Development Clinic, Harrisonburg, VA: http://www.jmucdc.org/
- Children's Specialty Group Child Development Centers,Norfolk, VA: https://csgdocs.com/specialties/developmental-pediatrics/
- Virginia Commonwealth University Child Development Clinic, Richmond, VA: https://www.chrichmond.org/Services/Developmental-Pediatrics.htm
- Carillion Pediatric Neurodevelopmental Clinic, Roanoke, VA: https://www.carilionclinic.org/specialties/pediatric-child-development

CARE CONNECTION FOR CHILDREN (CCC)

- Southwest Virginia Care Connection for Children, Washington County Community Services, Bristol, VA: http://www.vdh.virginia.gov/mount-rogers/maternal-and-child-health/
- Blue Ridge Care Connection for Children, Charlottesville,VA: https://childrens.uvahealth.com/services/blueridge-care-connection
- Northern Virginia Care Connection for Children, Fairfax, VA: https://www.inova.org/ccc
- Hampton Roads Care Connection for Children, Children's Hospital of the King's Daughter's, http://www.chkd.org/Our-Services/Specialty-Care-and-Programs/Support-Services/CareConnection-for-Children/
- Central Virginia Care Connection for Children, Virginia Commonwealth University, Richmond, VA, https://careconnections.vcu.edu/
- Roanoke Area Care Connection for Children, Carilion, Roanoke, https://www.carilionclinic.org/care-connectionchildren

SICKLE CELL

- Children's Hospital of Richmond at VCU, Richmond, VA: https://www.chrichmond.org/Services/Hematologyand-Oncology.htm
- University of Virginia, Charlottesville, VA: https://childrens.uvahealth.com/services/pediatric-blood-disorders
- Children's Hospital of the King's Daughters, Norfolk, VA: http://www.chkd.org/our-services/specialty-care-andprograms/cancer-and-blood-disorders-center/about-sickle-cell-anemia/
- Pediatrics Specialists of Virginia, Fairfax, VA: https://psvcare.org/specialty/cancer-and-blood-disorders

BLEEDING DISORDERS

- Virginia Commonwealth University, Richmond, VA: https://htc.vcu.edu/
- University of Virginia, Charlottesville, VA: https://childrens.uvahealth.com/services/pediatric-blood-disorders
- Children's Hospital of the King's Daughters, Norfolk, VA: http://www.chkd.org/our-services/specialty-care-and-programs/cancer-and-blood-disorders-center/about-pediatric-bleeding-disorders/
- Children's National Medical Center, Washington DC (satellite clinic in Falls Church,VA): https://childrensnational.org/departments/center-for-cancer-and-blood-disorders/programs-andservices/blood-disorders/programs-and-services/comprehensive-hemostasis-and-thrombosis-program

OTHER PROGRAMMATIC ACTIVITIES DURING FY20

During the COVID crisis, CYSHCN program staff worked to staff COVID clinics at times and in the beginning, two staff members served on the State's Receipt, Staging, and Storage Emergency Response Team. Please note the list of additional activities below:

- The CYSHCN Program Director continued to serve on the AMCHP Board of Directors as the Region III Director;
- The CYSHCN Program Director serves on the *Learn the Signs Act Early,* COVID 19 Response Team Partnership. The Partnership for People with Disabilities received a grant to promote developmental screening;
- Collaborated with AMCHP to do a pre-recorded, "on demand" presentation for the Family Voices Conference. Our part of the presentation focused on the Care Connection for Children Program and the work we do to support families;
- The CYSHCN Program Director continued to serve on the VA LEND, Multicultural Advisory Committee. Virginia Commonwealth University manages the program for Virginia. VDH also supported UVA regarding their efforts to start a LEND in the Blue Ridge Region. We wrote a letter of support and agreed to work closely with UVA. They were funded;
- The CYSHCN, Blood Disorders Coordinator received funding from the Centers for Disease Control and Prevention (CDC) to manage a Sickle Cell Data Collection (SCDC) program. VDH will hire a data manager, create a data repository and share data with CDC;
- CYSHCN program worked with the state pharmacy to request that our partners obtain prescriptions for 60-supplies

of medication for our Pool of Funds Program at the beginning of the COVID pandemic;

- CYSHCN program served on a panel at the *I'm Determined Youth Summit*. This event is held yearly and it is a partnership between the Virginia Department of Education and the Partnership for People with Disabilities. VDH spoke about the importance of transition services for children with special health care needs. More information about the summit can be found at: https://www.imdetermined.org/event/youth-summit/;
- The CYSHCN program completed a submission to the AMCHP Innovation Station. The submission was for the Child Development Clinic program.

PROGRAM LOGOS/BRANDING

The Care Connection for Children logo has been with the program for more than a decade and was developed under previous leadership. The Blood Disorders Program Coordinator developed the Virginia Sickle Cell Awareness program logo in 2017 in collaboration with VDH Communication Team and received feedback/input from medical center and community-based partners. This logo is placed on all sickle cell related program activities. During the first year of the new logo, there was an unprecedented demand for education materials from the community, so much so that the Program was unable to keep up initially with literature requests.

CHILDREN WITH SPECIAL HEALTHCARE NEEDS DOMAIN SUMMARY/OVERVIEW FY22 APPLICATION YEAR

2021-2025 MCH Priority Needs Addressed in this Domain
Strong systems of care for all children
Finances as a root cause
Community, family & youth partnerships

IDENTIFIED NPMs/SPMs FOR STATE ACTION PLAN 2021-2025	
NPM 11 Medical Home (CSHCN ages 0-17 years)	The NSCH (2018-2019) showed that 48.6% of CSHCN had a medical home. Children with a stable and continuous source of health care are more likely to receive appropriate preventive care.
NPM 12 Transition (CSHCN ages 12-17 years)	The NSCH (2018-2019) showed that 14.5% of CSHCN ages 12-17 years were engaged in transition services to adult health care.
NPM 15 Continuous and adequate insurance (CSHCN Ages 12-17 years)	The NSCH (2018-2019) showed that 66.9% of CSHCN were continuously and adequately insured. There were 32.3% of CSHCN that had public insurance, 61.6% private insurance, and 2.1% uninsured.

During FY22, the following programmatic strategies and activities have been identified as methods to advance and improve outcomes in this domain.

IDENTIFIED STATE PRIORITY	Strong systems of care for all children
STRATEGY 1:	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)

The transition and medical home education online modules were launched in Fall 2019 after more than two years of development. VDH plans to continue to meet with UVA and our goal will be to seek broader utilization of the modules among providers to promote medical home and its key components as recommended by the AAP.

Activity	Expected Completion Date	Responsible Staff
Renew contract with UVA	7/1/2022	CYSHCN Director
Hold quarterly meeting with UVA to encourage promotion of the resource. Discussions will include a stronger partnership with the AAP and other organizations and broader sharing of the resource at forums such as the AMCHP National Conference	Quarterly	CYSHCN Director, DCFH Director
Continue to communicate with partners to promote the modules	Ongoing	CYSHCN Director and UVA
Gather any evaluation data or feedback from UVA about the modules	By 6/30/2022	VDH & UVA
Tracking of people who complete the modules	By 6/30/2022	VDH & UVA

IDENTIFIED STATE PRIORITY	Strong systems of care for all children
STRATEGY 2:	Assure children with special healthcare needs receive coordinated, ongoing, comprehensive care within a medical home (CYSHCN National Standard: Medical Home).

As a unit, the CYSHCN Team will continue to require that all of its programs include work plan language regarding promoting the importance of a medical home to all families served. These requirements will continue to go beyond promotion and require that centers connect families to a medical home, if they do not have one. The CCC Program will continue to work directly with primary care and specialty care providers to provide care coordination services for families and help link them to services as needed. The Program will also continue to help obtain prior authorizations; explain health insurance/benefits to families/link families to sometimes hard to find durable medical equipment providers; and help to overcome any barriers that are making it difficult for the child with special needs to get services. The CDC program will continue to serve as a resource for providers and families to provide assessments of children suspected of having developmental or behavioral conditions. Upon diagnosis, the centers will share results with families and providers (as approved by parents) and will connect diagnosed CYSHCN to resources within their own community. In addition, Central Office staff will work with state Medicaid and Managed Care Organizations to address any reimbursement issues that may arise, as has occurred in previous years. The VBDP and Pediatric Comprehensive Sickle Cell Centers will continue to partner with medical homes to coordinate care in partnership with families.

Activity	Expected Completion Date	Responsible Staff
Partner with family-identified medical home to coordinate care for CYSHCN served through CCCs, CDC, SCPs, and Bleeding Disorders programs	Ongoing	CYSHCN Director, Blood Disorders Program Coordinator
Partner with family-identified medical home to coordinate entry into specialty care for newborns with positive hemoglobinopathy screening	Ongoing	Blood Disorders Program Coordinator
All CYSHCN programs will continue to promote medical home and help families find one if needed	Ongoing	CYSHCN Director, Blood Disorders Program Coordinator
Seek update from State/National AAP to see if they are still interested in promoting the fact sheet for pediatricians on the National Survey of Children's Health. The document focuses on medical home and the plan was to promote the fact sheet here in Virginia	By 6/30/2022	CYSHCN Director, Blood Disorders Program Coordinator, State/National AAP
CYSHCN Leadership will continue to work with state Medicaid on any issues that may be a barrier to care for the children served by the program	Ongoing	CYSHCN Director, DMAS, MCOs, CDCs

IDENTIFIED STATE PRIORITY	Strong systems of care for all children
STRATEGY 3:	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)*

The CYSHCN program in Virginia partners very closely with major medical centers across the state. Contractual partners include: Children's Hospital of the King's Daughters in the Tidewater Region, the University of Virginia Health System in the Blue Ridge region, Carilion Health System in the Roanoke/southwest region, INOVA Health System and Children's National Medical Center in the northern region, and Virginia Commonwealth University Health System in the central region. This partnership benefits families tremendously because they are able to receive the services they need through one "open door". For example, children with sickle cell disease often need care from several specialty providers such as nephrologists, neurologists, and radiologists. The health systems VDH partners with readily refer children to specialties within their own health system and services are generally offered on the same campus. This same benefit exists for CYSHCN served through the CCC, CDC, and bleeding disorder programs.

Two of the SCP sites implement satellite clinics in areas with geographic need for services in order to improve family access of care. They also address issues of family support, health insurance, and identify transportation barriers for patients getting to appointments and provide assistance in obtaining bus tickets, Medicaid cabs, gas vouchers, etc. The centers refer patients to the appropriate community-based organizations, such as the Sickle Cell Association program, Catholic Charities, food banks and other community resources. The centers encourage staff and patients to participate in events such as Camp Young Blood, sickle cell walks, holiday parties and a sickle cell ball. Activities will continue to be limited in the upcoming FY due to COVID-19, but the centers will adjust to still make sure that the patients and families have the needed resources.

The VBDP program manager works with the Virginia Hemophilia Foundation on education to families regarding ED/EMS, dental services, and education regarding schools. VBDP helps families fill out applications for children to participate in a summer camp. In addition, families continue to have access to Virginia Department of Education (DOE) consultants and social workers who often work at program sites and function as part of a comprehensive team that strives to meet the needs of CYSHCN. Services provided in this manner help ameliorate barriers and assure that providers work together to most effectively serve families.

COVID-19 has made CYSHCN program work very challenging at times. Many of the CCC program care coordinators work from home and this will likely continue into FFY 2022. The staff have adapted well as much of their work is remote (in general). One of the biggest strengths during this time has been the trusting relationship that care coordinators have with their clients. They often have been a comforting ear for parents who needed someone to listen to them even if the care coordinator may not be able to provide them with a solution to their problem. Center program directors meet more frequently with the CYSHCN Director so that he can offer any needed technical assistance.

The CDC program is starting to overcome some of the challenges it faced regarding having to shutter services due to COVID. Centers are mostly back to full operation but COVID has helped them to be more flexible regarding the provision of services. Telemedicine has emerged as a complement to traditional in person services. Some staff have expressed that observing children in their natural environment/home has made them easier to assess because it helps to get rid of the anxiety many children feel when in a strange environment such as a clinic. In order to continue to improve, the CYSHCN Director will continue to work with one of the center program leads to hold regular virtual meetings. These meetings have been useful in helping centers work through challenging issues with reimbursement and telemedicine.

Activity	Expected Completion Date	Responsible Staff
Conduct subrecipient monitoring to ensure partners meet required services levels for providing care coordination and other similar services	Ongoing	CYSHCN Director, Blood Disorders Program Coordinator
Maintain infrastructure for centralized data system (CCC-SUN) for use by statewide CCC staff to track and document case management and care coordination services, insurance type, pool of funds, and I&Rs	Ongoing	CYSHCN Director
Collaborate with CCC Directors to encourage staff to become and maintain certifications as case managers	Ongoing	CYSHCN Director
Convene center director/consultant meetings to provide technical assistance and troubleshoot issues. Staff will make annual site visits (when possible and after COVID restrictions are removed) and/or offer technical assistance via phone/email	Ongoing	CYSHCN Director, Blood Disorders Program Coordinator
CDC program will continue to provide assessments of children throughout the state of Virginia suspected of having developmental and/or behavioral conditions. Once diagnosed, the results will be shared with the medical home (with permission from the family) and children will be referred for services	Ongoing	CYSHCN Director, CDC Centers
CYSHCN Program will continue to promote telehealth and support the CDC centers as they provide services remotely. Regular calls will be held statewide with centers to encourage teamwork to overcome barriers and to deal with any other program issues	Ongoing	CDC Centers
Sickle Cell Centers will continue to offer satellite clinics as capacity allows, as well as telehealth services. These off-site clinics are in two regions of Virginia and telehealth services during the pandemic improve access to care for families.	Ongoing	Blood Disorders Program Coordinator, Sickle Cell Centers
Southwest Virginia CCC will continue to support onsite telehealth services for families in partnership with UVA	Ongoing	SWVA CCC Staff and UVA

IDENTIFIED STATE PRIORITY	Strong systems of care for all children
STRATEGY 4:	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)*

The CCC program will continue to use its program specific transition tool. This tool will be utilized to help families prepare their child with special needs to transition clinically, socially, educationally, and vocationally. All CYSHCN programs will be expected to support VDH in promoting the online transition modules to all of their partners and to families who receive services. The CDC program will continue to work with in-house Virginia Department of Education staff to refer older youth to their local school system for transition services when required (all youth served by this program are referred for clinical services as needed). The bleeding disorders program will continue to refer clients for adult services at VCU or within the client's own community.

The sickle cell program has been working on establishing an Adult Comprehensive Sickle Cell Network for the past 2 years. This process required a change in state law, the drafting of new regulations, and the allocation of state general funds. The program is a priority of the current Governor and the goal is to establish at least 4 regional centers in the Commonwealth.

Activity	Expected Completion Date	Responsible Staff
Through CCCs, facilitate transition from child to adult-oriented health care systems (e.g., transition planning tools, educational plans)	Ongoing	CYSHCN Director
Partner with Comprehensive Sickle Cell Centers to ensure that all transition-age patients complete the American Society of Hematology transition readiness assessment tool or a similar tool/process	Ongoing	Blood Disorders Program Coordinator
Partner with funded hemophilia treatment centers to ensure the transition process from pediatric to adult treatment centers (e.g., biannual transition calls between regional hemophilia treatment centers and the state's only comprehensive adult treatment center; development of transition plan of care)	Ongoing	Blood Disorders Program Coordinator
Encourage all CYSHCN programs to promote the transition and medical home community/family modules and provider modules	Ongoing	CYSHCN Director, Blood Disorders Program Coordinator, UVA Development Team
Complete the process of establishing and Adult Comprehensive Sickle Cell Network by executing contract with regional providers	Ongoing	Blood Disorders Program Coordinator

IDENTIFIED STATE PRIORITY	Finances as a root cause
STRATEGY	Collaborate with Medicaid to strengthen the relationship between Title V funded care coordinators and Medicaid-funded care coordinators. The goal is to fortify relationships (by region) to reduce barriers that families face and to ultimately improve their outcomes.

The CYSHCN programs will continue to help families struggling with insurance issues by connecting them to public and private options as needed. The CCC program reports that about 93% of CYSCHN served are insured and the CDC program reports that 99% are insured. As for the VBDP, 97% of patients have private or public insurance. The VBDP has a trained social worker who is very knowledgeable of health insurance options and works very closely with families to find the most cost effective insurance solutions that meet both family and client medical needs. One of the VBDP's most important partners in this process is Patient Services Incorporated (PSI). PSI will continue to provide insurance case management and premium assistance to help eligible families maintain insurance coverage.

The expansion of Medicaid continues to be popular in Virginia and has been received well. Program partners continue to support families as they seek to access insurance options. This is critical for all programs but it makes the most difference for young adults transitioning and for people of all ages who have hemophilia. Since implementation of Medicaid expansion, the CYSHCN program has already had a number of clients with hemophilia transition to Medicaid.

VDH will continue to manage a Pool of Funds (POF) for the CCC and VBDP. The POF is the payer of last resort, and helps families purchase needed medications when no other viable options are present, including insurance. The Hearing Aid Loan

Bank is located at one of the regional CCC centers and continues to provide gap-filling services to families of children with hearing loss.

VDH worked with DMAS (state Medicaid Agency) to coordinate a statewide (virtual) meeting about care coordination services provided by Title V funded care coordinators and Medicaid funded care coordinators. The meeting was a success as more than 300 people attended. The next step in this process is for the two agencies to work together to help care coordinators work more seamlessly by region. Our ultimate goal is to formalize partnerships by region so that staff can solve problems at their own level rather than having to reach out to VDH/DMAS central office for support.

Activity	Expected Completion Date	Responsible Staff
Through CYSHCN programs, conduct medical insurance benefits evaluation and coordination, to include identifying potential Medicaid-eligible families, providing assistance with applying, and providing ongoing education and support to access covered services	Ongoing	CYSHCN Director, Blood Disorders Program Coordinator
Work towards increased support from health systems to pay for care coordination services through the CCC program	Ongoing	CYSHCN Director
Administer a Care Connection for Children pool of funds for payment of direct medical care services for the uninsured and underinsured clients	Ongoing	CYSHCN Director
Administer a bleeding disorders pool of funds for payment of direct medical care services for the uninsured and underinsured clients	Ongoing	CYSHCN Director, Blood Disorders Program Coordinator
Manage an insurance case management contract (PSI) to help assure people with bleeding disorders have ongoing access to insurance	Ongoing	Blood Disorders Program Coordinator
Continue to encourage social work support at the VBDP and SCP centers across the state	Ongoing	Blood Disorders Program Coordinator
Hold several brainstorming meetings with DMAS staff regarding strengthening regional partnerships for care coordination for Medicaid recipients. During FY21, VDH/DMAS led a statewide meeting to describe our care coordination work and to encourage continued partnerships. We will help to facilitate these partnerships in FY22	By September 2022	CYSHCN Director, DMAS Staff
The Virginia Bleeding Disorders program will complete a needs assessment in partnership with Virginia Commonwealth University (VCU) to evaluate the extent to which the program serves its target population and is maximizing the funding based on changes in healthcare and treatment options. The needs assessment began in FY21 but is not complete	By June 2022	Blood Disorders Program Coordinator, VCU Staff
CYSHCN Director will fully implement new CCC and CDC work plan templates that include a focus on health equity	By October 2021	CYSHCN Director, CCC/CDC Staff
VDH will explore a regional meeting in the SWVA area to discuss issues related to developmental/behavioral follow-up services. The proposed meeting would focus on potential solutions to the problem. This is a holdover from FY21. COVID made it impossible to hold this meeting	By September 2022	CYSHCN Director, SWVA CDC Staff

Cross-Cutting/Systems Building

State Performance Measures

SPM 1 - Cross-Cutting (Early and Continuous Screening): Percent of infants who are diagnosed with a newborn screening disorder that are referred to care coordination services in the CYSHCN program

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	100	100
Numerator		436
Denominator		436
Data Source	VDH Newborn Screening Program, VDH EHDI	VDH Newborn Screening Program, VDH EHDI
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

SPM 2 - Cross-Cutting (Youth Leadership): Develop and sustain the Virginia Department of Health Youth Advisor Program

Measure Status:	Active

State Provided Data			
	2018	2019	2020
Annual Objective			0
Annual Indicator		Yes	Yes
Numerator			
Denominator			
Data Source		VDH Adolescent Health Program	VDH Adolescent Health Program
Data Source Year		2019	2020
Provisional or Final ?		Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

SPM 3 - MCH Workforce Development (Racial Equity): Develop and implement MCH workforce development policies addressing racial equity for all Title V program staff and subrecipient staff

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		No
Numerator		
Denominator		
Data Source		OFHS MCH Program Documentation
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

State Action Plan Table

State Action Plan Table (Virginia) - Cross-Cutting/Systems Building - Entry 1
Priority Need
Community, Family, & Youth Leadership: Provide dedicated space, technical assistance, and financial resources to advance community leadership in state and local maternal and child health initiatives.
SPM
SPM 2 - Cross-Cutting (Youth Leadership): Develop and sustain the Virginia Department of Health Youth Advisor Program
Objectives
By June 30, 2021, increase equity in VDH’s public health initiatives by incorporating youth voice into the development, planning and management of public health initiatives that impact young people.
Strategies
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

State Action Plan Table (Virginia) - Cross-Cutting/Systems Building - Entry 2

Priority Need

Racism: Explore and eliminate drivers of structural and institutional racism within OFHS programs, policies, and practices to improve maternal and child health.

SPM

SPM 3 - MCH Workforce Development (Racial Equity): Develop and implement MCH workforce development policies addressing racial equity for all Title V program staff and subrecipient staff

Objectives

By September 31, 2021, develop and implement MCH workforce development policies addressing racial equity for all Title V program staff and subrecipient staff.

Strategies

Engage in Healthy Beginnings with Title V: Advancing Anti-Racism in Preterm Birth prevention – Learning and Practice Cohort

Partner with Blue Ridge Health District in CityMatCH Alignment for Action Learning Collaborative

Support 35 local health districts in developing and maintaining equity-focused, data-driven workplans aligned with findings from the 2020 MCH Needs Assessment and local Community Health Assessments, to include (1) MCH equity considerations, (2) coordination with community-based organizations, (3) upstream/cross-sector strategic planning, and (4) coordination with broader systems of care for children.

Identify internal VDH partners to explore impact and define strategies across MCH population regarding Virginia’s 2021 marijuana legalization

State Action Plan Table (Virginia) - Cross-Cutting/Systems Building - Entry 3

Priority Need

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

SPM

SPM 1 - Cross-Cutting (Early and Continuous Screening): Percent of infants who are diagnosed with a newborn screening disorder that are referred to care coordination services in the CYSHCN program

Objectives

By June 30, 2020, increase the percentage of infants with confirmed newborn screening disorder that are referred to care coordination services, from 57% (2017) to 60%.

Strategies

Maintain the VaCARES Registry and expand capacity to document and track referrals of infants from the Newborn Screening Program to CYSHCN programs.

Partner with NYMAC (New York - Mid-Atlantic Regional Genetics Network) to assess and respond to state needs related to genetic services.

State Action Plan Table (Virginia) - Cross-Cutting/Systems Building - Entry 4

Priority Need

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

SPM

SPM 1 - Cross-Cutting (Early and Continuous Screening): Percent of infants who are diagnosed with a newborn screening disorder that are referred to care coordination services in the CYSHCN program

Objectives

By June 30, 2020, increase the percentage of infants with confirmed newborn screening disorder that are referred to care coordination services, from 57% (2017) to 60%.

Strategies

Maintain and expand family engagement on state NBS Advisory Committee.

Sustain Early Hearing Detection & Intervention Program, to include support for paid 1-3-6 Family Educators.

2016-2020: State Performance Measures

2016-2020: SPM 6 - Cross-cutting (Family Engagement): Implement and develop report on survey of families served by the VDH Care Connection for Children (CCC) programs

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			0	0
Annual Indicator		Yes	Yes	Yes
Numerator				
Denominator				
Data Source		VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program
Data Source Year		2018	2019	2020
Provisional or Final ?		Final	Final	Final

2016-2020: SPM 7 - Cross-Cutting (Early and Continual Screening): Percent of infants with confirmed newborn screening disorders who are enrolled in supportive services no later than 6 months of age

Measure Status:			**Active**
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			60
Annual Indicator			17.9
Numerator			78
Denominator			436
Data Source			VDH NBS
Data Source Year			2019
Provisional or Final ?			Final

CROSS-CUTTING/SYSTEMS BUILDING DOMAIN
SUMMARY/OVERVIEW
FY20 ANNUAL REPORT

2016-2020 MCH Priority Needs Addressed in this Domain
Early & Continuous Screening (Newborn Screening)
Family Engagement
Youth Engagement

NOTE: The FY20 Annual Report represents the final year of priorities, strategies and activities aligned with the 2016-2020 needs assessment and state action plan for the Women/Maternal Health Domain.

DOMAIN CONTRIBUTORS:
Newborn Screening Program– Division of Child and Family Health
Adolescent Health Program - Division of Child and Family Health
Children and Youth with Special Health Care Needs – Division of Child and Family Health

DOMAIN OVERVIEW

NEWBORN SCREENING PROGRAM: The Virginia Newborn Screening Program includes the Dried Blood Spot (DBS) Newborn Screening, Early Hearing Detection and Intervention (EHDI), and the Virginia Congenital Anomalies Reporting and Education System (VaCARES) Birth Defects Surveillance (BDS) programs. The Critical Congenital Heart Disease (CCHD) pulse oximetry screening program is under the BDS program. Special revenue funds from the Division of Consolidated Laboratory Services (DCLS) sustain the DBS program. Other programs receive CDC and HRSA funding. Title V funds provide partial salary and special project support.

ADOLESCENT HEALTH PROGRAM: The goal of VDH's Adolescent Health Program is to empower youth with the information, resources and access they need to make informed decisions about their health.

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS: CYSHCN Program promotes the optimal health and development of individuals living in the Commonwealth with special health care needs by working in partnership with families, service providers, and communities.

STATE ACTION PLAN UPDATES

IDENTIFIED STATE PRIORITY	Early and Continuous Screening: Support optimal physical, mental health and social emotional development for all children
STRATEGY	Coordinate and partner with Virginia's Part C program to ensure timely referral of newborns and infants into EI services Coordinate and partner with external stakeholders to increase the percentage of birthing facilities that report CCHD information into the current information system (IS) from 65% (2018 baseline) to 75% by September 2020 Partner with internal agency teams to identify needs, gaps and future direction of the current birth defects surveillance system
OBJECTIVE	By June 30, 2020, increase the percentage of infants with confirmed hearing loss who are enrolled in the Early Intervention (EI) services by six months of age, from 57% (2017) to 60%
PERFORMANCE MEASURE	SPM 7 – Cross cutting (early and continual screening): Percent of infants with confirmed newborn screening disorders who are enrolled in supportive services no later than 6 months of age

2016-2020 SUMMARY				
Data Source: VDH Newborn Screening Program, VDH EHDI				
2016	**2017**	**2018**	**2019**	**2020**
				17.9%
GOAL FOR 2021-2025 SAP:	By June 30, 2025, increase the percentage of infants with confirmed newborn screening disorder that are referred to care coordination services, from 85% (2019) to 95%. (2021-2025) SPM 1 - Cross-Cutting (Early and Continuous Screening): Percent of infants who are diagnosed with a newborn screening disorder that are referred to care coordination services in the CYSHCN program.			

Newborn Screening Program:

The Code of Virginia mandates that all Virginia infants are screened for thirty-three disorders tested through dried blood spot (DBS) screening, Critical Congenital Heart Disease (CCHD) and hearing loss within 24-48 hours of birth and/or before discharge from the hospital. The Virginia Newborn Screening Program consists of DBS newborn screening, the Early Hearing Detection and Intervention (EHDI) and CCHD follow-up teams. The DBS and EHDI teams track and follow-up on all out-of-range results, facilitates access to specialty services for further testing and confirmation of diagnosis, and infants that are diagnosed with a newborn screening disorder are referred to CYSHCN's Care Connection for Children Centers (CCC) for care coordination services. EHDI also refers diagnosed infants to Early Intervention (EI) and maintains contracts with multiple institutions to assure family-to-family support and a hearing aid loan bank. The DBS program maintains contracts with four regional medical centers to assure timely diagnosis and treatment of infants who screen positive for a dried blood spot genetic disorder. The CCHD team primarily confirms diagnosis reported from hospital facilities, refers diagnosed infants to CCC programs and performs QA/QI by analyzing CCHD data to assure that reporting is consistent, accurate and complete.

Per the Code of Virginia, all infants born in Virginia are to be screened for thirty-one errors of metabolism, critical congenital heart disease (CCHD) and hearing loss. Virginia's newborn screening (NBS) programs, as well as its Birth Defects Surveillance Program, are housed under the Division of Child and Family Health (DCFH) and managed by Christen Crews, MSN, RN. Each program has a team that utilizes specific, evidence-based approaches to education, tracking of screening results, follow-up, facilitating access to diagnostic and specialty services and referring to supportive services, post

diagnosis. The CCHD program falls under the BDS program. The VDH Newborn Dried Blood Spot Screening (NBS DBS) Follow-Up Program and the Department of General Services (DGS) Division of Consolidated Laboratory Services (DCLS) work in close collaboration to maintain the operations of Virginia's NBS-DBS program. This program is solely funded through fee-for-service enterprise funding. Fees are collected by DCLS from birthing hospitals and certain medical providers who perform the collection of DBS specimens. The current fee is $138/infant as of October 1, 2019. Fees are evaluated periodically and typically increased when new disorders are added to the panel in order to cover the cost of supplies, equipment, staffing and management of obtaining confirmatory diagnostic services, etc. VDH receives approximately $1.7 million annually from the enterprise fund via DCLS to conduct follow-up activities. The funding supports the DBS team who are VDH employees and co-locate at VDH and DCLS. The team consists of a program supervisor, 4.5 public health nurses and two administrative staff who follow over 15,000 infants who have abnormal or critical screen results. Funding also supports contractual genetic services for four regional medical centers to assist in the follow-up of infants who screen abnormal for metabolic disorders. These centers provide healthcare provider consultation, diagnostic work-up of infants and treatment services once diagnosed. Approximately 150 infants in the Commonwealth are diagnosed with a core NBS-DBS disorder every year and then referred to CYSHCN care coordination programs for further support.

Two new disorders, Spinal Muscular Atrophy (SMA) and X-linked Adrenoleukodystrophy (X-ALD) are currently going through the regulatory process to be added to Virginia's core newborn screening panel. Screening is expected to start in late 2021. Additionally, the implementation of hearing targeted congenital Cytomegalovirus (cCMV) screening in September 2021 has been successful and education for best practices continues by EHDI staff. Any infant who fails the final hearing screen at birth should be screened for cCMV before hospital discharge. An infant who has been identified with cCMV to is referred to the CYSHCN CCC for care coordination services as well as provides a referral network for Regional Infectious disease specialist and Otolaryngologists to Primary Care Providers.

Dried Blood Spot Newborn Screening (DBS)

- Expanded REDCap pilot of electronically reporting presumptive positive DBS disorder results and receiving timely follow-up to the following referral centers: Genetics, Cystic Fibrosis, and Hemoglobinopathies.
- Initiated pilot of reporting presumptive positive DBS disorder results and receiving timely follow-up to several high volume neonatal intensive care units (NICU) around the state.
- Presented nationally on benefits of co-location between the newborn screening DBS and follow-up nursing staff
- Convened bi-annual advisory committee meetings to review current status of DBS in Virginia and QA/QI projects
- Coordinated series of workgroup meetings including experts, research, and family participation and engagement due to legislative mandate to review recommendation of adding Krabbe disease to the core Virginia NBS panel
- Began preparations for implementation of two new disorders, Spinal Muscular Atrophy (SMA) and X-linked Adrenoleukodystrophy (X-ALD). These two disorders were recommended to be added by the DBS advisory board in December 2019 and presented to the Board of Health in June 2020. The regulatory process for initiating screening is still in process.
- Continued to operate 7 days a week, 365 days a year during COVID-19 pandemic

Early Hearing Detection and Intervention Program (EHDI)

- Regionally based 1-3-6 family educators continue to provide education and support via a contract with the Center for Family Involvement at Virginia Commonwealth University. In Calendar Year 2019, Family-to- Family support was provided to 42 parents who requested support following diagnosis.
- In September 2019, Virginia EHDI exhibited at the national Hands and Voices Conference. The focus was to relay to parents and other state organizations tools for effective family support and parent/ professional communication throughout the entire EHDI process.
- In October 2019, Virginia EHDI presented to audiologists at the JMU Ruth Symposium. The meeting focused on identification and reporting for children diagnosed with hearing impairment to ensure timely follow-up and referrals.
- In January 2020, Virginia EHDI held the Holding Space meeting for parents and professionals. This was a two-day session to share the importance of effective parent/ professional communication during the EHDI process and the sensitivity in relaying the diagnosis of hearing loss to families.

- Throughout FY 2019, VA EHDI provided support to 6 regional learning community networks to ensure support in hosting meetings in each community to address regional concerns and barriers to providing timely services and referrals and ensuring early identification of children with hearing impairment.
- In June 2020, Virginia EHDI began planning for hearing targeted congenital Cytomegalovirus (cCMV) screening implementation in Virginia. Three cCMV trainings were developed and EHDI hosted live training sessions for hospitals in June-August 2020: https://www.vdh.virginia.gov/early-hearing-detection-and-intervention/training/
- In preparation for implementation of cCMV, trainings were developed and hosted live sessions for hospitals in June-August 2020: https://www.vdh.virginia.gov/early-hearing-detection-and-intervention/training/
- As of September 1, 2020, Virginia implemented hearing targeted congenital Cytomegalovirus (cCMV) screening. Any infant who fails the final hearing screen at birth should be screened for cCMV before hospital discharge. An infant who has been identified with cCMV to is referred to the CYSHCN CCC for care coordination services as well as provides a referral network for Regional Infectious disease specialist and Otolaryngologists to Primary Care Providers.

Birth Defects Surveillance Program

- Completed Zika BDS project and reporting to CDC in October 2019; Zika BDS data contributed to publications and presentations
- Completed Zika Pregnancy Registry follow-up and reporting to CDC in January 2020
- A dedicated BDS Program Supervisor was hired in August 2020 to further establish the program with a mission to enhance Virginia's surveillance efforts and capacity to verify birth defects reported into VaCARES, respond to changing birth defects surveillance needs, and refer infants to CYSHCN programs.
- Initiated VaCARES/BDS program evaluation with VDH Policy Evaluator in September 2020
- Attended Care Connection for Children conference VA in October 2019, National Birth Defects Prevention Network (NBDPN) conference in March 2020, and Society for Birth Defects Research and Prevention (BDRP) virtual meeting in June-July 2020; participated in quarterly NBDPN BDS Program Managers meetings

Critical Congenital Heart Disease (CCHD) Screening

- CCHD NBS Coordinator position recruited in October 2019 (separated from service March 2020)
- Confirmed CCHD diagnosis reported into the Virginia Congenital Anomalies Reporting and Education System (VaCARES) and referred infants to Care Connection for Children (CCC)
- Entered data for confirmed cases into the Newborn Screening Technical assistance and Evaluation Program (NewSTEPs) data repository
- Developed CCHD NBS program policies and procedures
- Reviewed VDH CCHD NBS educational content, including NBS Education website training modules, to prepare for potential American Academy of Pediatrics (AAP) endorsement of updated recommendations for CCHD pulse oximetry screening (POS)
- Participated in quarterly NewSTEPS CCHD Data Response Team meetings and NewSTEPs office hours, met with other states to discuss Virginia's CCHD program (Louisiana in August), attended webinars and meetings to stay current with updates to AAP endorsement process

CONSUMER FAMILY ENGAGEMENT/PARTNERSHIP WITHIN NBS

Dried Blood Spot Newborn Screening (DBS)

- The Virginia DBS program worked with several external stakeholders including:
    - Bi-annual meetings with the Advisory Board
    - Collaboration with the Association of Public Health Laboratories (APHL) and other states DBS programs to improve quality assurance, share lessons learned, and identify needs and challenges during the COVID-19 Pandemic.
    - Formation of X-ALD and SMA workgroups to work on implementation of these two new disorders moving through the regulatory process
- The Virginia DBS program worked with several internal stakeholders including:
    - Division of Consolidated Laboratory Services (DCLS) to perform DBS newborn screen testing 7 days a

week, 365 days a year, and prepare for implementation of X-ALD and SMA
    - Referral of all infants with a confirmed core panel DBS newborn screening disorder to CYSHCN's CCC for care coordination
    - Virginia Immunization Program for locating infants for timely newborn screening follow-up
    - Other NBS programs to share contacts and resources

Early Hearing Detection and Intervention Program (EHDI)

- The Virginia EHDI program worked with several external stakeholders including:
    - Quarterly meetings with the Advisory Board
    - Collaboration with the Virginia Hearing Aid Loan bank to provide loaner hearing aids to children diagnosed with hearing impairment in Virginia
    - The Center for Family Involvement at VCU to provide family support to parents requesting support after diagnosis
    - Virginia Head Start Program- to perform hearing screening in early school aged children.
- Internal Stakeholders/Partners:
    - cCMV workgroup- developed in March 2019 to develop planning for implementation of screening. Met with the workgroup throughout FY 2019 to develop legislation and protocols for implementation of cCMV screening in Virginia.
    - DCLS- collaborated with DCLS in preparation for implementation on cCMV screening. Merging of electronic databases to develop method of electronic communication of cCMV orders and results with VA EHDI database VISITS with DCLS database LIMS.
    - Regional Learning Communities (6)- worked with each learning community co leaders (parent and professional) to continue to host meetings every 6-8 weeks and assisted with development of agenda topics and meeting logistics.
- Family Engagement:
    - Regionally based 1-3-6 family educators continue to provide education and support via a contract with the Center for Family Involvement at Virginia Commonwealth University. In Calendar Year 2019, family-to- family support was provided to 42 parents.

IDENTIFIED STATE PRIORITY	Family Engagement: Foster a culture of family/youth engagement and leadership
STRATEGY	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.
OBJECTIVE	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.
PERFORMANCE MEASURE	SPM 7 – Cross cutting (early and continual screening): Percent of infants with confirmed newborn screening disorders who are enrolled in supportive services no later than 6 months of age

2016-2020 SUMMARY				
Data Source: VDH Newborn Screening Program, VDH EHDI				
2016	2017	2018	2019	2020
				17.9%
GOAL FOR 2021-2025 SAP:	By June 30, 2025, increase the percentage of infants with confirmed newborn screening disorder that are referred to care coordination services, from 85% (2019) to 95%. (2021-2025) SPM 1 - Cross-Cutting (Early and Continuous Screening): Percent of infants who are diagnosed with a newborn screening disorder that are referred to care coordination services in the CYSHCN program.			

Care Connection for Children (CCC) continued to employ parent coordinators as staff at two of our six centers. Another center has a contract with a parent organization to offer family support and the fourth center employees a resource coordinator who fills this role. Vacancies exist at the other two centers. Most of our employed staff have a child with a special health care need so they understand the unique challenges families face. In addition to providing general support to families, staff across the Commonwealth work to: Maintain center resource lists; Create newsletters; Lead educational activities and trainings and work closely with families on overcoming barriers to care.

Another one of our core programs, the Child Development Clinics (CDCs) continued to engage families. The CDCs provide assessments of children suspected of having developmental and/or behavior conditions. Families are an active part of the assessments and they receive documentation regarding diagnoses. In addition, center staff members refer them to clinical and non-clinical resources for assistance and share the results of their assessments with other providers serving the family (with permission from parents).

The VBDP continued to educate families on home therapy management for those who infuse at home and the SCP centers offered genetic counseling to aide in future reproductive decision making. The regional centers generally provide events for families, including social gatherings and overnight camps with educational and group activities focusing on transition and self-advocacy. However, this was not possible this year due to COVID. Social workers continued to send out pertinent information to families as topics arise pertaining to medical advances in SCD. Families with newborns diagnosed with SCD were given a copy of *Hope and Destiny: A Patient's and Parent's Guide to Sickle Cell Anemia* and patients entering the transition phase were given a copy of *Hope and Destiny Jr* (as funding allows).

Activities for Strategy	Expected Completion Date	Responsible Staff
Maintain paid parent coordinators at each CCC center to provide support and resources to families served	Ongoing	CYSHCN Director
Assure CYSHCN centers identify and address family barriers, priorities, and concerns (EG sickle cell psychosocial assessments) while promoting family engagement in decision making at all levels of care planning and management (EG IEP/504 plans, home management of bleeding disorders)	Ongoing	CYSHCN Director, Blood Disorders Program Coordinator
Solicit, document, and respond to family feedback on satisfaction with services (eg, bleeding disorders family satisfaction survey every over year, CCC parent survey every 5 years)	Ongoing	CYSHCN Director, Blood Disorders Program Coordinator
Empower and equip populations impacted by sickle cell and bleeding disorders to manage complexities of disease through various community support and education activities/programs (eg youth transition camp, faith-based outreach)	Ongoing	Blood Disorders Program Coordinator

IDENTIFIED STATE PRIORITY	Family Engagement: Foster a culture of family/youth engagement and leadership
STRATEGY	Hire two part-time Youth Advisors to provide expertise, guidance and feedback on current and future public health initiatives Fund regional Youth Advisory Councils to implement public health initiatives within their communities Engage youth and families in program development and outreach for medical home and transition (Standard: Got Transition's Six Core Elements of Health Care Transition – Transition Completion and Youth and Family Engagement)
OBJECTIVE	By June 30, 2020, amplify youth voice in Virginia's public health initiatives by hiring two Youth Advisors and funding regional youth advisory councils
PERFORMANCE MEASURE	SPM 2: Cross-cutting (youth leadership): Develop and sustain the Virginia Department of Health Youth Advisor Program

2016-2020 SUMMARY				
Data Source:				
2016	**2017**	**2018**	**2019**	**2020**
			Yes	Yes
GOAL FOR 2021-2025 SAP:		SPM 2: Cross-cutting (youth leadership): Develop and sustain the Virginia Department of Health Youth Advisor Program		

VDH's Adolescent Health Program has most notably built family/consumer partnerships through the hiring of two Youth Advisors in March of 2021. Youth Advisors are part-time VDH employees that provide input and leadership on public health initiatives in Virginia that impact young people. VDH employees fill out a project request form, and Youth Advisors then complete the deliverables outlined in the project request. So far, Youth Advisors have contributed to the tailoring of public health materials for young people, created public health outreach content, participated on panels evaluating grantee applications, advised the planning of Virginia's State Health Assessment, and provided input on survey content and dissemination. Upcoming projects include convening young people from throughout Virginia to create VDH's first ever Youth Advisory Council, which will allow a larger, more diverse group of youth to provide leadership and input on VDH's adolescent health initiatives.

PROGRAM LOGOS AND BRANDING

VDH's Youth Advisors designed logos for the VDH Youth Advisor TikTok and Instagram accounts. Youth Advisors will use these accounts to advertise Youth Advisory Council meetings and share public health information with young people throughout the Commonwealth. Screenshots of the logos that Youth Advisors designed are below:


ADOLESCENT HEALTH
VDH
YOUTH ADVISORS


YOUTH
ADVISORY COUNCIL

CROSS-CUTTING/SYSTEMS BUILDING DOMAIN
SUMMARY/OVERVIEW
FY22 APPLICATION YEAR

2021-2025 MCH Priority Needs Addressed in this Domain
Racism as a root cause
Upstream/cross-sector strategic planning

IDENTIFIED NPMs/SPMs FOR STATE ACTION PLAN 2021-2025	
SPM 1 Cross Cutting – Early and continuous screening	Early identification of developmental disorders is critical. The newborn screening and birth defects surveillance program seek to maintain the VaCARES Registry and expand capacity to document and track referrals of infants from the Newborn Screening Program to CSHCN program
SPM 2 Cross Cutting – Youth Leadership	Through the development of a Youth Advisor Program, the Adolescent Health Program seeks to increase equity in VDH's public health initiatives by incorporating youth voice into the development, planning, and management of public health initiatives that impact young people
SPM 3 MCH Workforce development	VDH MCH Program will develop and implement MCH workforce development policies addressing racial equity for all Title V program staff and subrecipient staff
SPM 5 Cross Cutting – Family Leadership	VDH MCH Program seeks to maintain and expand family engagement ot assure families of children with special health care needs partner in decision making at all levels and are satisfied with the services they receive

During FY22, the following programmatic strategies and activities have been identified as methods to advance and improve outcomes.

IDENTIFIED STATE PRIORITY	Racism as a root cause
MCH Workforce Development	
FY22 STRATEGIES:	• Engage in Healthy Beginnings with Title V: Advancing Anti-Racism in Preterm Birth prevention – Learning and Practice Cohort • Partner with Blue Ridge Health District in CityMatCH Alignment for Action Learning Collaborative • Support 35 local health districts in developing and maintaining equity-focused, data-driven work plans • Identify internal VDH partners to explore impact and define strategies across MCH population regarding Virginia's 2021 marijuana legalization

Strategy: Engage in Healthy Beginnings with Title V: Advancing Anti-Racism in Preterm Birth prevention – Learning and Practice Cohort

Urban Baby Beginnings (a leading community-based organization providing supportive services for pregnant and parenting families across the state), in partnership with Virginia's Title V program, was one of six applicants selected for AMCHP's initiative entitled: Healthy Beginnings with Title V: Advancing Anti-Racism in Preterm Birth Prevention. This learning and practice cohort which began in July 2021, will span 18 months, identifying and addressing racism in policy, data and funding structures at the state level that sustain inequities in perinatal health, including preterm birth, in Black, Latine/x, Indigenous, Asian, Pacific Islander, and other communities of color. VDH participation in the cohort includes: MCH/Title V Director, DCFH Director, Epidemiology Director, Early Childhood Health Unit Supervisor/MIECHV Project Director, and State Resource Mothers Program Coordinator.

Strategy: Partner with Blue Ridge Health District in CityMatCH Alignment for Action Learning Collaborative

The purpose of this project is to better align state- and local-level MCH work. Virginia's Title V leadership is providing consultation and partnering with the Blue Ridge Health District to assist in their plan of providing opportunities for anti-racism and implicit bias training for OB-GYN, Family Medicine and Pediatric providers as well as to facilitate maternal child health career paths for persons of color.

Strategy: Support 35 local health districts in developing and maintaining equity-focused, data-driven work plans

In FY22**,** MCH/Title V Director, along with Maternal and Infant Health Coordinator, will conduct extensive review of LDH work plans, identifying areas of process improvement, policy alignment and technical assistance needs regarding health equity.

Strategy: Identify internal VDH partners to explore impact and define strategies across MCH population regarding Virginia's 2021 marijuana legalization

With Virginia's legalization of marijuana beginning July 1, 2021, MCH/Title V Director will engage with internal VDH Partners (Office of Health Equity, Office of Health Prevention and Promotion) to explore and define programmatic needs and impact to the MCH population.

IDENTIFIED STATE PRIORITY	Upstream/cross-sector strategic planning
Cross Cutting – Early and Continuous Screening	
FY22 STRATEGIES:	• Maintain the VaCARES Registry and expand capacity to document and track referrals of infants from the Newborn Screening Program to CYSHCN programs. • Partner with NYMAC (New York - Mid-Atlantic Regional Genetics Network) to assess and respond to state needs related to genetic services.

Strategy: Maintain the VaCARES Registry and expand capacity to document and track referrals of infants from the Newborn Screening Program to CYSHCN program.

In FY22, state newborn screening information will continue to be delivered to providers and parents in a timely fashion with documentation made regarding arrangements made for necessary follow-up services. If indicated, the need for repeat screening and follow-up will be communicated to the providers by hospital or state program.

Virginia's Birth Defect Surveillance (BDS) program is in the process of being revamped with increased active as opposed to historical passive surveillance. Due to the recent hire of the BDS Program Coordinator, and the implementation of certain information system enhancements, VDH will be well equipped to respond and expand documentation to emerging infections

or conditions, such as Neonatal Abstinence Syndrome (NAS). Title V funding has historically only funded the maintenance of the reporting system, VaCARES, and additional funding now supports critical staff positions to maintain, evaluate, plan and grow the program. Title V funding is supporting a Birth Defects Program Coordinator, who was hired in July 2020, and a contracted position to maintain the CCHD NBS program. CCHD NBS is considered a point-of-care test done at the bedside before discharge of the infant. If an infant fails its CCHD screening, immediate action is routinely taken before the infant's discharge and well before it is reported to VDH. For that reason the Virginia CCHD NBS program centers its activities on confirmation of diagnosis, quality assurance and referral to services, which is more in alignment with current birth defect surveillance activities and thus moved to that team in 2019. Future programmatic activities include the goals of creating the ability to expand CCHD-NBS activities beyond case confirmation and referral, but to include quality assurance, technical assistance, and educational outreach.

Ongoing Activities by NBS to advance and improve outcomes::

- Provide staff support to the newly established Rare Disease Council (RDC)
- Review BDS and CCHD NBS data requests and provide data to support approved projects
- Develop program work plan from VaCARES and BDS program evaluation logic model
- Participate in BDS conferences, trainings, and workgroups to support BDS programs on a national level
- Support the RDC Coordinator to help ensure completion of required RDC activities
- Implement select activities from program work plan developed from VaCARES and BDS program evaluation
- Identify and apply for appropriate funding sources to support BDS program activities
- Update BDS program processes to respond to potential emerging threats and to address changing national guidelines for BDS
- Review and update program educational content, as needed, including program webpages

CCHD

Ongoing:

- Perform core CCHD follow-up activities, including confirming CCHD diagnosis, referring infants to CCC, and reporting data into NewSTEPs
- Participate in NewSTEPs meetings, trainings, and workgroups to support CCHD NBS programs on a national level
- Program recruited for CCHD NBS Coordinator contractor position in May 2021 but did not identify a suitable candidate. Work with contracting agency to recruit for CCHD NBS Coordinator position and identify an appropriate candidate by the end of the reporting period
- Establish process to identify birthing facilities with gaps in reporting CCHD NBS data; Create an outreach and education plan; Initiate quarterly QA/QI analysis of CCHD NBS program data
- Review CCHD NBS regulations for potential updates and develop program work plan
- Identify and apply for appropriate funding sources to support CCHD NBS program activities (ex. providing assistance to help midwives access POS equipment)
- Update program processes and educational content as needed to reflect national guidelines and AAP endorsements
- Determine if half-time contractor support is sufficient to meet CCHD NBS program activities

Strategy: Partner with NYMAC (New York - Mid-Atlantic Regional Genetics Network) to assess and respond to state needs related to genetic services.

NYMAC has partnered with Virginia to establish a workgroup focusing on issues that prevent families from having access to genetic services. There is strong interest in having Title V involved in all of our state teams. A team of stakeholders has been created with to review priorities and needs in Virginia. The project has monthly team calls to discuss progress and next steps. The current project being evaluated is to consider a training module for a "Genetics Navigator" and outreach to underserved communities to engage more interest in Genetics. The NBS Program Manager and Title V state representative serve as team co-leads. The Title V and CYSHCN Directors serve on the state team.

IDENTIFIED STATE PRIORITY	Upstream/cross-sector strategic planning
Youth Leadership	
FY22 STRATEGIES:	• Expand Youth Advisor role, providing expertise, guidance and feedback on current and future initiatives across all MCH populations • Fund, develop and establish regional Youth Advisory Councils

In March of 2021, VDH hired its first Youth Advisors. Youth Advisors are young people who provide their leadership and expertise on public health initiatives that impact adolescents in the Commonwealth. Keerthi Dasoju and Avani Hariprashad are part-time paid employees, and both are undergraduates at a local university. Their leadership in FY21 was invaluable to increasing the effectiveness of MCH programs in FY21, and VDH plans to build on this work going into FY22.

In FY21, Youth Advisors created a project request form that allowed any employee at VDH to request their support on an adolescent health project. Through this project request process, Keerthi and Avani have provided input on Virginia's State Health Assessment; created materials to communicate important public health information to young people; provided feedback on public health materials, contributed to survey creation and distribution plans, reviewed grantee applications during a request for proposal process, and advised a local organization on how to effectively train youth to encourage COVID-19 vaccination among their peers. In FY22, Youth Advisors will continue to advertise their expertise to VDH employees and field project requests in this format.

In FY21, VDH's Youth Advisors began planning for Virginia's first ever statewide public health Youth Advisory Council. This council will meet virtually, and will include high school students from throughout the Commonwealth. Keerthi and Avani have created VDH Youth Advisor TikTok and Instagram accounts in order to advertise these meetings, and plan to begin convening this group in early September. The goal of the Youth Advisory Council is to involve young people throughout Virginia in public health initiatives; through these meetings, Keerthi and Avani will solicit feedback about VDH's public health initiatives and materials, help to better understand the public health challenges that young people think are most urgent, and provide small grants for young people to design and implement public health solutions in their schools and communities.

IDENTIFIED STATE PRIORITY	Upstream/cross-sector strategic planning
Family Leadership	
FY22 STRATEGIES:	• Maintain and expand family engagement on state NBS Advisory Committee • Sustain Early Hearing Detection & Intervention Program to include support for paid 1-3-6 Family Educators

Strategy: Maintain and expand family engagement on state NBS Advisory Committee

The voting membership of the Virginia Newborn Screening Advisory Committee consists of multiple stakeholders representing all aspects of the newborn screening system, including affected family and parent representatives. This body meets bi-annually to provide consultation to the program and when needed, workgroups are convened to review disorders requested to be on the Virginia DBS NBS panel. Starting January 1, 2019, the program implemented screening for two new disorders, Pompe and Mucopolysaccharidosis Type I (MPS I), and expanded its operations to seven days/week. Currently, the regulatory review and program planning is underway to implement screening capability for two additional disorders, Spinal Muscular Atrophy (SMA) and X-linked adrenoleukodystrophy (X-ALD). Consumer/Family Engagement & Partnership

occurs on a daily basis, the follow-up nurses engage independently with parents who call with questions and concerns.

The program is currently adding to the body of knowledge and collaborating with Children's National Medical Center (CNMC) on a study with the goal to learn more about the experiences of parents after they receive their child's newborn screening result. The study is being led by a study team at CNMC and it is anticipated that 1,500 people from multiple states will take part. The study is providing quantitative data on the emotional impact of a false positive newborn screen on the family unit. The NBS Program Manager also participates on the Genetics Alliance Family Training and Education Workgroup and informs educational initiatives. The VDH NBS-DBS program has also entered into an agreement to become a "Community Outreach Partner" for their Newborn Screening Family Education Program. Genetic Alliance's Expecting Health program is building a network to support the dissemination of Navigate Newborn Screening, a free online newborn screening educational module for families to learn vital knowledge and skills to participate in the newborn screening system.

Strategy: Sustain Early Hearing Detection & Intervention Program, to include support for paid 1-3-6 Family Educators

The Virginia Early Hearing Detection and Intervention (EHDI) Program provides technical assistance and follow-up for hearing loss newborn screening services. The Virginia EHDI Program budget totals approximately $750,000 and is funded through a variety of federal grantors: HRSA EHDI, CDC EHDI and HRSA Title V. The funding supports the VDH EHDI team which consists of a program supervisor, two full-time follow-up specialists, 2 wage staff and fifty percent of an epidemiologist to support programmatic data needs. Funding also supports contractual services with VDH Office of Information Management for IS support, Virginia Commonwealth University's (VCU) Center for Family Involvement (CFI) and the University of Virginia's (UVA) Hearing Aid Loan Bank (HALB). Program activities focus on meeting the overall goal of developing and maintaining a comprehensive and well coordinated system of care that promotes early diagnosis and early entry into supportive family services.

A long-standing goal of the program has been to increase family and health care provider engagement and leadership within the EHDI system. A major component of the HRSA EHDI grant was to increase family engagement throughout the 1-3-6 process. The Virginia EHDI Advisory Committee's voting membership is now made of up of 25% parents and the co-chair is a parent of a child who is deaf/hard of hearing. The Virginia EHDI program has also coordinated and hosted many initiatives and events to engage families and healthcare providers together. Along with outreach to many conferences and support group events, these include funding for regional 1-3-6 family educators and the implementation of six regional learning communities, which eventually transfer to parent lead communities, and the funding and hosting of a trauma informed care conference and the nationally recognized The Care Project retreat (http://www.thecareproject.com/retreats/). Out of the EHDI Learning Communities came a Shared Plan of Care (SpoC) specifically for families and their primary professional support systems. Guides/checklists have been created for families, providers, audiologists and Early Interventionists to assist them in their specific key roles and functions as it pertains to the navigation of services to a newly diagnosed infant in their first year of life.

The EHDI program successfully implemented, in collaboration with DCLS, screening for targeted congenital cytomegalovirus (cCMV) in newborns who fail their newborn hearing screening. A total of $198,000 was included in the state general fund budget for FY20 to initiate the cCMV program at the state level. First year funds will be utilized to hire a wage staff resource and make enhancements to the EHDI-IS. Funding in subsequent state fiscal years will only support staff resources. Another major focus of the Virginia EHDI Program is assuring infants diagnosed with any type of hearing loss are entered into the Early Intervention system in a timely manner and based on 1-3-6 national EHDI guidelines. The Virginia Department of Behavioral Health and Developmental Services (DBHDS) is the leady agency for Part C in Virginia. Historical analysis of EHDI data reflects that mothers reporting less than a high school education or GED, mothers less than 20 years of age, African Americans and families in the Blue Ridge and Southwest regions of the state are less likely to enroll in EI services. Since an automated referral system was added to the EHDI-IS, the system has proven to ensure that all diagnosed children are referred to EI on a timely basis, but reporting of enrollment has declined due to factors such as FERPA requirements that DBHDS adheres to, lack of knowledge of reporting capabilities, and lack of knowledge and

socioeconomic factors of families. A data sharing agreement is being developed to better enhance the full impact of these referrals.

The Virginia EHDI Program continues to partner with multiple stakeholders and spearhead efforts to educate and promote appropriate resources for families affected by a diagnosis of hearing loss, including VCU CFI 1-3-6 Family Educators, the Virginia chapter of Hands and Voices, and six regional Learning Communities. A collaborative effort with DBHDS will improve data sharing, ensure compliance with national guidelines and improve the quality of enrollment information reported to VDH. VDH contracts with VCU CFI to implement the 1-3-6 Family Educators Program and assist in the start-up and maintenance of six regional learning communities throughout the Commonwealth.

III.F. Public Input

Virginia's MCH Needs Assessment is conducted every five years to identify pressing health concerns and shifts in program/workforce capacity. This needs assessment, paired with continuous input received from families, programmatic partners, and other stakeholders, informs the state's Title V MCH Action Plan.

Ongoing Stakeholder Input

Title V staff have the opportunity to partner with a large body of stakeholders through various coalitions, advisory boards, and special projects. Informal stakeholder feedback is regularly requested as part of day-to-day program operations to ensure the state's Title V MCH Action Plan remains relevant to current needs of MCH populations. This feedback is taken into account during program planning and is reflected in annual updates to the state action plan.

Annual Formal Public Comment: Virtual 'Town Hall' and Virginia Register of Regulations

Annually, VDH makes the Title V Application/Report available for formal public comment via Virginia's "Town Hall" virtual platform.

The site is a source of information about proposed changes to state regulations and includes a calendar of key meetings and board minutes. The site also facilitates solicitation of public input through online comment forums and an email notification service.

The "Town Hall" platform is maintained by the Virginia Department of Planning & Budget and is available at: https://townhall.virginia.gov/index.cfm.

An announcement of the availability of the Title V Application/Report for public comment is also published within the "General Notices" section of the Virginia Register of Regulations.

Formal public comments are typically solicited after the state's annual federal grant review and before the federal deadline for edits to the state's Title V submission.

Historically, few formal public comments have been received. No formal comments on last year's FY20 Application / FY18 Annual Report were logged.

Annual Public Input Survey

An annual public input survey is distributed to supplement responses to formal public comment solicitations. The survey was first piloted in 2017 (for the FY18 Application / FY16 Annual Report). It generated over 80 responses, greatly exceeding prior responses to public calls for input.

The survey is administered as follows:

- The draft application/report are posted on the VDH Title V website with a link to the survey. The public is asked to review the draft and then complete the survey.
- To recruit respondents, the survey details are emailed directly from program staff to a wide range of state and local partners. The state family representative (Dana Yarbrough) is also emails survey details directly to families.
- Respondents have the opportunity to (1) rate whether the state priorities align with their perceived priorities

for each MCH population, (2) rate the appropriateness and fit of the selected strategies, and (3) provide feedback on any important details, topics, or strategies they feel are missing.
- Respondents can also opt-in to receive program surveys and information about MCH needs assessment activities by providing their contact information. Once the survey closes, responses are compiled and presented back to staff during Title V monthly meetings.

Survey respondents represent individuals identifying as parents, youth/adolescents, state agency employees, community service providers, researchers/academia, and health care providers. Last year's FY21 Application / FY19 Annual Report saw a dip in responses for public input. Among responses, participants did agree that the following were important issues/priorities for Virginia's MCH populations:

- Woman/Maternal Mental Health (e.g. postpartum depression, emotional wellness)
- Infant Mortality (e.g. racial and ethnic disparities)
- Unintended Pregnancy (e.g. preventive care visit, family planning, sexual and reproductive health education)
- Child/Adolescent mental health and socioemotional development
- Family-centered care and connection to necessary services

Direct Submission of Comments or Inquiries

A copy of the current application and contact information for the Title V Director are made publically available on the VDH Title V website to facilitate submission of any additional public comments or inquiries throughout the year.

III.G. Technical Assistance

VIRGINIA
MATERNAL & CHILD HEALTH

TECHNICAL ASSISTANCE

1. **NEW REQUEST:** Virginia Title V Program requests TA regarding Financial Reporting: Specifically, the Program seeks support in ensuring that Budget/Expenditure monitoring and reporting aligned with the requirements of Title V.

2. **CURRENT TA:** Virginia was selected to receive technical assistance (TA) from the National MCH Workforce Development Center in Chapel Hill, North Carolina, as part of the Cohort 2021 – Advancing Health Transformation. This 8-month cohort provides guidance on systems integration, change management and adaptive leadership, and evidence-based decision making. Virginia's application to this Cohort states the following: *VA's Title V Program would like to expand further and operationalize our definition [of family engagement and partnership] into a process that positions families as co-designers and drivers in creating Title V policies and programming (local and state) based on their experiences, hopes, expectations and interests. Ultimately, our question is: Is family leadership the goal or is it equitable collaboration? Should we reframe family engagement into a family leadership construct? OR Do these two concepts really go hand in hand – in other words, leaders arise from those who are engaged and equitably involved.*

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Medicaid MOU.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - Maternal Health Strategic Plan.pdf

Supporting Document #02 - 2020 Report to the General Assembly Plan for Services for Substance Exposed Infants.pdf

Supporting Document #03 - CYSHCN CCC and CDC work plans.pdf

Supporting Document #04 - CYSCHN Services Map.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - VDH Organizational Chart.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Virginia

	FY 22 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 12,457,398	
A. Preventive and Primary Care for Children	$ 3,795,675	(30.4%)
B. Children with Special Health Care Needs	$ 5,130,124	(41.1%)
C. Title V Administrative Costs	$ 1,227,859	(9.9%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 10,153,658	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 6,092,387	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 1,702,690	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 1,547,972	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 9,343,049	
A. Your State's FY 1989 Maintenance of Effort Amount $ 8,718,003		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 21,800,447	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 17,859,944	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 39,660,391	

OTHER FEDERAL FUNDS	FY 22 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	$ 773,249
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 7,622,952
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 235,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 160,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 2,522,297
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Comprehensive Cancer Control Program (NCCCP)	$ 366,200
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 4,660,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Sexual Risk Avoidane Education	$ 1,324,796
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sickel Cell Data Collection Program (SCDC)	$ 195,450

	FY 20 Annual Report Budgeted		FY 20 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 12,287,553		$ 11,750,864	
A. Preventive and Primary Care for Children	$ 3,795,675	(30.9%)	$ 4,931,980	(41.9%)
B. Children with Special Health Care Needs	$ 5,130,124	(41.8%)	$ 3,936,809	(33.5%)
C. Title V Administrative Costs	$ 1,227,859	(10%)	$ 746,320	(6.4%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 10,153,658		$ 9,615,109	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 9,215,665		$ 6,169,903	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 1,618,704		$ 1,625,174	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 2,086,819		$ 1,547,972	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 12,921,188		$ 9,343,049	
A. Your State's FY 1989 Maintenance of Effort Amount $ 8,718,003				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 25,208,741		$ 21,093,913	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 16,989,838		$ 14,682,649	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 42,198,579		$ 35,776,562	

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 122,290	$ 180,658
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 1,178,197	$ 1,035,715
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 7,860,627	$ 7,997,141
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000	$ 272,188
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	$ 1,139,160	$ 835,433
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 2,635,000	$ 4,012,291
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Zika Surveillance Systems Grant Program	$ 560,000	$ 50,440
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Prescription Drug Overdose: Prevention for States Program	$ 2,019,910	$ 298,783
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Innovation Grants	$ 1,224,654	$ 0

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: Newborn Screening	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Personnel not coded correctly, causing Preventive and Primary Care for Children budget for FY20 to be understated.	
3.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Personnel not coded correctly, causing CSHCN budget for FY20 to be overstated.	
4.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Personnel vacancies and hiring freezes left vacancies due the COVID19 pandemic during the last six months of the grant year.	
5.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Unanticipated vacancies and the difficulty of filling those vacancies during the COVID-19 pandemic caused the State MCH budget to be underspent.	
6.	**Field Name:**	**5. OTHER FUNDS**

	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Newborn Screening	
7.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Child Development clinic Revenue - 5 contracts with centers. Revenue does not come back to VDH and stays with the contractor to support the operation of the program. FY 2020 Revenue- Child Development Clinics Center Revenue Reported by Center JMU $142,834.17 VCU $266,720.00 Lenowisco $86,631.72 CSG $427,701.00 Carilion $624,084.62 Total $1,547,971.51	

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Virginia

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 977,906	$ 655,203
2. Infants < 1 year	$ 1,288,462	$ 804,795
3. Children 1 through 21 Years	$ 3,795,675	$ 4,931,980
4. CSHCN	$ 5,130,124	$ 3,936,809
5. All Others	$ 37,372	$ 675,757
Federal Total of Individuals Served	$ 11,229,539	$ 11,004,544

IB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 589,546	$ 551,133
2. Infants < 1 year	$ 1,913,456	$ 551,133
3. Children 1 through 21 Years	$ 1,179,093	$ 903,983
4. CSHCN	$ 870,772	$ 3,193,978
5. All Others	$ 3,899,789	$ 1,102,265
Non-Federal Total of Individuals Served	$ 8,452,656	$ 6,302,492
Federal State MCH Block Grant Partnership Total	$ 19,682,195	$ 17,307,036

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Virginia

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 211,776	$ 199,764
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 38,618	$ 36,427
B. Preventive and Primary Care Services for Children	$ 42,355	$ 39,953
C. Services for CSHCN	$ 130,803	$ 123,384
2. Enabling Services	$ 6,355,764	$ 5,995,291
3. Public Health Services and Systems	$ 5,889,858	$ 5,555,809
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 106,674
Physician/Office Services		$ 148
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 59,305
Laboratory Services		$ 27,932
Other		
Sustance Use		$ 5,705
Direct Services Line 4 Expended Total		$ 199,764
Federal Total	$ 12,457,398	$ 11,750,864

IIB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 158,831	$ 22,265
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 28,963	$ 3,227
B. Preventive and Primary Care Services for Children	$ 31,766	$ 3,227
C. Services for CSHCN	$ 98,102	$ 15,811
2. Enabling Services	$ 4,766,824	$ 1,671,166
3. Public Health Services and Systems	$ 4,417,394	$ 1,533,381
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 12,646
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 4,535
Laboratory Services		$ 0
Other		
Substance Use		$ 5,084
Direct Services Line 4 Expended Total		$ 22,265
Non-Federal Total	$ 9,343,049	$ 3,226,812

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIA. Federal MCH Block Grant, 4. Pharmacy**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: VDH Pharmacy fills meds and we reimburse them.	
2.	**Field Name:**	**IIA. Federal MCH Block Grant, 4. Durable Medical Equipment and Supplies.**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: This includes durable medical equipment like hearing aids and orthotics. It also includes specialty co-pays.	

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Virginia

Total Births by Occurrence: 97,401 **Data Source Year: 2019**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	95,881 (98.4%)	6,553	436	372 (85.3%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Hearing Loss	Holocarboxylase Synthase Deficiency
Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency
Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Mucopolysaccharidosis Type 1	Primary Congenital Hypothyroidism	Propionic Acidemia
S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	ß-Ketothiolase Deficiency
Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency		

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

There is no formal long-term monitoring or follow-up process that occurs with infants diagnosed through the Virginia Newborn Screening Program (VNSP); however, the VNSP does have a process in place to refer screen positive infants to Care Connection for Children (CCC) of the VDH Children with Special Health Care Needs Program. The CCC is a statewide network of Centers of Excellence for Children with Special Health Care Needs (CSHCN) that facilitates access to comprehensive medical, support, and case management services for all CSHCN served under VDH programs.

Form Notes for Form 4:

Note for 2020 reporting year: Data reported from most recent validated data year 2019; compiled by the Virginia Newborn Screening and Birth Defects Surveillance Programs and Early Hearing Detection Intervention (EHDI); Division of Child and Family Health

Data Sources: Virginia Department of General Service StarLIMS (State Laboratory Newborn Screening Database), VACares (Birth Defects Registry)

Field Level Notes for Form 4:

1.	**Field Name:**	**Core RUSP Conditions - Total Number Confirmed Cases**
	Fiscal Year:	**2020**
	Column Name:	**Core RUSP Conditions**
	Field Note: *For Glycogen Storage Disease Type II (Pompe): 5 cases of possible/probable late onset- not including in count because not confirmed.	
2.	**Field Name:**	**Core RUSP Conditions - Total Number Referred For Treatment**
	Fiscal Year:	**2020**
	Column Name:	**Core RUSP Conditions**
	Field Note: *Critical Congenital Heart Disease: Regulations require only well-born infants (excludes NICU, specialty care, and prenatal diagnosis) and it is not expected to have 100% infants screened. The majority of infants diagnosed with CCHD in Virginia are found through prenatal anatomical ultrasounds; however, the newborn screening program still refers these cases to Care Connection for Children (CCC) of the VDH Children with Special Health Care Needs Program. For CCHD data, 29074 infants did not have record of screening reported, and 4957 infants were not screened due to prenatal diagnosis, parent refusal, NICU admission, or other reasons.	

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Virginia

Annual Report Year 2020

Form 5a – Count of Individuals Served by Title V (Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	11,159	30.5	0.0	63.5	5.8	0.2
2. Infants < 1 Year of Age	1,416	30.5	0.0	63.5	5.8	0.2
3. Children 1 through 21 Years of Age	16,268	25.0	0.0	69.0	6.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	3,096	36.0	0.0	62.0	2.0	0.0
4. Others	24,610	10.0	0.0	82.0	8.0	0.0
Total	53,453					

Form 5b – Total Percentage of Populations Served by Title V (Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	97,429	Yes	97,429	100.0	97,429	11,159
2. Infants < 1 Year of Age	97,400	Yes	97,400	100.0	97,400	1,416
3. Children 1 through 21 Years of Age	2,218,884	Yes	2,218,884	100.0	2,218,884	16,268
3a. Children with Special Health Care Needs 0 through 21 years of age^	447,132	Yes	447,132	100.0	447,132	3,096
4. Others	6,218,771	Yes	6,218,771	30.5	1,896,725	24,610

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2020**
	Field Note: Data note for reporting year 2020: Data note for reporting year 2020: Resource Mothers Program Data (REDCap entries from community health workers); WebVision – Report #081 from the Data Warehouse using the date range Oct 1, 2019 to Sep 30, 2020; Number reported Title V funded Baby Care (Prenatal) services from LHDs (WebVision – Report #009 using the date range Oct 1, 2019 to Sep 30, 2020); Number reported includes pregnant and postpartum women receiving safe sleep kits/counseling/education services from LHDs - obtained from LHD reports	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2020**
	Field Note: Data note for reporting year 2020: Number of infants with a confirmed CCHD diagnosis referred to Care Connection for Children services before 1 year of age (CCHD NBS program follow up and referrals documentation); Number of infants with a confirmed hearing loss referred for treatment (CY2019, VA EHDI); Resource Mothers Program Data (REDCap entries from community health workers); Number reported Title V funded Baby Care (Infant) services from LHDs (WebVision – Report #009 using the date range Oct 1, 2019 to Sep 30, 2020)	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Data note for reporting year 2020: WebVision – Report #081 from the Data Warehouse using the date range Oct 1, 2019 to Sep 30, 2020; Number of children with a confirmed CCHD diagnosis referred to Care Connection for Children services between 1 and 2 years of age (CCHD NBS program follow up and referrals documentation); Contraceptive Access Initiative program data (claims submitted for reimbursement); Young people served through SRAE	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Data note for reporting year 2020: CCC-SUN, Individual Program Reports from partners (CCC, CDC, Sickle cell, and Bleeding Disorders programs under 21)	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**
	Field Note: Data note for reporting year 2020: WebVision – Report #081 from the Data Warehouse using the date range Oct 1, 2019 to Sep 30, 2020; Bleeding Disorders program age 22+; Enabling serviced (family to family) to 44 families referred by the EHDI program to the MCHB Family to Family Health Information Center; Contraceptive Access Initiative program data (claims submitted for reimbursement)	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2020**

Field Note:
Data note for reporting year 2020: Statewide efforts attributed to programs receiving Title V funding: Provide 100% of Mat/Inf salaries and funding for MMRT salaries, and partial salary and funding for Reproductive Health and Child Health/Home-visiting, partial salary and funding Resources Mothers (pregnant and parenting teens); MCH epi team partial salaries; Needs Assessment support; Pop Health Data Manager salary; Cancer epi partial salaries; support to maternal collaboratives

2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2020**

Field Note:
Data note for reporting year 2020: Title V provides 100% salary support for Mat/Inf and EHDI program manager staff; provides support for VACARES; support to perinatal collaboratives

3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2020**

Field Note:
Data note for reporting year 2020: Includes Medical Home and Transition initiatives for school-aged children with and without special health care needs; Partnership to develop training module for health care providers and families to educate on a comprehensive care approach to provide a medical home and a module on best practices regarding the delivery of transition services; participation in state child health planning and advisory boards including the Child Health Insurance Plan Advisory Committee (CHIPAC), Virginia Interagency Coordinating Council (VICC); development of school health guidelines for all public schools and in consultation for private/parochial schools

4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**

Field Note:
Data note for reporting year 2020: Includes Medical Home and Transition initiatives for school-aged children with and without special health care needs; Partnership to develop training module for health care providers and families to educate on a comprehensive care approach to provide a medical home and a module on best practices regarding the delivery of transition services; development of school health guidelines for all public schools and in consultation for private/parochial schools (including recommendations for development of local programs and policies related to health care services for students with special health care needs)

5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**

Field Note:
Data note for reporting year 2020: Title V provides funding to local health districts to carry out essential public health services in every community in Virginia (includes reproductive health education services that are available to women and men)

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Virginia

Annual Report Year 2020

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	101,525	54,949	22,413	14,920	174	3,981	915	0	4,173
Title V Served	5,664	2,364	490	1,725	12	104	3	0	966
Eligible for Title XIX	29,871	11,553	10,912	5,983	48	409	84	0	882
2. Total Infants in State	97,400	52,731	21,432	14,509	167	3,888	891	0	3,782
Title V Served	2,942	1,844	458	0	12	20	2	0	606
Eligible for Title XIX	29,743	11,502	10,862	5,969	48	409	84	0	869

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Note for reporting year 2020: data reported is most recent validated year (2019) of Virginia Vital Events Statistics	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Data note for reporting year 2020: WebVision – Report #082 and #083 from the Data Warehouse using the date range Oct 1, 2019 to Sep 30, 2020	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Note for reporting year 2020: data reported is most recent validated year (2019) of Virginia Vital Events Statistics	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Note for reporting year 2020: data reported is most recent validated year (2019) of Virginia Vital Events Statistics	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Data note for reporting year 2020: Number reported Title V funded Baby Care (Infant) services from LHDs (WebVision – Report #006 using the date range Oct 1, 2019 to Sep 30, 2020)	
6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Note for reporting year 2020: data reported is most recent validated year (2019) of Virginia Vital Events Statistics	

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Virginia

A. State MCH Toll-Free Telephone Lines	2022 Application Year	2020 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 230-6977 x211	(800) 230-6977 x211
2. State MCH Toll-Free "Hotline" Name	2-1-1 Virginia	2-1-1 Virginia
3. Name of Contact Person for State MCH "Hotline"	Cindy deSa	Carla Hegwood
4. Contact Person's Telephone Number	(804) 864-7674	(804) 864-7674
5. Number of Calls Received on the State MCH "Hotline"		18,351

B. Other Appropriate Methods	2022 Application Year	2020 Annual Report Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		0
3. State Title V Program Website Address	https://www.vdh.virginia.gov/vdhlivewell/maternal-and-child-health-services-title-v-block-grant/	https://www.vdh.virginia.gov/vdhlivewell/maternal-and-child-health-services-title-v-block-grant/
4. Number of Hits to the State Title V Program Website		648
5. State Title V Social Media Websites	VDH Facebook, Instagram, Twitter, Pinterest, TikTok, Livestories	LiveWell FB, Twitter, Instagram, Pinterest; MCH LiveStories
6. Number of Hits to the State Title V Program Social Media Websites		193,211

Form Notes for Form 7:

Application Year 2022, Section B7: Title V-MCH related messages that were posted on the former LiveWell social media sites have transitioned to the Main VDH social media pages. VDH as an agency is not paying for the LiveWell domain any longer.

Annual Report Year 2020, Section B6: Breakdown of social media website traffic
Facebook = 10,978 views
Instagram = 1,023 followers and 834 posts
Twitter = 103,000 impressions
Pinterest = 77,142 impressions
MCH LiveStories (not social media, but relevant website https://insight.livestories.com/s/v2/maternal-and-child-health-virginia-overview/9c64848e-1a0c-4d5b-9f0f-2a571c37e076) = 1,068 page views

Form 8
State MCH and CSHCN Directors Contact Information

State: Virginia

1. Title V Maternal and Child Health (MCH) Director	
Name	Cynthia deSa, MPH, MSW, LCSW
Title	Maternal Child Health/Title V Director
Address 1	Virginia Department of Health
Address 2	109 Governor Street
City/State/Zip	Richmond / VA / 23219
Telephone	(804) 864-7674
Extension	
Email	cynthia.desa@vdh.virginia.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Marcus Allen, MPH
Title	CSHCN Director
Address 1	Virginia Department of Health
Address 2	109 Governor Street
City/State/Zip	Richmond / VA / 23219
Telephone	(804) 864-7716
Extension	
Email	marcus.allen@vdh.virginia.gov

3. State Family or Youth Leader (Optional)	
Name	Dana Yarbrough, MS, MA
Title	Director, Center for Family Involvement
Address 1	Virginia Commonwealth University
Address 2	700 E. Franklin Str
City/State/Zip	Richmond / VA / 23219
Telephone	(804) 828-0352
Extension	804728
Email	dvyarbrough@vcu.edu

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Virginia

Application Year 2022

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

Form Notes for Form 9:

None

Field Level Notes for Form 9:

Field Name:

Priority Need 8

Field Note:
This may include: developmental screening, EHDI, NBS, referrals to CSHCN and community supports, school health nursing, Early Intervention, Bright Futures/AAP, and all CYSHCN programs.

Field Name:

Priority Need 9

Field Note:
This may include: Black infant health strategies (breastfeeding, safe sleep, LISSDEP, home visiting support, NAS Project ECHO) + Black maternal health strategies (e.g. MCH PIP substance use project, $$ to community orgs, MMRT, normalizing health-seeking behaviors around prenatal care, doulas, $$ to VHHA, VNPC if partnering, etc).

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

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

Form Notes for Form 9:

None

Field Level Notes for Form 9:

Field Name:

Priority Need 8

Field Note:
This may include: developmental screening, EHDI, NBS, referrals to CSHCN and community supports, school health nursing, Early Intervention, Bright Futures/AAP, and all CYSHCN programs.

Field Name:

Priority Need 9

Field Note:
This may include: Black infant health strategies (breastfeeding, safe sleep, LISSDEP, home visiting support, NAS Project ECHO) + Black maternal health strategies (e.g. MCH PIP substance use project, $$ to community orgs, MMRT, normalizing health-seeking behaviors around prenatal care, doulas, $$ to VHHA, VNPC if partnering, etc).

Form 10
National Outcome Measures (NOMs)

State: Virginia

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	79.2 %	0.1 %	74,754	94,377
2018	78.6 %	0.1 %	73,790	93,921
2017	79.0 %	0.1 %	74,267	94,044
2016	79.9 %	0.1 %	78,094	97,753
2015	79.9 %	0.1 %	72,042	90,155
2014	80.9 %	0.1 %	60,618	74,896
2013	77.5 %	0.2 %	57,327	73,938

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	69.2	2.8	634	91,627
2017	64.1	2.6	595	92,796
2016	70.6	2.7	667	94,514
2015	68.5	3.1	487	71,128
2014	70.2	2.7	664	94,533
2013	67.0	2.7	624	93,169
2012	70.7	2.8	655	92,668
2011	70.5	2.8	652	92,540
2010	68.3	2.7	634	92,781
2009	67.9	2.7	640	94,226
2008	57.9	2.5	556	96,008

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2019	18.5	1.9	93	503,426
2014_2018	17.1	1.8	87	509,297

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	8.4 %	0.1 %	8,132	97,380
2018	8.2 %	0.1 %	8,175	99,788
2017	8.4 %	0.1 %	8,393	100,344
2016	8.1 %	0.1 %	8,263	102,404
2015	7.9 %	0.1 %	8,111	103,273
2014	7.9 %	0.1 %	8,130	103,255
2013	8.0 %	0.1 %	8,182	102,091
2012	8.1 %	0.1 %	8,375	102,940
2011	8.0 %	0.1 %	8,184	102,590
2010	8.2 %	0.1 %	8,448	102,949
2009	8.4 %	0.1 %	8,779	104,992

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	9.9 %	0.1 %	9,625	97,388
2018	9.4 %	0.1 %	9,401	99,797
2017	9.5 %	0.1 %	9,582	100,343
2016	9.6 %	0.1 %	9,792	102,422
2015	9.2 %	0.1 %	9,549	103,273
2014	9.2 %	0.1 %	9,517	103,268
2013	9.4 %	0.1 %	9,599	102,083
2012	9.5 %	0.1 %	9,774	102,964
2011	9.5 %	0.1 %	9,738	102,598
2010	10.1 %	0.1 %	10,395	102,963
2009	10.2 %	0.1 %	10,702	104,987

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	26.8 %	0.1 %	26,088	97,388
2018	25.9 %	0.1 %	25,893	99,797
2017	25.1 %	0.1 %	25,147	100,343
2016	24.6 %	0.1 %	25,192	102,422
2015	24.1 %	0.1 %	24,902	103,273
2014	24.0 %	0.1 %	24,775	103,268
2013	24.3 %	0.1 %	24,807	102,083
2012	24.7 %	0.1 %	25,457	102,964
2011	25.2 %	0.1 %	25,905	102,598
2010	26.6 %	0.1 %	27,356	102,963
2009	27.2 %	0.1 %	28,588	104,987

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019/Q1-2019/Q4	1.0 %			
2018/Q4-2019/Q3	1.0 %			
2018/Q3-2019/Q2	1.0 %			
2018/Q2-2019/Q1	1.0 %			
2018/Q1-2018/Q4	1.0 %			
2017/Q4-2018/Q3	1.0 %			
2017/Q3-2018/Q2	1.0 %			
2017/Q2-2018/Q1	1.0 %			
2017/Q1-2017/Q4	1.0 %			
2016/Q4-2017/Q3	1.0 %			
2016/Q3-2017/Q2	1.0 %			
2016/Q2-2017/Q1	1.0 %			
2016/Q1-2016/Q4	1.0 %			
2015/Q4-2016/Q3	1.0 %			
2015/Q3-2016/Q2	1.0 %			
2015/Q2-2016/Q1	1.0 %			
2015/Q1-2015/Q4	1.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	2.0 %			
2014/Q2-2015/Q1	2.0 %			
2014/Q1-2014/Q4	2.0 %			
2013/Q4-2014/Q3	3.0 %			
2013/Q3-2014/Q2	4.0 %			
2013/Q2-2014/Q1	5.0 %			

Legends:

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	5.7	0.2	572	100,116
2017	5.4	0.2	540	100,609
2016	5.6	0.2	579	102,737
2015	5.5	0.2	566	103,560
2014	5.6	0.2	582	103,562
2013	6.3	0.3	650	102,432
2012	6.6	0.3	686	103,300
2011	6.7	0.3	691	102,938
2010	6.6	0.3	680	103,306
2009	6.4	0.3	676	105,331

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	5.6	0.2	560	99,843
2017	5.9	0.2	592	100,391
2016	5.8	0.2	599	102,460
2015	5.9	0.2	610	103,303
2014	5.7	0.2	584	103,300
2013	6.2	0.3	631	102,147
2012	6.5	0.3	668	103,013
2011	6.8	0.3	697	102,652
2010	6.8	0.3	703	103,002
2009	7.1	0.3	750	105,059

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	3.7	0.2	371	99,843
2017	4.0	0.2	399	100,391
2016	3.8	0.2	387	102,460
2015	3.9	0.2	399	103,303
2014	3.8	0.2	391	103,300
2013	4.4	0.2	451	102,147
2012	4.7	0.2	480	103,013
2011	4.7	0.2	481	102,652
2010	4.6	0.2	475	103,002
2009	4.7	0.2	493	105,059

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	1.9	0.1	189	99,843
2017	1.9	0.1	193	100,391
2016	2.1	0.1	212	102,460
2015	2.0	0.1	211	103,303
2014	1.9	0.1	193	103,300
2013	1.8	0.1	180	102,147
2012	1.8	0.1	188	103,013
2011	2.1	0.1	216	102,652
2010	2.2	0.2	228	103,002
2009	2.4	0.2	257	105,059

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	176.3	13.3	176	99,843
2017	212.2	14.6	213	100,391
2016	205.9	14.2	211	102,460
2015	210.1	14.3	217	103,303
2014	198.5	13.9	205	103,300
2013	264.3	16.1	270	102,147
2012	249.5	15.6	257	103,013
2011	262.1	16.0	269	102,652
2010	259.2	15.9	267	103,002
2009	290.3	16.7	305	105,059

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	103.2	10.2	103	99,843
2017	97.6	9.9	98	100,391
2016	114.2	10.6	117	102,460
2015	84.2	9.0	87	103,303
2014	101.6	9.9	105	103,300
2013	75.4	8.6	77	102,147
2012	88.3	9.3	91	103,013
2011	94.5	9.6	97	102,652
2010	104.9	10.1	108	103,002
2009	107.6	10.1	113	105,059

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	9.3 %	1.5 %	8,428	90,711
2018	7.5 %	1.3 %	6,908	92,292
2017	7.3 %	1.2 %	6,723	92,156
2016	8.4 %	1.4 %	7,975	95,548
2015	9.3 %	1.3 %	8,901	95,804

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	7.3	0.3	653	90,068
2017	7.7	0.3	709	91,688
2016	6.7	0.3	636	94,439
2015	5.7	0.3	405	71,397
2014	5.4	0.2	512	94,776
2013	4.7	0.2	437	93,393
2012	3.8	0.2	353	92,827
2011	3.2	0.2	287	90,911
2010	3.0	0.2	272	91,919
2009	2.4	0.2	227	94,034
2008	2.0	0.1	189	95,336

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

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

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	7.3 %	1.1 %	130,237	1,777,721
2017_2018	10.4 %	1.6 %	183,802	1,765,309
2016_2017	12.2 %	1.6 %	213,906	1,750,946
2016	9.9 %	1.4 %	172,390	1,749,952

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	15.1	1.3	139	922,499
2018	14.0	1.2	130	926,120
2017	17.0	1.4	157	925,835
2016	15.6	1.3	145	928,114
2015	17.5	1.4	163	930,662
2014	16.3	1.3	152	931,531
2013	14.6	1.3	136	932,216
2012	17.4	1.4	161	927,706
2011	19.1	1.4	176	922,806
2010	16.1	1.3	148	921,396
2009	15.7	1.3	143	913,341

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	29.0	1.7	309	1,067,063
2018	32.0	1.7	343	1,070,646
2017	28.7	1.6	306	1,064,407
2016	30.4	1.7	323	1,062,972
2015	29.5	1.7	313	1,059,818
2014	26.1	1.6	277	1,059,336
2013	26.8	1.6	283	1,057,209
2012	28.9	1.7	306	1,058,560
2011	29.6	1.7	314	1,059,168
2010	27.3	1.6	290	1,062,211
2009	26.1	1.6	278	1,063,377

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2019	9.3	0.8	151	1,624,051
2016_2018	9.9	0.8	160	1,623,012
2015_2017	9.8	0.8	159	1,619,060
2014_2016	10.6	0.8	171	1,616,229
2013_2015	9.8	0.8	158	1,612,618
2012_2014	10.6	0.8	171	1,616,074
2011_2013	11.2	0.8	181	1,623,241
2010_2012	11.8	0.9	193	1,637,028
2009_2011	11.8	0.8	194	1,648,677
2008_2010	14.3	0.9	237	1,657,939
2007_2009	17.2	1.0	285	1,657,396

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2019	11.9	0.9	193	1,624,051
2016_2018	11.6	0.8	188	1,623,012
2015_2017	9.9	0.8	161	1,619,060
2014_2016	9.8	0.8	159	1,616,229
2013_2015	9.1	0.8	147	1,612,618
2012_2014	9.0	0.8	145	1,616,074
2011_2013	8.3	0.7	134	1,623,241
2010_2012	7.8	0.7	127	1,637,028
2009_2011	7.4	0.7	122	1,648,677
2008_2010	7.7	0.7	128	1,657,939
2007_2009	7.5	0.7	125	1,657,396

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	19.3 %	1.5 %	360,019	1,862,836
2017_2018	20.9 %	1.7 %	389,683	1,863,052
2016_2017	21.0 %	1.5 %	391,467	1,864,161
2016	21.0 %	1.6 %	391,428	1,864,898

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	15.0 %	2.7 %	54,140	360,019
2017_2018	18.2 %	3.8 %	70,872	389,683
2016_2017	19.8 %	3.7 %	77,681	391,467
2016	16.1 %	2.9 %	62,910	391,428

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	4.1 %	1.0 %	64,068	1,578,260
2017_2018	4.6 %	1.1 %	73,660	1,616,650
2016_2017	3.2 %	0.6 %	51,310	1,579,497
2016	3.0 %	0.6 %	46,358	1,548,323

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	8.6 %	1.1 %	134,427	1,554,156
2017_2018	9.7 %	1.4 %	156,226	1,605,708
2016_2017	9.7 %	1.2 %	153,338	1,574,511
2016	9.9 %	1.2 %	152,374	1,538,283

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	49.4 %	5.3 %	98,029	198,549
2017_2018	49.7 %	5.8 %	94,052	189,236
2016_2017	56.4 %	5.1 %	108,269	192,099
2016	61.7 %	5.6 %	132,277	214,368

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	90.3 %	1.3 %	1,679,703	1,859,822
2017_2018	91.1 %	1.3 %	1,695,882	1,861,519
2016_2017	93.7 %	0.9 %	1,745,549	1,863,556
2016	92.9 %	1.0 %	1,731,288	1,863,687

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	15.8 %	0.2 %	6,230	39,404
2016	15.3 %	0.2 %	7,235	47,376
2014	20.0 %	0.2 %	11,616	57,983
2012	20.1 %	0.2 %	10,385	51,739
2010	21.5 %	0.2 %	10,527	48,920
2008	20.2 %	0.2 %	8,538	42,364

Legends:

Indicator has a denominator <50 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	14.8 %	1.2 %	53,149	358,950
2017	12.7 %	0.9 %	46,280	363,195
2015	13.0 %	0.9 %	39,226	301,582
2013	12.0 %	0.6 %	42,338	352,225
2011	11.1 %	1.2 %	40,631	366,797

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	13.0 %	2.1 %	102,809	792,832
2017_2018	13.2 %	2.1 %	108,022	820,588
2016_2017	13.2 %	1.8 %	102,942	782,456
2016	14.1 %	2.4 %	103,901	737,946

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	4.6 %	0.3 %	84,967	1,856,489
2018	4.4 %	0.2 %	82,865	1,867,261
2017	4.5 %	0.2 %	83,047	1,865,872
2016	4.9 %	0.3 %	91,347	1,864,204
2015	4.9 %	0.3 %	91,415	1,869,889
2014	5.9 %	0.3 %	109,627	1,867,159
2013	5.7 %	0.3 %	106,008	1,863,314
2012	5.5 %	0.3 %	102,837	1,855,004
2011	5.8 %	0.3 %	107,695	1,853,192
2010	6.5 %	0.3 %	119,764	1,853,506
2009	6.7 %	0.3 %	124,160	1,846,249

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	76.1 %	3.7 %	79,000	104,000
2015	71.7 %	4.2 %	74,000	104,000
2014	76.2 %	4.0 %	79,000	103,000
2013	63.6 %	4.3 %	67,000	106,000
2012	62.1 %	4.7 %	66,000	106,000
2011	65.8 %	5.2 %	70,000	106,000

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	70.3 %	1.2 %	1,239,475	1,763,122
2018_2019	69.6 %	1.6 %	1,225,859	1,761,798
2017_2018	65.2 %	2.0 %	1,141,897	1,752,024
2016_2017	60.2 %	2.2 %	1,056,622	1,754,894
2015_2016	62.4 %	2.2 %	1,086,888	1,740,971
2014_2015	65.0 %	2.2 %	1,135,952	1,746,813
2013_2014	61.9 %	2.4 %	1,059,657	1,711,340
2012_2013	61.3 %	2.9 %	1,060,831	1,729,774
2011_2012	50.6 %	2.9 %	882,291	1,743,986
2010_2011	54.9 %	2.3 %	941,040	1,714,099
2009_2010	49.8 %	3.3 %	849,428	1,705,679

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	75.2 %	3.7 %	395,240	525,741
2018	67.2 %	4.5 %	352,380	524,007
2017	75.6 %	3.4 %	398,447	526,872
2016	53.6 %	3.8 %	281,939	526,294
2015	50.4 %	4.1 %	264,630	524,771

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	89.1 %	2.8 %	468,600	525,741
2018	90.3 %	2.7 %	473,264	524,007
2017	89.3 %	2.6 %	470,632	526,872
2016	87.1 %	2.6 %	458,489	526,294
2015	82.2 %	3.3 %	431,301	524,771
2014	91.2 %	2.0 %	476,967	522,759
2013	83.6 %	3.3 %	433,804	518,865
2012	88.7 %	2.2 %	458,761	517,148
2011	77.9 %	2.9 %	405,505	520,702
2010	72.0 %	3.2 %	365,111	506,826
2009	56.1 %	3.2 %	286,211	510,091

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	86.7 %	2.9 %	456,071	525,741
2018	79.7 %	3.7 %	417,432	524,007
2017	80.0 %	3.3 %	421,267	526,872
2016	71.5 %	3.6 %	376,523	526,294
2015	66.8 %	3.9 %	350,435	524,771
2014	72.5 %	3.4 %	379,117	522,759
2013	64.2 %	4.3 %	333,122	518,865
2012	62.1 %	3.8 %	321,221	517,148
2011	61.8 %	3.1 %	321,925	520,702
2010	54.5 %	3.5 %	276,139	506,826
2009	48.1 %	3.2 %	245,326	510,091

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	13.6	0.2	3,625	266,936
2018	14.3	0.2	3,803	266,855
2017	15.0	0.2	3,987	265,153
2016	15.5	0.2	4,114	265,098
2015	17.1	0.3	4,508	263,523
2014	18.5	0.3	4,859	263,184
2013	20.0	0.3	5,300	264,395
2012	22.9	0.3	6,076	265,903
2011	24.4	0.3	6,524	267,267
2010	27.4	0.3	7,374	269,197
2009	30.4	0.3	8,228	270,590

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	14.6 %	1.9 %	13,025	89,128
2018	13.5 %	1.7 %	12,376	91,962
2017	12.4 %	1.7 %	11,459	92,173
2016	12.9 %	1.7 %	12,138	94,152
2015	11.7 %	1.6 %	11,030	94,096

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	1.7 %	0.4 %	31,396	1,860,091
2017_2018	2.2 %	0.6 %	41,650	1,856,693
2016_2017	2.1 %	0.6 %	38,366	1,856,963
2016	1.6 %	0.6 %	30,045	1,857,731

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Virginia

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2019	**2020**
Annual Objective		
Annual Indicator	82.9	91.7
Numerator	73,338	84,128
Denominator	88,459	91,769
Data Source	NIS	NIS
Data Source Year	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	84.6	85.4	86.2	87.1	87.9	88.7

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**

Field Note:
% increase needed to meet Goal of 10% based on 2016 NIS as state baseline

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

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2019	**2020**
Annual Objective		
Annual Indicator	26.4	30.4
Numerator	22,710	27,265
Denominator	85,942	89,656
Data Source	NIS	NIS
Data Source Year	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	27.5	28.0	28.5	29.0	29.6	30.1

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**

Field Note:
% increase needed to meet Goal of 10% based on 2016 NIS as state baseline

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

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			27.1	27.9	28.3
Annual Indicator		26.8	29.1	31.4	29.9
Numerator		67,562	59,469	54,036	67,406
Denominator		252,334	204,083	171,987	225,762
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	29.5	29.9	30.3	30.7	31.1	31.5

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**

Field Note:
% increase needed to meet National 2016-2017 metric based on NSCH 2016-2017 as state baseline

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

Federally Available Data					
Data Source: HCUP - State Inpatient Databases (SID)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	86.5	85.5	94.9	92.8	90.7
Annual Indicator	87.0	101.5	95.4	98.6	88.4
Numerator	899	785	982	1,013	906
Denominator	1,033,738	773,528	1,029,557	1,026,897	1,025,381
Data Source	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	88.7	86.7	84.8	82.9	81.0	79.2

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**

Field Note:
Projections based on average annual percent change from 2008-2015 available data

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

Federally Available Data					
Data Source: HCUP - State Inpatient Databases (SID)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	180	172	162.9	156.8	151
Annual Indicator	172.4	182.6	196.3	184.5	168.1
Numerator	1,826	1,451	2,087	1,964	1,800
Denominator	1,059,470	794,656	1,062,972	1,064,407	1,070,646
Data Source	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	145.3	139.9	134.7	129.6	124.8	120.1

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**

Field Note:
Projections based on average annual percent change from 2008-2015 available data

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

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			44.9	46	47.1
Annual Indicator		42.7	44.2	48.4	48.6
Numerator		167,058	172,978	188,625	174,804
Denominator		391,428	391,467	389,683	360,019
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	46.9	47.8	48.8	49.7	50.6	51.5

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note:	% increase needed to meet Goal of 10% increase based on 2017-2018 state baseline data

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			19.3	19.5	19.7
Annual Indicator		18.8	28.1	26.5	14.5
Numerator		31,194	48,657	47,355	22,590
Denominator		166,277	172,958	179,018	155,964
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	19.9	20.3	20.7	21.1	21.5	21.8

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note:	
	% increase needed to meet Goal of 10% increase based on 2017-2018 state baseline data	

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - Adolescent Health - NONCSHCN

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - NONCSHCN		
	2019	**2020**
Annual Objective		
Annual Indicator	11.6	16.5
Numerator	56,684	71,210
Denominator	489,697	431,868
Data Source	NSCH-NONCSHCN	NSCH-NONCSHCN
Data Source Year	2017_2018	2018_2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	16.7	16.8	17.0	17.1	17.3	17.5

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**

Field Note:
% increase needed to meet HRSA Region III 2018-2019 metric (18.1%) in 10 years based on 2018-2019 state metric

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

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2017	**2018**	**2019**	**2020**
Annual Objective	45	49.7	50.8	50.4
Annual Indicator	46.5	44.7	49.9	48.4
Numerator	44,225	42,882	46,558	43,840
Denominator	95,088	95,839	93,304	90,596
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2016	2018	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		45	49.7	50.8	50.4
Annual Indicator	43.6				
Numerator					
Denominator					
Data Source	PRAMS				
Data Source Year	2010-2011				
Provisional or Final ?	Provisional				

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	50.9	51.4	51.9	52.4	52.9	53.4

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**

Field Note:
% increase needed to meet 5% goal based on 2018 VA PRAMS as baseline data

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

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			93.2	94.3	79.7
Annual Indicator		81.4	83.1	82.4	80.5
Numerator		1,407,907	1,448,110	1,463,318	1,432,504
Denominator		1,729,004	1,741,839	1,775,616	1,778,464
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			79.7	80.7	79.7
Annual Indicator		75.7	78.4	78.9	77.6
Numerator					
Denominator					
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	80.5	81.3	82.1	82.9	83.7	84.5

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2017: the data source is the latest available data year (2016) from the National Survey of Children's Health. Data is reported from age break-out for children age 1-5 years and children age 6-11 years.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2018: the data source is the latest available data year (2016_2017) from the National Survey of Children's Health. Data is reported from age break-out for children age 1-5 years and children age 6-11 years.	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2019: the data source is the latest available data year (2017_2018) from the National Survey of Children's Health. Data is reported from age break-out for children age 1-5 years and children age 6-11 years.	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2020: the data source is the latest available data year (2018_2019) from the National Survey of Children's Health. Data is reported from age break-out for children age 1-5 years and children age 6-11 years.	
5.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: % increase needed to meet Goal of 5% increase based on 2017_2018 state baseline data	

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

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			93.2	94.3	89.1
Annual Indicator	90.9	90.9	90.5	88.2	86.6
Numerator					
Denominator					
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016	2016_2017	2017_2018	2018_2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	90.0	90.8	91.7	92.6	93.5	94.4

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2017: the data source is the latest available data year (2016) from the National Survey of Children's Health. Data is reported from age break-out for children age 12-17 years.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2018: the data source is the latest available data year (2016_2017) from the National Survey of Children's Health. Data is reported from age break-out for children age 12-17 years.	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2019: the data source is the latest available data year (2017_2018) from the National Survey of Children's Health. Data is reported from age break-out for children age 12-17 years.	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2020: the data source is the latest available data year (2018_2019) from the National Survey of Children's Health. Data is reported from age break-out for children age 12-17 years.	
5.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: % increase needed to meet Goal of 5% increase based on 2017_2018 state baseline data	

NPM 15 - Percent of children, ages 0 through 17, who are continuously and adequately insured - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2019	**2020**
Annual Objective		
Annual Indicator	71.2	68.5
Numerator	1,323,014	1,274,181
Denominator	1,857,510	1,859,679
Data Source	NSCH	NSCH
Data Source Year	2017_2018	2018_2019

State Provided Data		
	2019	**2020**
Annual Objective		
Annual Indicator	71.3	66.9
Numerator		
Denominator		
Data Source	NSCH	NSCH
Data Source Year	2017_2018	2018_2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	72.0	72.7	73.4	74.2	74.9	75.6

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2019: the data source is the latest available data year (2017_2018) from the National Survey of Children's Health. Data is reported from SHCN status break-out for CYSHCN.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2020: the data source is the latest available data year (2018_2019) from the National Survey of Children's Health. Data is reported from SHCN status break-out for CYSHCN.	
3.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: % increase needed to meet Goal of 5% increase based on 2017_2018 state baseline data	

Form 10
National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)

State: Virginia

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

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2017	**2018**	**2019**	**2020**
Annual Objective	81	81.6	82.8	84
Annual Indicator	78.0	78.0	82.0	80.7
Numerator	73,007	73,211	75,207	71,462
Denominator	93,567	93,856	91,692	88,597
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2016	2018	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	78.5	81	81.6	82.8	84
Annual Indicator			75.9	82	
Numerator					
Denominator					
Data Source			VA PRAMS	VA PRAMS	
Data Source Year			2017	2018	
Provisional or Final ?	Final		Final	Final	

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2018: data reported is VA PRAMS (2017).	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2019: data reported is VA PRAMS (2018).	

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

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2018	**2019**	**2020**
Annual Objective		33.3	33.6
Annual Indicator	32.0	28.8	31.4
Numerator	28,740	25,307	26,629
Denominator	89,922	87,734	84,895
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2016	2018	2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			33.3	33.6
Annual Indicator	73.3	75.7	73.8	
Numerator				
Denominator				
Data Source	VA PRAMS	VA PRAMS	VA PRAMS	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Final	Final	

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2017: data reported is most recent available data year for VA PRAMS (2016). Question reads, “In the past 2 weeks, how often has your baby slept alone in his or her own crib or bed?” Indicator reported is percent of infants who always/often slept alone in his or her own crib or bed.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2018: data reported is most recent available data year for VA PRAMS (2017). Question reads, “In the past 2 weeks, how often has your baby slept alone in his or her own crib or bed?” Indicator reported is percent of infants who always/often slept alone in his or her own crib or bed.	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2019: data reported is most recent available data year for VA PRAMS (2086). Question reads, “In the past 2 weeks, how often has your baby slept alone in his or her own crib or bed?” Indicator reported is percent of infants who always/often slept alone in his or her own crib or bed.	

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

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2018	**2019**	**2020**
Annual Objective		48.2	49.4
Annual Indicator	44.6	46.9	53.4
Numerator	39,580	40,840	45,255
Denominator	88,829	87,067	84,743
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2016	2018	2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			48.2	49.4
Annual Indicator	79.6	84.7	83.1	
Numerator				
Denominator				
Data Source	VA PRAMS	VA PRAMS	VA PRAMS	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Final	Final	

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2017: data reported is most recent available data year for VA PRAMS (2016). Question reads, “How did your baby usually sleep in the past 2 weeks?" With a blanket, With toys cushions or pillows, or With crib bumper pads” Indicator reported is percent of infants who did not sleep with a blanket, With toys cushions or pillows, or With crib bumper pads	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2018: data reported is most recent available data year for VA PRAMS (2017). Question reads, “How did your baby usually sleep in the past 2 weeks?" With a blanket, With toys cushions or pillows, or With crib bumper pads” Indicator reported is percent of infants who did not sleep with a blanket, With toys cushions or pillows, or With crib bumper pads	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2019: data reported is most recent available data year for VA PRAMS (2018). Question reads, “How did your baby usually sleep in the past 2 weeks?" With a blanket, With toys cushions or pillows, or With crib bumper pads” Indicator reported is percent of infants who did not sleep with a blanket, With toys cushions or pillows, or With crib bumper pads	

Form 10
State Performance Measures (SPMs)

State: Virginia

SPM 1 - Cross-Cutting (Early and Continuous Screening): Percent of infants who are diagnosed with a newborn screening disorder that are referred to care coordination services in the CYSHCN program

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	100	100
Numerator		436
Denominator		436
Data Source	VDH Newborn Screening Program, VDH EHDI	VDH Newborn Screening Program, VDH EHDI
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Note for Reporting Year 2020: All confirmed newborn screening disorders on Virginia's NBS panel are referred for care coordination services.

SPM 2 - Cross-Cutting (Youth Leadership): Develop and sustain the Virginia Department of Health Youth Advisor Program

Measure Status:	Active

State Provided Data			
	2018	2019	2020
Annual Objective			0
Annual Indicator		Yes	Yes
Numerator			
Denominator			
Data Source		VDH Adolescent Health Program	VDH Adolescent Health Program
Data Source Year		2019	2020
Provisional or Final ?		Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 reporting year: The Adolescent Health Program is currently in the process of hiring two Youth Advisors, young people who will provide their expertise on VDH's public health programs and initiatives.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Note for 2020 reporting year: The Adolescent Health Program used FY20 to create new positions, write job descriptions and complete the administrative processes required by the Virginia Department of Health's business unit. The positions were listed and the Adolescent Health Coordinator began screening the pool of applicants in September 2020. A few months later, VDH's Youth Advisors were onboarded and began their work at VDH.	

SPM 3 - MCH Workforce Development (Racial Equity): Develop and implement MCH workforce development policies addressing racial equity for all Title V program staff and subrecipient staff

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		No
Numerator		
Denominator		
Data Source		OFHS MCH Program Documentation
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Note for 2020 reporting year: VDH MCH began the following activities during program period 10/1/2020-09/30/2021:

Healthy Beginnings Learning & Practice cohort: As part of the Healthy Beginnings with Title V: Advancing Anti-Racism in Preterm Birth Prevention program, VDH MCH is partnered with the local organization Urban Baby Beginnings to identify and address racism in policy, data and funding structures at the state level that sustain inequities in perinatal health, including preterm birth, in Black, Latine/x, Indigenous, Asian, Pacific Islander, and other communities of color.

National Maternal Child Health Workforce Development Center cohort: VDH's Title V staff is partnering with family based organizations to determine what a well-functioning, MCH system would like that is co-powered with families. This cohort is an opportunity to ensure families equitably benefit from working together with local and state MCH leaders to develop and implement better polices, programs, and practices.

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	25.3	27.1
Numerator		
Denominator		
Data Source	VA PRAMS	VA PRAMS
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	23.8	23.3	22.8	22.3	21.8	21.3

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 reporting year: 2018 VA PRAMS data; Survey Question: Thinking back to just before you got pregnant with your new baby, how did you feel about becoming pregnant?; Answer options included in analysis: "I wanted to be pregnant later" and "I didn't want to be pregnant then or at any time in the future"; Division of Population Health Data, Office of Family Health Services.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Note for 2020 reporting year: 2019 VA PRAMS data; Survey Question: Thinking back to just before you got pregnant with your new baby, how did you feel about becoming pregnant?; Answer options included in analysis: "I wanted to be pregnant later" and "I didn't want to be pregnant then or at any time in the future"; Division of Population Health Data, Office of Family Health Services.	

SPM 5 - Cross-Cutting (Family Leadership): Percentage of VDH CYSHCN programs (i.e. Care Connection for Children, Child Development Centers, Bleeding Disorders Program, Sickle Cell Program) actively incorporating family engagement annually

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		100
Numerator		4
Denominator		4
Data Source		CYSHCN Program Documentation
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Note for 2020 reporting year: The CCCs have family engagement written into their workplans, where they either have a parent staff member on board or they partner with a family organization. The spirit of the CCC program is to support parents caring for CSHCN. The CDC program partners survey families who have received services for feedback. They also involve parents in their assessments. This often includes interviewing the parent or legal guardian regarding what they have observed about their child. The Sickle Cell Program families are representatives for the CDC workgroup that will help states determine what data is needed and help disseminate it once we have something. The Bleeding Disorders Program families were involved in the needs assessment focus groups.

Form 10
State Performance Measures (SPMs) (2016-2020 Needs Assessment Cycle)

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

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective	2.6	33.3	34.1	34.9
Annual Indicator	35.5	31	65.1	70.1
Numerator				
Denominator				
Data Source	VA PRAMS	VA PRAMS	VA PRAMS	VA PRAMS
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Note for 2017 reporting year: data source change; 2015 VA PRAMS data; Survey Question: What kind of birth control are you or your husband or partner using now to keep from getting pregnant?; Tiered Postpartum Birth Control includes: Tier 1 (Tubes tied, vasectomy, implant, IUD), Tier 2 (BC Pills, Injection, Patch), Tier 3(Condoms, rhythm, withdrawal, abstinence); Division of Population Health Data, Office of Family Health Services... Updated to 2016 VA PRAMS on 6.12.2019	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for 2018 reporting year: 2017 VA PRAMS data; Survey Question: What kind of birth control are you or your husband or partner using now to keep from getting pregnant?; Tiered Postpartum Birth Control includes: Tier 1 (Tubes tied, vasectomy, implant, IUD), Tier 2 (BC Pills, Injection, Patch), Tier 3(Condoms, rhythm, withdrawal, abstinence); Division of Population Health Data, Office of Family Health Services; 2016-2017 combined 33.2%	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 reporting year: 2018 VA PRAMS data; Survey Question: What kind of birth control are you or your husband or partner using now to keep from getting pregnant?; Tiered Postpartum Birth Control includes: Tier 1 (Tubes tied, vasectomy, implant, IUD), Tier 2 (BC Pills, Injection, Patch), Tier 3(Condoms, rhythm, withdrawal, abstinence); Division of Population Health Data, Office of Family Health Services.	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Note for 2020 reporting year: 2019 VA PRAMS data; Survey Question: What kind of birth control are you or your husband or partner using now to keep from getting pregnant?; Tiered Postpartum Birth Control includes: Tier 1 (Tubes tied, vasectomy, implant, IUD), Tier 2 (BC Pills, Injection, Patch), Tier 3(Condoms, rhythm, withdrawal, abstinence); Division of Population Health Data, Office of Family Health Services.	

2016-2020: SPM 6 - Cross-cutting (Family Engagement): Implement and develop report on survey of families served by the VDH Care Connection for Children (CCC) programs

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			0	0
Annual Indicator		Yes	Yes	Yes
Numerator				
Denominator				
Data Source		VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program
Data Source Year		2018	2019	2020
Provisional or Final ?		Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for 2018 reporting year: The Care Connection for Children (CCC) Family Survey was developed during FY18 with implementation and completion during FY18 and FY19.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 reporting year: The Care Connection for Children (CCC) Family Survey Report was drafted during FY18 and completed in November 2018 (FY19). The report was attached to the FY18 Report/FY20 Application. The team presented results to CCC directors and stakeholder, and also participated in an AMCHP 2020 workshop during FY20.	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Note for 2020 reporting year: The Care Connection for Children (CCC) Family Survey Report was drafted during FY18 and completed in November 2018 (FY19). The report was attached to the FY18 Report/FY20 Application. The team presented results to CCC directors and stakeholder, and also participated in an AMCHP 2020 workshop during FY20.	

2016-2020: SPM 7 - Cross-Cutting (Early and Continual Screening): Percent of infants with confirmed newborn screening disorders who are enrolled in supportive services no later than 6 months of age

Measure Status:			**Active**
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			60
Annual Indicator			17.9
Numerator			78
Denominator			436
Data Source			VDH NBS
Data Source Year			2019
Provisional or Final ?			Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 reporting year: This measure is replaced with SPM 1 - Cross-Cutting (Early and Continual Screening): Percent of infants who are diagnosed with a newborn screening disorder that are referred to care coordination services in the CYSHCN program.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Note for Reporting Year 2020: This measure will be replaced by SPM 1 (2021-2025). Although all infants with a confirmed Virginia core panel newborn screening disorder are referred for supportive services, the family has the option to decline services at that time or enroll in the future.	

Form 10
State Outcome Measures (SOMs)

State: Virginia

SOM 1 - Infant Mortality Disparity: Black/White Infant Mortality Ratio

Measure Status:	Active

State Provided Data			
	2018	2019	2020
Annual Objective			1.8
Annual Indicator	2.2	2	2.3
Numerator	9.6	9.7	10.6
Denominator	4.4	4.9	4.7
Data Source	VDH Division of Health Statistics	VDH Division of Health Statistics	VDH Division of Health Statistics
Data Source Year	2017	2018	2019
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	2.1	1.9	1.7	1.5	1.2	1.0

Field Level Notes for Form 10 SOMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2018: the data source is the latest available data year (2017) from the VDH Division of Health Statistics. Data reported is the black/white infant mortality rates per 1000 for VA residents	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2019: the data source is the latest available data year (2018) from the VDH Division of Health Statistics. Data reported is the black/white infant mortality rates	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2020: the data source is the latest available data year (2019) from the VDH Division of Health Statistics. Data reported is the black/white infant mortality rates	
4.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: reduce disparity to 1.24 based on 2019 state indicator data	

SOM 2 - Maternal Mortality Disparity: Black/White Maternal Mortality Ratio

Measure Status:	Active

State Provided Data			
	2018	2019	2020
Annual Objective			2.8
Annual Indicator	1.9	2.2	2.7
Numerator	52.6	32.4	38.2
Denominator	27.7	14.5	14.1
Data Source	National Vital Statistics System	National Vital Statistics System	National Vital Statistics System
Data Source Year	2013-2017	2014-2018	2015-2019
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	2.4	2.1	1.8	1.5	1.2	1.0

Field Level Notes for Form 10 SOMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2018: the data source is the National Vital Statistics System (NVSS), Federally Available Data Resource Document, NOM 3 - Maternal mortality rate per 100,000 live births, 2013-2017. Data from the VA Maternal Mortality Review show the following for 2015: VA maternal mortality ratio (42 days) = 1.0 VA White maternal mortality ratio (42 days) = 0.0 VA Black maternal mortality ratio (42 days) = 4.6	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2019: the data source is the National Vital Statistics System (NVSS), Federally Available Data Resource Document, NOM 3 - Maternal mortality rate per 100,000 live births, 2014-2018.	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2020: the data source is the National Vital Statistics System (NVSS), Federally Available Data Resource Document, NOM 3 - Maternal mortality rate per 100,000 live births, 2015-2019.	
4.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: reduce disparity to 1.23 in 5 years based on 2015_2019 state indicator data	

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Virginia

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective	7	15	20	25
Annual Indicator	15	30	30	30
Numerator				
Denominator				
Data Source	VDH Division of Child and Family Health	VDH Division of Child and Family Health	VDH Division of Child and Family Health	VDH Division of Child and Family Health
Data Source Year	2016-2017	2017-2018	2018-2019	2019-2020
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	35.0	50.0	100.0	100.0	100.0	125.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Data note for reporting year 2017: Developmental screening resources, training, and TA were provided to local health district staffs and non-MIECHV home visiting staff. The training included two face-to-face events and one poly com linked to eight sites. In addition, training requests were referred to community ASQ trainers to assure timely response in addressing needs. TA and resources were provided upon request via email, nursing newsletter to the health districts, or phone call.

2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Data note for reporting year 2018: Trainings were done with the local health department staff administering Resource Mothers, Healthy Start, MIECHV and other non-evidence based home visiting programs.

3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Data note for reporting year 2019: Work with the Virginia Early Childhood Foundation and selection of the 6 hub sites began late summer 2019. Hubs started surveying the screening landscape and establishing relationships and partnerships to support on-going systems collaboration and infrastructure building. Within the hubs, over 50 potential or informal partners were identified across hubs. Partners included several local coalitions which are themselves comprised of multiple stakeholders with capacity for resource sharing and cross-sector collaboration. Systems coordination activities included hosting informational meetings, identifying potential partners, learning which entities are already conducting screens and assessing how screens are being conducted (paper, online, ASQ or other, referral capacity, etc.).

4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Data note for reporting year 2020: In reporting year FY20, the contract was established with the Virginia Early Childhood Foundation (VECF). Over the past year, the six Developmental Screening Initiative (DSI) Hubs continued to make progress onboarding partners into the online ASQ platform, as well as collecting self-reported number of screens completed by/through other partners. This growth is evidenced by the increase in the number of documented screens. The six DSI Hubs reportedly conducted 915 screens documented in the final quarter: 102 total partners, 75 administering screens, 16 not conducting screens but planning to, and 11 not conducting screens. Data sharing agreements are planned through the VECF with 47 partners.

ESM 7.1.1 - Number of maternity centers disseminated Virginia's injury prevention curriculum

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	14
Numerator	
Denominator	
Data Source	VDH - Injury and Violence Prevention Program
Data Source Year	2020
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	16.0	17.0	18.0	19.0	20.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Note for 2020 reporting year: This ESM replaces the 2016-2020 ESM "Proportion of maternity centers with prenatal courses including Virginia's injury prevention curriculum"

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

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			2,549	2,549
Annual Indicator		2,596	1,560	1,738
Numerator				
Denominator				
Data Source		VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program
Data Source Year		2018	2019	2020
Provisional or Final ?		Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	2,549.0	2,549.0	2,549.0	2,549.0	2,549.0	2,549.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for 2018 reporting year: During FY18, 2,244 convertible safety seats and 352 boosters, totaling 2,596 were distributed to income eligible families.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 reporting year: The Low Income Safety Seat Distribution and Education Program, LISSDEP, network distributed 1,342 convertible seats and 218 booster seats, totaling 1,560 seats distributed to income eligible families, however, the network experienced a decrease in eligibility applications by clientele during the FY19. The program continued its programmatic evaluation to determine root cause(s) and uncover vulnerable communities within the network.	

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

Measure Status:	Active

State Provided Data

	2017	2018	2019	2020
Annual Objective			10	20
Annual Indicator		102	195	237
Numerator				
Denominator				
Data Source		VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program
Data Source Year		2018	2019	2020
Provisional or Final ?		Final	Final	Final

Annual Objectives

	2021	2022	2023	2024	2025	2026
Annual Objective	250.0	300.0	350.0	400.0	450.0	500.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for 2018 reporting year: 102 gatekeepers were trained in the prevention of suicide among youth for FY18	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 reporting year: During FY19, IVPP contracted with the James Madison Campus Suicide Prevention Center to coordinate Applied Suicide Intervention Skills Trainings, Recognizing and Responding to Suicide Risk trainings and Suicide to Hope evidence based trainings that are recognized by the Suicide Prevention Resource Center, the US Department of Health and Human Services and the Substance Abuse and Mental Health Services Administration (SAMSHA) for a total of 195 gatekeepers trained during the contracted period.	

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

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		25	100	250	400
Annual Indicator	0	0	0	0	37
Numerator					
Denominator					
Data Source	Division of Child and Family Health	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	40.0	45.0	50.0	55.0	60.0	65.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Note for 2017 reporting year: Modules are not complete at this time due to contract negotiations	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for 2018 reporting year: The program did not meet the annual target for this ESM because the modules are still under development. As was described in last year's report, the execution of the contract was a very difficult task to achieve and took the better part of a year. Since the execution of the contract, VDH has submitted outlines of the agency's content expectations for transition and medical home. The intent is for UVA to create online training modules for each topic that will have a provider and family track. Both will be free for families who live in Virginia and for providers who practice in the state (CME's will be offered).	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 reporting year: It is important to note that the modules were released in the fall of 2019 and VDH/UVA are working on a plan to promote them fully. The official public launch date of the module is November 24, 2019. As of January 27, 2020, Medical Home provider completed = 10 and Medical Home provider in progress = 11.	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Note for 2020 reporting year: The total number of people who enrolled for the medical home modules is 57. The breakdown by module type can be viewed below. This data is from state fiscal year 2020 (7/1/2019-6/30/2020). VDH's contract with UVA is on the state fiscal year. Medical Home for Healthcare Family=20 Medical Home for Healthcare Providers=37	

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

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		90	91.5	93	94.5
Annual Indicator	89.2	98.9	96.8	99	96
Numerator	4,061	4,391	4,239	4,788	5,490
Denominator	4,555	4,439	4,377	4,835	5,719
Data Source	Office of Family Health Services, VDH	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	96.0	97.5	98.0	99.5	99.5	99.5

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Note for 2017 reporting year: This figure represents data taken from 3 of our programs (CDC, VBDP, and SCP).	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for 2018 reporting year: Data provided for this ESM includes 3 of the 4 Children and Youth with Special Health Care Needs Programs (Child Development Centers, Sickle Cell, and Bleeding Disorders). The Care Connection for Children Program collects data regarding primary care provider but it is via survey. The 2018 survey result showed that 97.5% of parents surveyed report that their child has a primary care provider. It should also be noted that the Bleeding Disorders Program serves people of all ages, however the data represents clients under the age of 21.	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 reporting year: During the previous fiscal year, 95% of bleeding disorders pediatric clients, 97.5% of CCC clients, 99% of CDC clients, and 98% of sickle cell clients reported having a primary care provider. Overall, 97.3% of CYSHCN program clients reported having a primary care provider. It is important to note that this figure does not include adults that the bleeding disorders program serves and the CCC numbers were taken from the last program survey that was done in 2018.	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Note for 2020 reporting year: The percentage of CYSHCN served by the VA CYSHCN program who report having a primary care provider is 96%. This includes three programs (CCC, CDC, and the VBDP).	

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

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		25	100	250	400
Annual Indicator	0	0	0	0	45
Numerator					
Denominator					
Data Source	Division of Child and Family Health	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Provisional	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	40.0	45.0	50.0	55.0	60.0	65.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Note for 2017 reporting year: Modules are not complete at this time due to contract negotiations	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for 2018 reporting year: The program did not meet the annual target for this ESM because the modules are still under development. As was described in last year's report, the execution of the contract was a very difficult task to achieve and took the better part of a year. Since the execution of the contract, VDH has submitted outlines of the agency's content expectations for transition and medical home. The intent is for UVA to create online training modules for each topic that will have a provider and family track. Both will be free for families who live in Virginia and for providers who practice in the state (CME's will be offered).	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 reporting year: It is important to note that the modules were released in the fall of 2019 and VDH/UVA are working on a plan to promote them fully. The official public launch date of the module is November 24, 2019. As of January 27, 2020, Transition provider completed = 10 and Transition provider in progress = 14.	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Note for 2020 reporting year: The total number of people who enrolled for the modules is 86. The breakdown by module type can be viewed below. This data is from state fiscal year 2020 (7/1/2019-6/30/2020). VDH's contract with UVA is on the state fiscal year. Healthcare Transition for Healthcare Family= 41 Healthcare Transition for Healthcare Providers= 45	

ESM 12.2 - Percentage of Virginia school divisions reporting into the VDOE school health data system

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		68.2
Numerator		90
Denominator		132
Data Source		VDH and VDOE School Health Nurse Documentation
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	75.0	77.0	79.0	81.0	83.0	85.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Note for 2020 reporting year: Data is collected by school divisions and reported to VDOE via SSWS. Barrier to data collection: The reporting of data is not mandated and many school divisions do not have the bandwidth to collect the requested data.

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

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			6	6
Annual Indicator		3	4	8
Numerator				
Denominator				
Data Source		VDH Oral Health Program documentation	VDH Oral Health Program documentation	VDH Oral Health Program documentation
Data Source Year		2018	2019	2020
Provisional or Final ?		Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	6.0	6.0	6.0	7.0	7.0	8.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for 2018 reporting year: There were 3 Regional Oral Health Collaborative Projects that implemented work plans to increase dental visits among pregnant women in FY18. South Hampton Roads, Northern Virginia, Richmond/Petersburg; Central Virginia, Newport News and Southside to come in 2019. SWVA to come in 2020.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 reporting year: There were 4 Regional Oral Health Collaborative Projects that implemented work plans to increase dental visits among pregnant women in FY19. Richmond/Petersburg, South Hampton Roads, Northern Virginia, and Newport News.	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Note for 2020 reporting year: There were 8 Regional Oral Health Collaborative Projects that implemented work plans to increase dental visits among pregnant women in FY20. Two projects in Roanoke, and one each in Richmond/Petersburg, South Hampton Roads, Northern Virginia, Fairfax, Lenowisco, and Newport News.	

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

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			6	6
Annual Indicator		3	4	8
Numerator				
Denominator				
Data Source		VDH Oral Health Program documentation	VDH Oral Health Program documentation	VDH Oral Health Program documentation
Data Source Year		2018	2019	2020
Provisional or Final ?		Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	6.0	6.0	6.0	7.0	7.0	8.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for 2018 reporting year: There were 3 Regional Oral Health Collaborative Projects that implemented work plans to increase dental visits among among children (ages 0-11 years) and adolescents (ages 12-17 years). South Hampton Roads, Northern Virginia, Richmond/Petersburg; Central Virginia, Newport News and Southside to come in 2019. SWVA to come in 2020.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 reporting year: There were 4 Regional Oral Health Collaborative Projects that implemented work plans to increase dental visits among pregnant women in FY19. Richmond/Petersburg, South Hampton Roads, Northern Virginia, and Newport News.	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Note for 2020 reporting year: There were 8 Regional Oral Health Collaborative Projects that implemented work plans to increase dental visits among children (ages 0-11 years) and adolescents (ages 12-17 years) in FY20. Two projects in Roanoke, and one each in Richmond/Petersburg, South Hampton Roads, Northern Virginia, Fairfax, Lenowisco, and Newport News.	

ESM 15.1 - Number of Managed Care Organizations (MCO) and Care Connection for Children (CCC) Care Coordinators that attend statewide meeting

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	40.0	40.0	40.0	40.0	40.0	40.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Note for 2020 reporting year: This is a new measure for the new Five-Year Reporting Cycle (beginning FY 2021 – Oct 1, 2020-Sept 30, 2021 (Year 01)). There is no baseline data to report. Data will be reported here for the FY21 report.

ESM 15.2 - Number of Managed Care Organization (MCO) and Care Connection for Children (CCC) regions that commit to partnering with each other to reduce barriers

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	3.0	3.0	4.0	5.0	6.0	6.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Note for 2020 reporting year: This is a new measure for the new Five-Year Reporting Cycle (beginning FY 2021 – Oct 1, 2020-Sept 30, 2021 (Year 01)). There is no baseline data to report. Data will be reported here for the FY21 report.

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

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

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective	150	200	250	300
Annual Indicator	1,373	2,756	2,628	2,287
Numerator				
Denominator				
Data Source	VDH-OFHS Communications Specialist	VDH-OFHS Communications	VDH-OFHS Communications	VDH-OFHS Communications
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Note for 2017 Reporting Year: Data reported from unique site visits/hits occurring FY17 (Oct 2016-Sept 2017)	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for 2018 Reporting Year: This was pulled from number of “pageviews” to the SafeSleepVa.com website; provided by the Office of Communications – OFHS VDH Analytics 2019	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 Reporting Year: This was pulled from number of “pageviews” to the SafeSleepVa.com website; provided by the Office of Communications – OFHS VDH Analytics 2019	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Note for 2020 Reporting Year: This was pulled from number of “pageviews” to the SafeSleepVa.com website for the period 10/1/2019-9/30/2020; provided by the Office of Communications – OFHS VDH Analytics 2019	

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

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective		10,000	10,000	10,000
Annual Indicator	9,924	20,216	22,658	6,462
Numerator				
Denominator				
Data Source	Maternal/Infant Health Program - LHD Reports	Maternal/Infant Health Program - LHD Reports	Maternal/Infant Health Program - LHD Reports	Maternal/Infant Health Program - LHD Reports
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Note for 2017 reporting year: data provided from Local Health District mid-year reports from LHD Grant Year 3 (FY17); 22 LHDs reported	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for 2018 reporting year: This was reported by the 23 LHDs who had selected Safe Sleep as a priority. Each LHD had a different approach to educating parents and family members, some went to Child Care facilities and provided the education to parents, others educated all their car seat class attendees on a Safe Sleep environment. Other LHDs provided education to families at health fairs, PTA school meetings, at post-partum visits, WIC clients and upon receiving a positive pregnancy test if they presented to the LHDs for a pregnancy test.	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 reporting year: This was reported by the LHDs who had selected Safe Sleep as a priority. Each LHD had a different approach to educating parents and family members, some went to Child Care facilities and provided the education to parents, others educated all their car seat class attendees on a Safe Sleep environment. Other LHDs provided education to families at health fairs, PTA school meetings, at post-partum visits, WIC clients and upon receiving a positive pregnancy test if they presented to the LHDs for a pregnancy test. Some LHDs began training community providers and organizations to give safe sleep education, broadening reach.	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Note for 2020 reporting year: This was reported by the LHDs who selected Safe Sleep as a priority. Each LHD had a different approach to providing safe sleep counseling/education. The COVID-19 pandemic created an insurmountable challenge to completing MCH workplans at the LHDs. A number of LHD staff were assigned to work on the COVID response containment efforts.	

2016-2020: ESM 5.4 - Number of providers (home-visitors, doctors, nurses, health educators, etc.) educated about Safe Sleep environments and resources provided at www.safesleepva.com

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			500	500
Annual Indicator		562	823	4
Numerator				
Denominator				
Data Source		VDH Maternal and Infant Health Program documents	VDH Maternal and Infant Health Program documents	VDH Maternal and Infant Health Program documents
Data Source Year		2019	2019	2020
Provisional or Final ?		Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Note for 2018 reporting year: This was reported by the 23 LHDs who had selected Safe Sleep as a priority. Each LHD had a different approach to educating providers, some went to Child Care facilities and provided the education, others trained home visitors about a Safe Sleep environment and provide motivational interview techniques to make a home a safe sleep environment. Other LHDs provided education to hospital L&D staff, pediatrician offices, WIC staff and/or all staff in the LHD who interact with families with infants.

2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Note for 2019 reporting year: This was reported by the 26 LHDs who had selected Safe Sleep as a priority. Each LHD had a different approach to educating providers, some went to Child Care facilities and provided the education, others trained home visitors about a Safe Sleep environment and provide motivational interview techniques to make a home a safe sleep environment. Other LHDs provided education to hospital L&D staff, pediatrician offices, WIC staff and/or all staff in the LHD who interact with families with infants. FQHCs and other community partners such as local churches and other non-profit orgs received training.

3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Note for 2020 reporting year: This was reported by the LHDs who selected Safe Sleep as a priority. Each LHD had a different approach to providing safe sleep education/training/resources. The COVID-19 pandemic created an insurmountable challenge to completing MCH workplans at the LHDs. A number of LHD staff were assigned to work on the COVID response containment efforts.

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

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			35	35
Annual Indicator			35	0
Numerator				
Denominator				
Data Source			VDH Maternal and Infant Health Program documents/a	VDH Maternal and Infant Health Program documents
Data Source Year			2019	2020
Provisional or Final ?			Final	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 reporting year: The LHDs attend live bimonthly polycoms, if they aren't available all polycoms were recorded and placed on the intranet for them to view at their convenience. The format for the polycoms consist of any updates, budget discussion, data about topic for that polycom, key presentation by topic for that polycom, selected LHDs present what they are doing related to the topic presented (lessons learned, challenges, opportunities and provide their own lens of success), upcoming deadlines, questions. As new staff are onboarded they are required to review TA polycoms.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Note for 2020 reporting year: Due to COVID-19 Pandemic Response and a vacancy in the VDH Maternal/Infant Coordinator position, the bimonthly LHD MCH polycoms were stalled. However, all polycoms previously held were recorded and placed on the intranet for convenient viewing. The COVID-19 pandemic created an insurmountable challenge to completing MCH workplans at the LHDs. A number of LHD staff were assigned to work on the COVID response containment efforts.	

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

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			375	400
Annual Indicator			243	247
Numerator				
Denominator				
Data Source			VDH Home visiting programs	VDH Home visiting programs
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Note for 2018 reporting year: Number of home visitors is compiled from JMU trainings and EIV trainings for the period noted. 84% of MIECHV sites reported safe sleep measures adhered to and 89% of Healthy Start sites reported safe sleep measures adhered to. For FY18 174 home visitors completed Early Impact Virginia training modules that discuss safe sleep environment.

2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Note for 2019 reporting year: The Safe Sleep trainings provided through The Institute consists of 4 modules that all cover safe sleep and environment in various contexts. Home visitors are only required to take them once but can repeat them as their training plans deems necessary. Each module averages about 100-200 participants annually. Due to this, an average was calculated to address this ESM. This gives a more accurate reflection of objective calculations.
A total of 243 home visitors completed one or more of the following modules - Infant Care--The ABCs of Safe Sleep for Infants (92), Child Development--Secrets of Baby Behavior (111), and Promoting Safe and Healthy Homes (40).

3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Note for 2020 reporting year: The Safe Sleep training provided through The Institute consists of 3 modules that all cover safe sleep and environment in various contexts. Home visitors are only required to take them once but can repeat them as their training plans deems necessary. Each module averages about 100-200 participants annually. Due to this, an average was calculated to address this ESM. This gives a more accurate reflection of objective calculations. A total of 247 home visitors completed one or more of the following modules - Infant Care--The ABCs of Safe Sleep for Infants (64) and 404 users across the nation took the module; Child Development--Secrets of Baby Behavior (122) and 928 users completed nationwide; and Promoting Safe and Healthy Homes (61) and 414 users completed nationwide. Number of home visitors is compiled from JMU training and EIV training for the period noted. 87.5% of MIECHV sites reported safe sleep measures adhered to and 71% of Healthy Start sites reported safe sleep measures adhered to.

2016-2020: ESM 6.2 - Number of hits to the VDH web pages by individuals seeking information about the importance of regular developmental screening and Bright Futures

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective	100	125	200	250
Annual Indicator	0	0	100	0
Numerator				
Denominator				
Data Source	VDH Division of Child and Family Health	VDH Division of Child and Family Health	VDH Division of Child and Family Health	VDH DCFH Child Health Unit
Data Source Year	2016-2017	2017-2018	2018-2019	2019-2020
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2017: Unfortunately, the Office of Information Management does not have the analytics for the Bright Futures site. This site is on the IIS (old) server and the ability to track analytics on the IIS server was lost when VDH switched to WordPress and Google Analytics. WebTrends was used for this purpose on the IIS server, but it became incredibly expensive to maintain so it was discontinued mid-year. The staff are working with the web master to convert Bright Futures web page to WordPress and Google Analytics.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2018: The agency migrated to a new platform; substantial revisions were required to re-establish the web page, therefore data is not available for FY 2018.	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 reporting year: ASQ navigators have been out in the community conveying the importance of developmental screening during face-to-face meetings with significant stakeholders. The South Hampton Roads Developmental Screening Initiative has its own page conveying information about the benefits of developmental screening on the GHRconnects.org webpage. DSI hubs are discussing possibilities for sharing and collaborating with messaging resources.	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Note for 2020 reporting year:The VDH agency web pages were transferred to a new server; the ASQ and Bright Future pages were not transferred. The web site is in the process of being re-created in partnership with the six hub sites. The ASQ3 and ASQ-SE2 materials in English and multiple languages have been uploaded to the VDH intranet (https://vdhweb.vdh.virginia.gov/nursing/directives-guidelines/) for use by health department home visiting programs and local health district staff. In moving forward, plans are underway to work with the six funded DSI hubs to build out resources for sharing and for collaborating with messaging resources. This measure is discontinued.	

2016-2020: ESM 6.3 - Completion of actionable 2-year plan (FY19-FY20) for strengthening the comprehensive, complex developmental screening system of care for children 0-8

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			0	0
Annual Indicator			Yes	Yes
Numerator				
Denominator				
Data Source			VDH Division of Child and Family Health	VDH DCFH Child Health Unit
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Not for 2018 reporting year: During FY 2018 and 2019, the module is under development. Contracts for uploading the final approved module to a training web site were under negotiation during FY 18.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 reporting year: The field note from last year does not apply to this project. A state strategic plan was developed from three stakeholder meetings from 2017-2018. A subrecipient agreement was initiated with the Virginia Early Childhood Foundation to forward progress within three key activity areas of the Developmental Screening Initiative: Partnerships and Systems Coordination, Increasing Child Development Screening, and Messaging based on the State Strategic Plan.	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Note for 2020 reporting year: The state strategic plan was used to revise and align the work plans for the six DSI hubs. Upon execution of VDH –VECF Memorandum of Understanding on December 12, 2019, VECF begin to revise VECF-Smart Beginnings statements of work accordingly and to shepherd appropriate joint signature processes with all six hubs. VECF developed a quarterly reporting format with input from VDH representatives and uploaded to the VECF platform “Foundant” for hub reporting going forward to assist with monitoring progress on work plans and budgets. This measure is discontinued.	

2016-2020: ESM 7.1.1 - Proportion of maternity centers with prenatal courses including Virginia's injury prevention curriculum

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		0	10	15	20
Annual Indicator	0	0	0	12	0
Numerator	0	0	0	3	
Denominator	60	60	53	25	
Data Source	Office of Family Health Services, VDH	Office of Family Health Services, VDH	VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Provisional	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for 2018 reporting year: Numerator 0; Deliverable addressed development of the curriculum for FY18.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 reporting year: During FY19, IVPP worked with 25 maternity hospitals to continue technical assistance in the readiness and implementation of Project Patience. During the course of the year, 3 Bon Secours maternity hospitals agreed to infuse the VDH curriculum into their current Love and Learn maternity hospital education. 1 VDH Local Health District adopted Project Patience content on Violence Prevention and Abusive Head Trauma prevention as an extension of 1 Northern Virginia hospital. The remaining hospitals are anticipated to embed the curriculum into its process given a two year approval cycle. The total number of maternity centers with prenatal courses including Virginia’s injury prevention curriculum is expected to rise in FY20 and FY21.	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Note for 2020 reporting year: This ESM is being replaced for 2021-2025 period by "Number of maternity centers disseminated Virginia's injury prevention curriculum"	

2016-2020: ESM 7.1.3 - Number of healthcare providers receiving Project ECHO content in reducing the impact of NAS

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			25	30
Annual Indicator			119	17
Numerator				
Denominator				
Data Source			VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for 2018 reporting year: Numerator 0; FY18 budget was not released to IVP until mid year. Contract process with UVA was extended over six months. Project ECHO lab was released in November 2018. The number of healthcare providers at current state for FY19 has exceeded the annual objectives.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 reporting year: During FY19, IVPP worked with the University of Virginia which held bi-weekly Project ECHO sessions from December 2018 to May 2019. 12 NAS ECHO labs were held during that time period. The remaining of the contracted period was spent evaluating progress and developing content for the following FY period. Content was delivered to 119 MDs, NPs, PAs and other healthcare providers caring for patients diagnosed and at risk for NAS. Content for each session was drawn form the SAMSHA Clinical Guide for Managing Pregnant and Parenting Patients with Opioid Use Disorder and their Infants.	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Note for 2020 reporting year: Decrease related to COVID-19 response	

2016-2020: ESM 11.3 - Percentage of children enrolled in public schools who report a primary care provider

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		40	42.5	45	47.5
Annual Indicator	30.6	0	0	0	0
Numerator	200,000				
Denominator	653,103				
Data Source	Virginia Department of Education	Virginia Department of Education	Virginia Department of Education	Virginia Department of Education	Virginia Department of Education
Data Source Year	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Note for 2017 reporting year: Data not available this reporting year due to question removal from the school nurse survey. The state MCH director, epidemiologist, and Title V coordinator are developing plans with the Department of Education school nurse contact to review processes and maximize opportunity for data collection.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for 2018 reporting year: Data not available this reporting year due to question removal from the school nurse survey. The state MCH director, epidemiologist, and Title V coordinator are developing plans with the Department of Education school nurse contact to review processes and maximize opportunity for data collection.	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 reporting year: Data not available this reporting year due to revision of the school nurse survey. The state Title V coordinator, epidemiologist, and school nurse consultant are developing plans with the Department of Education school nurse contact to review processes and maximize opportunity for data collection.	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Note for 2020 reporting year: Data not available for this measure due to revisions of the school nurse survey. This measure will be replaced by ESM 12.2.	

Form 10
State Performance Measure (SPM) Detail Sheets

State: Virginia

SPM 1 - Cross-Cutting (Early and Continuous Screening): Percent of infants who are diagnosed with a newborn screening disorder that are referred to care coordination services in the CYSHCN program
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Increase the percentage of infants with confirmed newborn screening disorders who enter care coordination
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of infants with a confirmed newborn screening disorders who are referred to care coordination **Denominator:** Total number of infants with a confirmed newborn screening disorder
Data Sources and Data Issues:	Data Source: NBS, EHDI Program, VISITS, VaCARES; Data lag is 2 years
Significance:	Early identification of developmental disorders is critical to the well-being of children and their families. The Virginia MCH priority for early and continual screening supports optimal physical, mental health and social emotional development for all children.

SPM 2 - Cross-Cutting (Youth Leadership): Develop and sustain the Virginia Department of Health Youth Advisor Program
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	To ensure VDH's Title V Programming is increasing family and youth leadership in Title V-funded initiatives.
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** N/A **Denominator:**
Data Sources and Data Issues:	VDH Adolescent Health Program documents
Significance:	One of the emerging priorities of VDH's Title V Program is increasing family and youth engagement in Title V-funded initiatives. As a result, VDH's Adolescent Health Program must establish a structure that consistently brings youth voice into adolescent health programs.

SPM 3 - MCH Workforce Development (Racial Equity): Develop and implement MCH workforce development policies addressing racial equity for all Title V program staff and subrecipient staff
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Eliminate drivers of structural and institutional racism
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** 0 **Denominator:**
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Child and Family Health
Significance:	The 10 Essential Public Health Services (EPHS) provide a framework for public health to protect and promote the health of all people in all communities.. For the past 25 years, the EPHS have served as a well-recognized framework for carrying out the mission of public health. The 2020 revised version places equity firmly at its core, actively promoting policies, systems, and overall community conditions that enable optimal health for all and seek to remove systemic and structural barriers that have resulted in health inequities. Such barriers include poverty, racism, gender discrimination, ableism, and other forms of oppression. Everyone should have a fair and just opportunity to achieve optimal health and well-being.

SPM 4 - Pregnancy Intention: Mistimed or Unwanted pregnancy (wanted to become pregnant later or never)
Population Domain(s) – Women/Maternal Health, Adolescent Health

Measure Status:	Active
Goal:	Virginians have access to equitable choice-centered reproduction-related services, including sex education, family planning, fertility/grief support, and parenting support.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women responding that they wanted to become pregnant later or never **Denominator:** Number of live births
Data Sources and Data Issues:	VA PRAMS
Significance:	This state priority measure was identified through the Title V needs assessment. The goal aligns with the Virginia Plan for Well-Being (Goal 2.1). Comprehensive family planning and preconception health lead to improved birth outcomes, which are associated with better health and cognition as children mature. Family planning services include providing education and contraception. These services help families have children when they are financially, emotionally, and physically ready. Publicly-supported family planning services prevent an estimated 1.3 million unintended pregnancies a year in the United States. The trend toward having smaller families and waiting at least 24 months between pregnancies has contributed to better health of infants and children. Preconception health services for females and males include health screenings, counseling, and clinical services that enable them to become as healthy as possible before pregnancy.

SPM 5 - Cross-Cutting (Family Leadership): Percentage of VDH CYSHCN programs (i.e. Care Connection for Children, Child Development Centers, Bleeding Disorders Program, Sickle Cell Program) actively incorporating family engagement annually
Population Domain(s) – Children with Special Health Care Needs

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>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).</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of CYSHCN programs documenting family engagement in work plans and annual reports</td></tr>
<tr><td>Denominator:</td><td>Number of CYSHCN programs</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>VDH CYSHCN Program and MCH Epidemiology Unit program documents</td></tr>
<tr><td>Significance:</td><td>Building the capacity of women and children, including CSHCN, and their families to partner in decision-making is a critical strategy in helping states to achieve the identified MCH priorities.</td></tr>
</table>

Form 10
State Performance Measure (SPM) Detail Sheets (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 4 - Unintended Pregnancy: Proportion of females ages 15-44 using Tier 1 (most effective) contraceptive methods
Population Domain(s) – Women/Maternal Health, Adolescent Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Virginians plan their pregnancies.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of females ages 15-44 using Tier 1 method of contraceptive</td></tr>
<tr><td>Denominator:</td><td>Number of females ages 15-44</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2020 Objective:</td><td>Increase the proportion of pregnancies that are intended (FP-1). Increase the percentage of adult females aged 20 to 44 years who are at risk of unintended pregnancy that adopt or continue use of the most effective or moderately effective methods of contraception (FP-16.1). Increase the percentage of adolescent females aged 15 to 19 years who are at risk of unintended pregnancy that adopt or continue use of the most effective or moderately effective methods of contraception (FP-16.2). Reduce pregnancies among adolescent females aged 15 to 17 years (FP-8.1). Reduce pregnancies among adolescent females aged 18 to 19 years (FP-8.2).</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>VA PRAMS</td></tr>
<tr><td>Significance:</td><td>This state priority measure was identified through the Title V needs assessment, CDC winnable battle, and Healthy People 2020. The goal aligns with the Virginia Plan for Well-Being (Goal 2.1).

Comprehensive family planning and preconception health lead to improved birth outcomes, which are associated with better health and cognition as children mature. Family planning services include providing education and contraception. These services help families have children when they are financially, emotionally, and physically ready. Publicly-supported family planning services prevent an estimated 1.3 million unintended pregnancies a year in the United States. The trend toward having smaller families and waiting at least 24 months between pregnancies has contributed to better health of infants and children. Preconception health services for females and males include health screenings, counseling, and clinical services that enable them to become as healthy as possible before pregnancy.</td></tr>
</table>

2016-2020: SPM 6 - Cross-cutting (Family Engagement): Implement and develop report on survey of families served by the VDH Care Connection for Children (CCC) programs
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Assure families of children with special health care needs partner in decision making at all levels and are satisfied with the services they receive (CYSHCN National Standard: Family Professional Partnerships / Cultural Competence)
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** N/A **Denominator:**
Healthy People 2020 Objective:	MICH-31: Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, and coordinated systems
Data Sources and Data Issues:	VDH CYSHCN Program and MCH Epidemiology Unit program documents
Significance:	Building the capacity of women and children, including CSHCN, and their families to partner in decision-making is a critical strategy in helping states to achieve the identified MCH priorities.

2016-2020: SPM 7 - Cross-Cutting (Early and Continual Screening): Percent of infants with confirmed newborn screening disorders who are enrolled in supportive services no later than 6 months of age
Population Domain(s) – Cross-Cutting/Systems Building

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percentage of infants with confirmed hearing loss who are enrolled in Early Intervention (EI) services by six months of age</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of infants with confirmed newborn screening disorders who are enrolled in supportive services by 6 months of age</td></tr>
<tr><td>Denominator:</td><td>Total number of infants up to 6 months of age with confirmed newborn screening disorders</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2020 Objective:</td><td>Related to Maternal, Infant, and Child Health (MICH) Objective 29-1: Increase the proportion of children (aged 10-35 months) who have been screened for an Autism Spectrum Disorder and other developmental delays.</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: NBS, EHDI Program, VISITS, VaCARES; Data lag is 2 years</td></tr>
<tr><td>Significance:</td><td>Early identification of developmental disorders is critical to the well-being of children and their families. The Virginia MCH priority for early and continual screening supports optimal physical, mental health and social emotional development for all children.</td></tr>
</table>

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Virginia

SOM 1 - Infant Mortality Disparity: Black/White Infant Mortality Ratio
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	Decrease the infant mortality disparity ratio for non-Hispanic White and non-Hispanic Black from 2.15 (2017) to 1.57 by 2022.
Definition:	**Unit Type:** Ratio **Unit Number:** 1 **Numerator:** Rate of non-Hispanic Black infant mortality **Denominator:** Rate of non-Hispanic White infant mortality
Data Sources and Data Issues:	Virginia Department of Health, Office of Information Management, Division of Health Statistics; compiled by the Division of Population Health Data, Office of Family Health Services
Significance:	A significant disparity exists in infant deaths between racial groups, especially for infants born to Black women. Black women had an infant mortality rate in 2013 at 12.2, 2.4 times that for White women (5.2). Goal 2.3 of Virginia's Plan for Well-Being is that the Racial Disparity in Virginia's Infant Mortality Rate is Eliminated.

SOM 2 - Maternal Mortality Disparity: Black/White Maternal Mortality Ratio
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	Decrease the racial disparity in the maternal mortality rate in Virginia
Definition:	**Unit Type:** Ratio **Unit Number:** 1 **Numerator:** Rate of Black maternal mortality **Denominator:** Rate of White maternal mortality
Data Sources and Data Issues:	National Vital Statistics System (NVSS) - (NOM 3 - Maternal mortality rate per 100,000 live births - Federally Available Data Resource Document) and Virginia Maternal Mortality Review Committee (MMRC); Also of note are significant data quality concerns for death certificate coding within the National Vital Statistics System (NVSS)
Significance:	Maternal mortality is a sentinel indicator of health and health care quality worldwide. There are also significant racial disparities with Black women having rates of maternal mortality over two times as high as White women in Virginia. On June 5, 2019 Virginia's governor announced a goal to eliminate the racial disparity in the maternal mortality rate in Virginia by 2025.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Virginia

ESM 4.1 - Development of a coordinated action plan of gap-filling activities for breastfeeding programming across VDH divisions
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Advance equity in breastfeeding, parenting, and childcare supports to further development of baby-friendly communities in Virginia
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** N/A **Denominator:**
Data Sources and Data Issues:	VDH Division of Child & Family Health program documentation
Significance:	The VDH Title V MCH needs assessment identified strong social supports and services as a need for families. Support system and service needs focused on financial stress and issues, access to and navigation within housing and transportation, lack of community, essential supplies for infants like diapers, breastfeeding, and mental health counseling.

ESM 6.1 - Number of LHDs, community partners, and providers receiving developmental screening resources, training, or TA
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	To increase developmental screening rates for all children in Virginia.
Definition:	**Unit Type:** Count **Unit Number:** 150 **Numerator:** Number of LHDs, community partners, and providers receiving developmental screening resources, training, or TA **Denominator:**
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Child and Family Health
Significance:	Increasing early identification of disease or conditions through developmental screening will improve referral and treatment for children with special needs.

ESM 7.1.1 - Number of maternity centers disseminated Virginia's injury prevention curriculum
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
Goal:	Reduce non-fatal injury related hospitalizations for children ages 0 through 9 and adolescents ages 10 through 19.
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of maternity centers disseminated Virginia's injury prevention curriculum. **Denominator:**
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Prevention and Health Promotion; Injury and Violence Prevention Program, piloting evaluation tool in REDCap to track information from maternity centers
Evidence-based/informed strategy:	Increase knowledge of best practices
Significance:	This ESM was identified through the Title V needs assessment, Virginia's Well-being Plan, and Healthy People 2020 (IVP 1.2). Research from a variety of external sources indicates that the impact of childhood injuries can be reduced with effective primary prevention strategies.

ESM 7.1.2 - Number of child safety seats disseminated through the LISSDEP network
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
Goal:	Reduce non-fatal injury related hospitalizations for children ages 0 through 9 and adolescents ages 10 through 19.
Definition:	**Unit Type:** Count **Unit Number:** 100,000 **Numerator:** Number of child safety seats disseminated through the LISSDEP network **Denominator:**
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Prevention and Health Promotion (DPHP); the DPHP tracks the inventory disseminated
Significance:	This ESM was identified through the Title V needs assessment, Virginia's Well-being Plan, and Healthy People 2020 (IVP 1.2). Research from a variety of external sources indicates that child restraint and restraint systems reduce injury and injury severity in children.

ESM 7.2.1 - Number of gatekeepers trained in the prevention of suicide among youth
NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Measure Status:	Active
Goal:	Reduce non-fatal injury related hospitalizations for children ages 0 through 9 and adolescents ages 10 through 19.
Definition:	**Unit Type:** Count **Unit Number:** 100,000 **Numerator:** Number of gatekeepers trained in the prevention of suicide among youth **Denominator:**
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Prevention and Health Promotion (DPHP); DPHP will track the number of participants from quarterly reports of program stakeholders
Significance:	Unintentional injury is the leading cause of child and adolescent mortality, from age 1 through 19. Homicide and suicide, violent or intentional injury, are the second and third leading causes of death for adolescents ages 15 through 19. Gatekeeper training is designed to help professionals interacting with youth and adolescents identify and refer students at risk for suicide.

ESM 11.1 - Number of providers in Virginia who have completed the medical home training module
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Increase the number of typical and children with special health care needs who can identify a primary care provider as a medical home
Definition:	**Unit Type:** Count **Unit Number:** 100,000 **Numerator:** Number of providers in Virginia who have completed the medical home training module **Denominator:**
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Child and Family Health
Significance:	This ESM was identified through the Title V needs assessment, Virginia's Well-being Plan, and Healthy People 2020 (MICH-30).

ESM 11.2 - Percentage of children served by the VA CYSHCN Program who report having a medical home
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Increase the number of typical and children with special health care needs who can identify a primary care provider as a medical home
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children served by the VA CYSHCN Program who report having a medical home **Denominator:** Total number of children served by the VA CYSHCN Program
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Services, Division of Child and Family Health, CYSHCN Program; includes the CCC-SUN database and figures reported directly by contractors/program partners for the state fiscal year.
Significance:	The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. Providing comprehensive care to children in a medical home is the standard of pediatric practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. The Maternal and Child Health Bureau uses the AAP definition of medical home.

ESM 12.1 - Number of providers in Virginia who have completed the transition training module.
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Measure Status:	Active
Goal:	Increase the number of children ages 10-24 engaged in transition services to adult health care
Definition:	**Unit Type:** Count **Unit Number:** 100,000 **Numerator:** Number of providers in Virginia who have completed the transition training module **Denominator:**
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Child and Family Health
Significance:	This ESM was identified through the Title V needs assessment, Virginia's Well-being Plan, and Healthy People 2020 (DH-5).

ESM 12.2 - Percentage of Virginia school divisions reporting into the VDOE school health data system
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Measure Status:	Active
ESM Subgroup(s):	CSHCN and non-CSHCN
Goal:	Maintain and expand MCH data capacity regarding school health
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Virginia school divisions reporting into the VDOE school health data system **Denominator:** Number of Virginia school divisions
Data Sources and Data Issues:	VDH and VDOE School Health Nurse Documentation (numerator); VDOE Statistics and Reports, Enrollment & Demographic tables, Local and Regional Schools and Centers (denominator) (http://www.doe.virginia.gov/statistics_reports/enrollment/index.shtml)
Significance:	School nurses recognize the importance of each student having a medical home and healthcare transition services, as supported by the American Academy of Pediatrics, American Academy of Family Physicians and American College of Physicians. Poor health has the potential to impact negatively the youth and young adults' academic and vocational outcomes. Health and health care are cited as two of the major barriers to making successful transitions. The VDH School Health Nurse Consultant partnership with the VDOE School Nurse Consultant is critical to understanding scope of needs and services regarding school health in Virginia.

ESM 13.1.1 - Number of Regional Oral Health Collaborative Projects that implemented work plans to increase dental visits among pregnant women
NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

Measure Status:	Active
Goal:	Assure access to oral health services for pregnant women, all children (including those with special health care needs), and their families.
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** Number of Regional Oral Health Collaborative Projects that implemented work plans to increase dental visits among pregnant women **Denominator:**
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Prevention and Health Promotion (DPHP); Oral Health Program documentation
Significance:	Oral health is a vital component of overall health and oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children's health, education, and ability to prosper. Preventive dental care in pregnancy is also recommended by the American College of Obstetricians and Gynecologists (ACOG) to improve lifelong oral hygiene habits and dietary behavior for women and their families.

ESM 13.2.1 - Number of Regional Oral Health Collaborative Projects that implemented work plans to increase dental visits among children (ages 0-11 years) and adolescents (ages 12-17 years)
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	Assure access to oral health services for pregnant women, all children (including those with special health care needs), and their families.
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** Number of Regional Oral Health Collaborative Projects that implemented work plans to increase dental visits among children ages 0-17 years **Denominator:**
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Prevention and Health Promotion (DPHP); Oral Health Program documentation
Significance:	Oral health is a vital component of overall health and oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children's health, education, and ability to prosper. To prevent tooth decay and oral infection, the American Academy of Pediatric Dentistry (AAPD) recommends preventive dental care for all children after the eruption of the first tooth or by 12 months of age, usually at intervals of every 6 months.

ESM 15.1 - Number of Managed Care Organizations (MCO) and Care Connection for Children (CCC) Care Coordinators that attend statewide meeting
NPM 15 – Percent of children, ages 0 through 17, who are continuously and adequately insured

Measure Status:	Active
Goal:	Increase the adequacy of insurance for children and youth with special health care needs (CYSHCN).
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** Number MCO and CCC Care Coordinators that attend statewide meeting **Denominator:**
Data Sources and Data Issues:	VDH CYSHCN Program Documents
Significance:	The VDH Title V MCH needs assessment identified that health insurance for health care services for CYSHCN is both an asset and a frustration for families. The assessment also demonstrated that parents struggle to understand their insurance and what it provides. Examples of barriers mentioned included: filling out required paperwork; understanding information about insurance/confusion; being able to access certain medications; language issues; not having insurance at all; and MCO/benefit changes mid-year that at times may disrupt services provided.

ESM 15.2 - Number of Managed Care Organization (MCO) and Care Connection for Children (CCC) regions that commit to partnering with each other to reduce barriers
NPM 15 – Percent of children, ages 0 through 17, who are continuously and adequately insured

Measure Status:	Active
Goal:	Increase the adequacy of insurance for children and youth with special health care needs (CYSHCN).
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of MCO/CCC regions that commit to partnering with each other **Denominator:**
Data Sources and Data Issues:	VDH CYSHCN Program Documents
Significance:	The VDH Title V MCH needs assessment identified that health insurance for health care services for CYSHCN is both an asset and a frustration for families. The assessment also demonstrated that parents struggle to understand their insurance and what it provides. Examples of barriers mentioned included: filling out required paperwork; understanding information about insurance/confusion; being able to access certain medications; language issues; not having insurance at all; and MCO/benefit changes mid-year that at times may disrupt services provided.

Form 10
Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 5.2 - Number of visits to the SafeSleepVA.com website
2016-2020: NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To promote safe sleep practices to parents, providers, and caregivers of infants.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>1,000,000</td></tr>
<tr><td>Numerator:</td><td>Number of visits to the SafeSleepVA.com website</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Virginia Department of Health, Office of Family Health Services, Division of Child and Family Health</td></tr>
<tr><td>Significance:</td><td>Reducing sleep-related infant deaths is a state priority.</td></tr>
</table>

2016-2020: ESM 5.3 - Number of individuals counseled/educated about Safe Sleep environments
2016-2020: NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	To increase consistent messaging regarding safe sleep practices.
Definition:	<table><tr><td>**Unit Type:**</td><td>Count</td></tr><tr><td>**Unit Number:**</td><td>100,000</td></tr><tr><td>**Numerator:**</td><td>Number of individuals counseled/educated about Safe Sleep environments</td></tr><tr><td>**Denominator:**</td><td></td></tr></table>
Data Sources and Data Issues:	VDH, Office of Family Health Services, Division of Child and Family Health - Maternal and Infant Health Program documentation; Local Health District reports
Significance:	The number of U.S. sleep-related Sudden Unexpected Infant Death (SUID) cases, including Sudden Infant Death Syndrome (SIDS), is approximately 3,500 deaths per year. Since the Back to Sleep campaign launched in 1994, the overall U.S. SIDS rate declined by more than 60%; the proportion of infants placed on their backs to sleep increased from 27% in 1993 to 74% in 2011. Strategies to increase the percentage of infants usually placed to sleep on their backs include supporting the implementation of safe sleep practices through policies, accreditation, and legislation.

2016-2020: ESM 5.4 - Number of providers (home-visitors, doctors, nurses, health educators, etc.) educated about Safe Sleep environments and resources provided at www.safesleepva.com
2016-2020: NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase safe sleep educational awareness to providers</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>100,000</td></tr>
<tr><td>Numerator:</td><td>Number of providers (home-visitors, doctors, nurses, health educators, etc.) educated about Safe Sleep environments and resources provided at www.safesleepva.com</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>VDH, Office of Family Health Services, Maternal and Infant Health Program documents; Local Health District Reports</td></tr>
<tr><td>Significance:</td><td>The number of U.S. sleep-related Sudden Unexpected Infant Death (SUID) cases, including Sudden Infant Death Syndrome (SIDS), is approximately 3,500 deaths per year. Since the Back to Sleep campaign launched in 1994, the overall U.S. SIDS rate declined by more than 60%; the proportion of infants placed on their backs to sleep increased from 27% in 1993 to 74% in 2011. Strategies to increase the percentage of infants usually placed to sleep on their backs include supporting the implementation of safe sleep practices through policies, accreditation, and legislation.</td></tr>
</table>

2016-2020: ESM 5.5 - Interdisciplinary Workforce Development - Number of Local Health Departments (LHD) attending VDH technical assistance for safe sleep environment.
2016-2020: NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To promote safe sleep practices to parents, providers, and caregivers of infants.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of LHDs attending VDH/Maternal & Infant Health Program polycom for technical assistance on safe sleep environment.</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Virginia Department of Health, Division of Child and Family Health; Maternal and Infant Health Program documents/attendance sheets.</td></tr>
<tr><td>Significance:</td><td>Sleep-related infant deaths, also called Sudden Unexpected Infant Deaths (SUID), are the leading cause of infant death after the first month of life and the third leading cause of infant death overall. Sleep-related SUIDs include Sudden Infant Death Syndrome (SIDS), unknown cause, and accidental suffocation and strangulation in bed. Due to heightened risk of SIDS when infants are placed to sleep in side (lateral) or stomach (prone) sleep positions, the American Academy of Pediatrics (AAP) has long recommended the back (supine) sleep position.

Successful methods for improving parent safe sleep knowledge range from hospital staff education to crib distribution programs. Such efforts have been shown to increase parental knowledge, reduce bed-sharing rates, increase supine sleeping rates, and decrease incidences of SIDS. Thus, increasing the number of health care professionals receiving the safe sleep training will increase the number of parents educated about sleep safety.</td></tr>
</table>

2016-2020: ESM 5.6 - Interdisciplinary Workforce Development - Number of home visitors completing Early Impact Virginia training modules that discuss safe sleep environment.
2016-2020: NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To promote safe sleep practices to parents, providers, and caregivers of infants.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>100,000</td></tr>
<tr><td>Numerator:</td><td>Number of home visitors completing Early Impact Virginia training modules that discuss safe sleep environment.</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Virginia Department of Health, Division of Child and Family Health; Home visiting program/Early Impact Virginia documentation</td></tr>
<tr><td>Significance:</td><td>Sleep-related infant deaths, also called Sudden Unexpected Infant Deaths (SUID), are the leading cause of infant death after the first month of life and the third leading cause of infant death overall. Sleep-related SUIDs include Sudden Infant Death Syndrome (SIDS), unknown cause, and accidental suffocation and strangulation in bed. Due to heightened risk of SIDS when infants are placed to sleep in side (lateral) or stomach (prone) sleep positions, the American Academy of Pediatrics (AAP) has long recommended the back (supine) sleep position.

Successful methods for improving parent safe sleep knowledge range from hospital staff education to crib distribution programs. Such efforts have been shown to increase parental knowledge, reduce bed-sharing rates, increase supine sleeping rates, and decrease incidences of SIDS. Thus, increasing the number of health care professionals receiving the safe sleep training will increase the number of parents educated about sleep safety. Modules through Early Impact Virginia include Secrets of Baby Behavior, Three-Step Counseling, Promoting Safe and Healthy Homes, and a new Safe Sleep module scheduled to launch August 2018.</td></tr>
</table>

2016-2020: ESM 6.2 - Number of hits to the VDH web pages by individuals seeking information about the importance of regular developmental screening and Bright Futures
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	To improve awareness and understanding among families, providers, and community members about the importance of regular developmental screening for children.
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** Number of hits to the VDH web pages by individuals seeking information about the importance of regular developmental screening and Bright Futures **Denominator:**
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Child and Family Health
Significance:	Increasing early identification of disease or conditions through developmental screening will improve referral and treatment for children with special needs.

2016-2020: ESM 6.3 - Completion of actionable 2-year plan (FY19-FY20) for strengthening the comprehensive, complex developmental screening system of care for children 0-8
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Improve the health status of Virginia’s children through ongoing optimal screening, monitoring and surveillance of development.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Text</td></tr>
<tr><td>Unit Number:</td><td>Yes/No</td></tr>
<tr><td>Numerator:</td><td>Completion of actionable 2-year plan (FY19-FY20) for strengthening the comprehensive, complex developmental screening system of care for children 0-8</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Virginia Department of Health; Division of Child and Family Health program data</td></tr>
<tr><td>Significance:</td><td>Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics (AAP) recommends screening tests begin at the nine month visit. The Virginia priority need is the enhancement of processes through which every child may succeed by providing a sustainable and coordinated system of developmental support, access and followup. The support for need is based on 1) Lack coordinated system for referrals and follow-up; 2) Lack of data to drive strategic planning; 3) Evidence-based research that universal developmental screening connects children at risk of developmental delay with early intervention services. The data to support this shows that 1 in 4 children under 5 are at risk for developmental, behavioral or social delays, fewer than 30% of delays are identified before kindergarten; only 29% of Virginia’s 0-5 children received any recommended developmental screening compared to the national average of 30% and that access to screening is even more difficult for children of color.</td></tr>
</table>

2016-2020: ESM 7.1.1 - Proportion of maternity centers with prenatal courses including Virginia's injury prevention curriculum
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
Goal:	Reduce non-fatal injury related hospitalizations for children ages 0 through 9 and adolescents ages 10 through 19.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of maternity centers with prenatal courses including Virginia's injury prevention curriculum **Denominator:** Number of maternity centers
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Prevention and Health Promotion; piloting evaluation tool in REDCap to track information from maternity centers
Significance:	This ESM was identified through the Title V needs assessment, Virginia's Well-being Plan, and Healthy People 2020 (IVP 1.2). Research from a variety of external sources indicates that the impact of childhood injuries can be reduced with effective primary prevention strategies.

2016-2020: ESM 7.1.3 - Number of healthcare providers receiving Project ECHO content in reducing the impact of NAS
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
Goal:	Reduce non-fatal injury related hospitalizations for children ages 0 through 9 and adolescents ages 10 through 19.
Definition:	**Unit Type:** Count **Unit Number:** 100,000 **Numerator:** Number of healthcare providers receiving Project ECHO content in reducing the impact of NAS **Denominator:**
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Prevention and Health Promotion (DPHP); DPHP will track using self-reports from UVA to project ECHO database
Significance:	The Project ECHO (Extension of Community Healthcare Outcomes) Opioid Case Management learning lab is a collaborative exchange of knowledge among providers across the Commonwealth. The goal of this program is to increase the capacity of primary care providers to safely and effectively treat chronic, common, and complex condition through bi-directional learning, knowledge sharing, and networking.

2016-2020: ESM 11.3 - Percentage of children enrolled in public schools who report a primary care provider
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Increase the number of typical and children with special health care needs who can identify a primary care provider as a medical home
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of children enrolled in public schools who report a primary care provider</td></tr><tr><td>**Denominator:**</td><td>Total number of children enrolled in public schools</td></tr></table>
Data Sources and Data Issues:	Department of Education
Significance:	This ESM was identified through the Title V needs assessment, Virginia's Well-being Plan, and Healthy People 2020 (MICH-30).

Form 11
Other State Data

State: Virginia

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
MCH Data Access and Linkages

State: Virginia

Annual Report Year 2020

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Daily	12		
2) Vital Records Death	Yes	Yes	Daily	12	Yes	
3) Medicaid	Yes	Yes	Annually	12	No	
4) WIC	Yes	No	Monthly	1	No	
5) Newborn Bloodspot Screening	Yes	Yes	Daily	1	No	
6) Newborn Hearing Screening	Yes	Yes	Daily	1	Yes	
7) Hospital Discharge	Yes	Yes	Annually	12	No	
8) PRAMS or PRAMS-like	Yes	Yes	Daily	12	Yes	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None