Maternal and Child Health Services Title V Block Grant

Virginia

FY 2023 Application/ FY 2021 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

COMMONWEALTH of VIRGINIA

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Acting State Health Commissioner
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August 8, 2022

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

Dear Mr. Dykton,

It is with pleasure that I submit Virginia's 2023 Title V block grant application and 2021 annual report. The attached document provides a detailed report regarding the depth and breadth of Title V funding utilization in the Commonwealth of Virginia, the dedication of a highly committed MCH workforce, and the funding impact on the lives of the women, infants, children, youth, and children with special healthcare needs.

We look forward to continued partnership.

Most sincerely,

Cynthia C. deSa

Cynthia C. deSa, MPH, MSW, LCSW
Maternal and Child Health/Title V Director
Division of Child and Family Health
Office of Family Health Services
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VDH VIRGINIA DEPARTMENT OF HEALTH
To protect the health and promote the well-being of all people in Virginia.

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

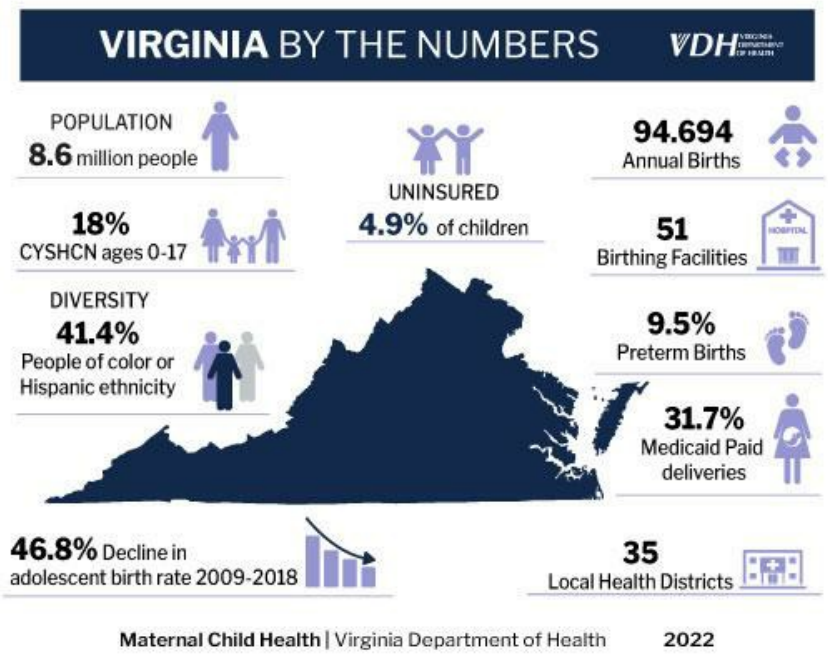
Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

The Virginia Department of Health (VDH) works to "Protect the health and promote the well being of all people in Virginia", with the vision to become the healthiest state in the nation. VDH's core values are service, equity, and making data-informed decisions. Spanning from the Atlantic Ocean to the Appalachian Mountains, Virginia's population of 8.63 million residents continues to increase annually, with 3.1 million residents (36%) residing in the Washington, D.C. metropolitan area, contrasted to 2,202 residents in rural Highland County, in the western edge of the Shenandoah Mountain range.



Virginia's Title V Program resides within the Division of Family Health Services in the Office of Family Health Services. Virginia's Title V Leadership Team provides programmatic oversight and ensures Title V's alignment and connectivity across programs in VDH's Division of Child Health Services, Division of Prevention and Health Promotion, and Division of Population Health Data. Virginia's Title V Program strives to eliminate health disparities, improve birth outcomes, and improve the health and wellbeing of Virginia's mothers, infants, children, and youth, including children and youth with special healthcare needs (CYSHCN) and their families. There are 15 state program managers, approximately 70 state-level staff and contractors, and over 110 local health district staff who are actively engaged in the development and implementation of the strategies and activities within Virginia's Five-Year State Action Plan.

In Virginia, Title V serves as the foundational funding stream for state, regional, and local MCH programs, and is a critical public health infrastructure component. Title V provides essential financial and technical support to approximately 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,

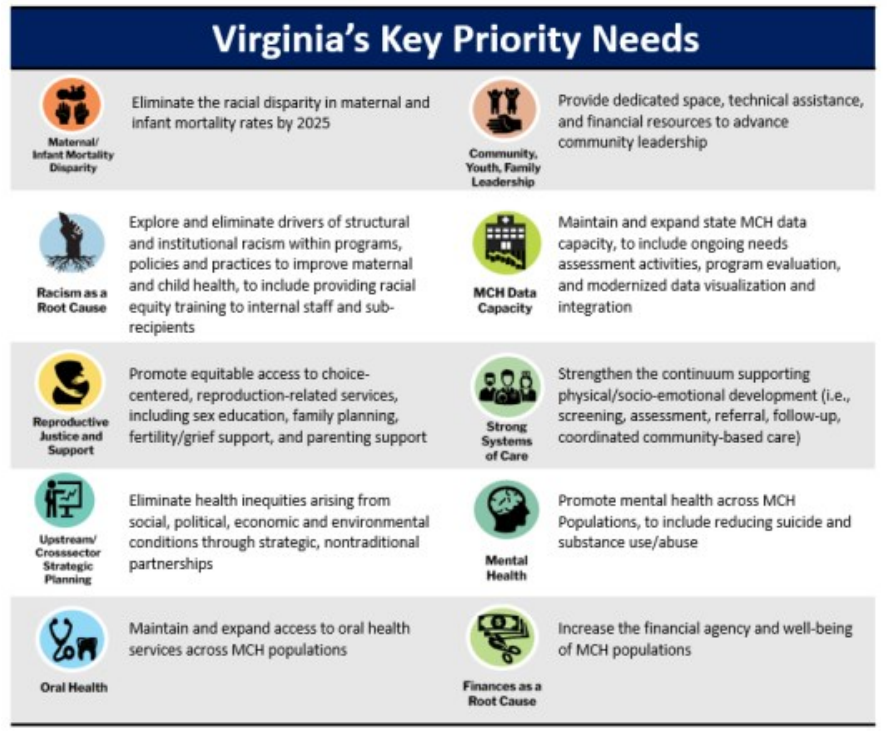
Title V funding supports the delivery of clinical services and health education within each of Virginia's 35 local health districts (LHDs).

NEEDS ASSESSMENT

Virginia conducted a needs assessment in 2019, and the key priorities identified during this assessment shape and drive the objectives and strategies over the 5-year period from 2020-2025. VA's Title V leadership and domain subject matter experts engage in ongoing programmatic strategy and priority/goal setting across the six MCH population health domains: women/maternal health, perinatal/infant health, child health, adolescent health, children and youth with special healthcare needs, and cross-cutting/systems building.

Virginia's Title V prioritizes the state's maternal and child health population who have been historically marginalized or made vulnerable through social injustices that negatively impact communities of color. This has led us to target our work to increase health equity through supporting community-driven solutions and tailoring efforts that have a direct link to eliminating the Black/White maternal and infant mortality disparity.

Strategic alignment and facilitation occurs across focused, multidisciplinary, collaborative, and inclusive internal and external subject matter experts and stakeholders that serve Virginia's MCH population. Virginia's Title V program also leverages robust family engagement–community, family, youth, and cultural brokers who are actively involved in the planning, development, and evaluation of programs across all domains.



Virginia ranks 18th for the overall health of women and children (2019)

Women's/Maternal Health

Title V's strategies align with the 2021 Maternal Health Strategic Plan, focusing on improving birth outcomes and reducing the Black/White maternal and infant mortality disparity. Virginia's Maternal Mortality Review Team findings influence Title V's priorities. Access to oral health services for pregnant people is also a priority.

• 7th overall for the health of women (2020)	
• Percentage of women reporting that they wanted to become pregnant later or never was 25.1% (2020)	▼
• 45.4% of pregnancies were described by women as unintended (2020)	▲
• Maternal morbidity rate was 66.9 per 10,000 delivery hospitalizations (NOM 2)	▼
• non-Hispanic White – 55.1;	▼
• non-Hispanic Black – 95.1;	▼
• ≥35 years – 102	▲
• Maternal mortality rate was 21.6 per 100,000 live births (NOM 3)	▲
• non-Hispanic White – 23.7;	▲
• non-Hispanic Black – 49.1	▲
• Leading causes of pregnancy-associated deaths were accidental overdoses, cancer, cardiac conditions, homicide, and infections	
• Percentage of women who experienced postpartum depressive symptoms following a recent live birth was 11.8% (2020)	▼
• 46.7% of moms had a preventive dental visit during pregnancy (NPM 13.1)	▼
• Percentage of women who did not attend postpartum care due to COVID-19 pandemic was 7.4% (2020)	
Perinatal/Infant Health Title V's statewide partnerships and fourth-trimester initiatives focus on sustaining breastfeeding and addressing social determinants of health and systemic structures affecting the infant mortality disparity between white and black infants.	
• 25th overall for the health of infants (2020)	▼
• 86.5% of moms ever breastfed and 22.4% breastfed for 1-10 weeks; 53.3% were still breastfeeding at the time of the VA PRAMS survey	▼
• non-Hispanic White – 56.6%;	▼
• non-Hispanic Black – 33.6%;	▼
• Hispanic – 55.8%	▲
• Infant mortality rate was 5.3 per 1,000 live births (2020)	▼
• White – 3.8;	▼
• Black – 10.2;	▼
• Other – 4.3	▲
• Leading causes of infant mortality were birth defects, disorders related to short gestation and low birth weight, and sudden infant death syndrome	
Child Health Title V promotes the value and availability of developmental screening, with early follow-up and referral for intervention services when needed. We work to reduce barriers to well-child health visits, increase and track rates of developmental screening, increase connection to services. Child safety, reduction of non-fatal hospitalizations, and access to oral health are additional priorities in this domain.	
• 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 31.3% (NPM 6)	▲
• Rate of hospitalization for non-fatal injury among children was 95.1 per 100,000 (NPM 7.1)	▲
• <1 year – 225.8;	▲
• 1-4 years – 102.7;	▲
• 5-9 years – 64.3	▲
• 57.5% of children ages 1-5 years and 87.7% of children ages 6-11 years had a preventive dental visit (NPM 13.2)	▼

Adolescent Health Virginia's Title V strategies to help address adolescent suicide include: Strategic partnering with VDH's Injury Prevention Team and School Health Programs to leverage and synthesize existing relationships to meaningfully engage in creating solutions to increase protection from suicide risk.	

• Rate of hospitalization for non-fatal injury among adolescents was 173.7 per 100,000 (NPM 7.2)
  • 10-14 years – 93.9;
  • 15-19 years – 251.2
	▲
	▲
	▲

• 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%).	
• 17.4% of adolescents received services necessary to make transitions to adult health care (NPM 12)	▲
• 83.4% of adolescents (ages 12-17) had a preventive dental visit (NPM 13.2)	▼
• Teen pregnancy rate is 17.3 per 1,000 females ages 15 to 19 years	▼
Children with Special Health Care Needs Virginia's statewide network of programs for children and youth with special healthcare needs are cornerstones of excellence for children who have or are at risk for chronic physical, developmental, behavioral, or emotional conditions. Legislatively mandated, Virginia's CYSHCN exceeds national benchmarks in its efforts to ensure the highest level of diagnostic services, care coordination, supportive services, and family engagement for all programs serving this population.	
• Percent of children with special health care needs (CSHCN) is 18.0% (NOM 17.1)	
• 46.4% of CSHCN had a medical home (NPM 11)	▼
• 17.4% of CSHCN age 12-17 years were engaged in transition services to adult health care (NPM 12)	▲
• 67.7% of CSHCN continuously and adequately insured (NPM 15)	▲
Cross-Cutting / Systems Building An important area of Title V's work is promoting the value and availability of a seamless comprehensive system of care from newborn screening to early follow-up and referral for intervention services when needed. Family engagement is essential to all Title V programs, and Virginia's Youth Advisors provide essential guidance across all programs regarding effective methods to shape programs that empower youth and young adults. Virginia's Title V program values a workforce that is equity focused. Prioritizing the identification and elimination of structural and systemic racism, focused efforts center around professional development and strategic community-led partnerships.	
• 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.	
• Develop and strengthen MCH workforce that advances racial equity.	
• Maintain and expand family engagement.	

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

Title V Funds are essential to maintaining and sustaining a strong core MCH infrastructure, complementing and supporting 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. Title V supports work on both the identified Title V priorities as well as ongoing MCH assessment and surveillance, policy and partnership work, and multiple planning and system development efforts to which staff contribute at the state and local level. Stakeholder engagement and partnerships are critical to all phases of Virginia's Title V work, enabling Title V to leverage work across the state on behalf of the MCH and CYSHCN populations. This work – especially with persons with lived experiences, families and communities – informs ongoing needs assessment, strategic implementation, evaluation, and activity modification throughout the 5-year cycle.

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
- 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 with braided MIECHV, Healthy Start and state Temporary Assistance for Needing Families (TANF) funding
- Supports child health by funding school health and developmental screening initiatives with braided HRSA Pediatric Mental Health Access Program, and Early Childhood Comprehensive Systems (ECCS) P-3 funding
- Supports Resource Mothers Program, Pregnancy Loss Initiative, Contraceptive Access Initiative, and Adolescent Program
- Funds family and youth leadership initiatives, including two part-time Youth Advisors

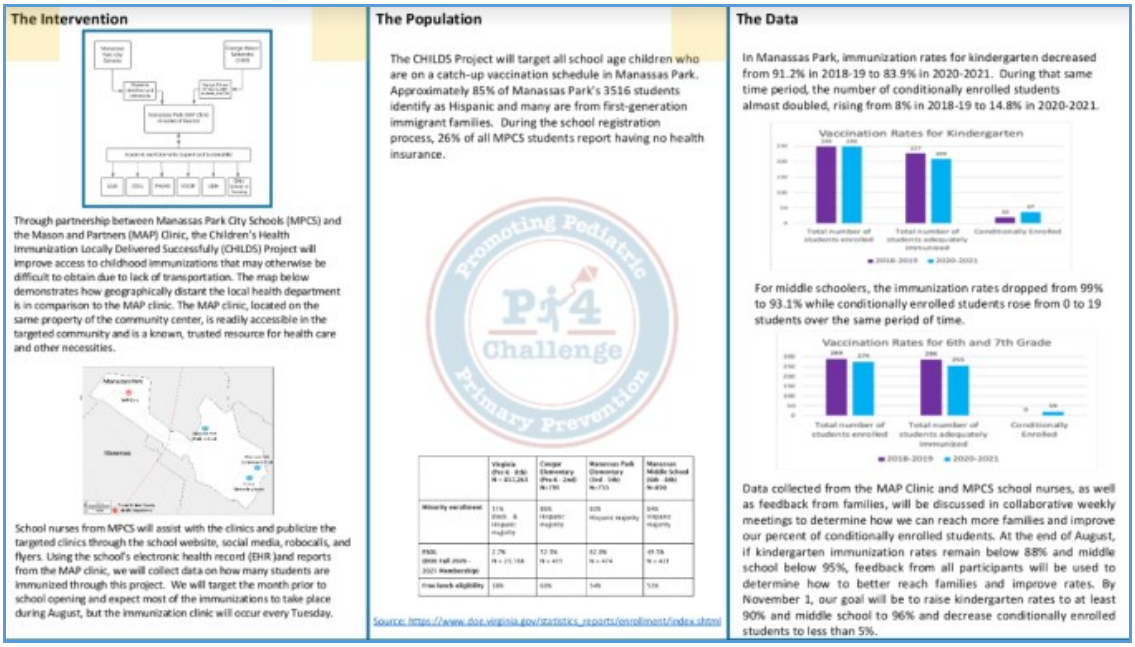
III.A.3. MCH Success Story

VDH's School Health Program was a Phase 1 winner in the HRSA MCHB Promoting Pediatric Primary Preventing P-4 Challenge, receiving an award of $10,000 for The CHILDs Project , which aimed to increase immunization rate and reduce conditional enrollment rates for Manassas Park City Public Schools. This project was one of fifty awardees, selected from a pool of 240 applications

Childhood and adolescent immunization rates across the Commonwealth of Virginia declined due to COVID-19 and this resulted in an increased number of students requiring conditional enrollment. A collaboration between Manassas Park City Public Schools, George Mason University School of Nursing and Social Work; Mason and Partners (MAP) clinics currently in Manassas Park Schools; state and local health departments; and in conjunction with Old Dominion University and University of Virginia Schools of Nursing; the Virginia Department of Health and Department of Education worked on an innovative solution to manage the increasing number of students requiring conditional enrollment. The proposal involved expanding the existing partnerships to bridge access to healthcare and school required vaccinations. The project increased access to vaccines for preventable diseases, promoted equity and opportunity for students and families in Manassas Park City schools and benefited overall student health and achievement.

This CHILDS Project is sustainable and easily replicated for other future healthcare endeavors that benefit underserved communities in other areas of the Commonwealth.

Implementation plan of Phase 2 HRSA MCHB's Promoting Pediatric Primary Prevention P-4 Challenge to increase immunization rates and reduce conditional enrollment rates for Manassas Park City Schools was submitted May 2021. Please see the submission below:



2022 Update: The CHILDS Project was selected as a Phase 2 winner and Manassas Park City Schools was awarded an additional $25,000.

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 six main operating divisions: Public Health & Preparedness, Administration, Community Health Services, Governmental and Regulatory Affairs, Epidemiology, and Diversity, Equity & Inclusion.

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:

- **Maternal/Infant Mortality Disparity:** Eliminate the racial disparity in maternal and infant mortality rates by 2025.
- **Racism as a Root Cause:** Explore and eliminate drivers of structural and institutional racism within OFHS programs, policies, and practices to improve maternal and child health.

- **Reproductive Justice & Support:** Promote equitable access to choice-centered reproduction-related services, including sex education, family planning, fertility/grief support, and parenting support.
- **Upstream / Cross-Sector Strategic Planning:** Eliminate health inequities arising from social, political, economic, and environmental conditions through strategic, nontraditional partnerships.
- **Oral Health:** Maintain and expand access to oral health services across MCH populations.
- **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.
- **MCH Data Capacity:** Maintain and expand state MCH data capacity, to include ongoing needs assessment activities, program evaluation, and modernized data visualization and integration**.**
- **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).
- **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.

Geography

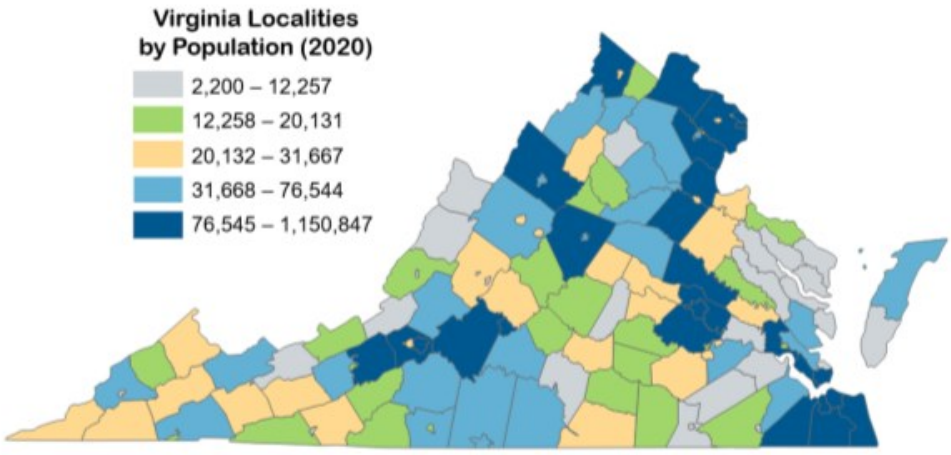
The Commonwealth of Virginia encompasses 42,774 square miles (110,784 km^2), including land and water areas, making it the thirty-fifth largest state by total area. The state is geographically located in the mid-Atlantic area of the United States, between the Atlantic Coast and the Appalachian Mountains. 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.

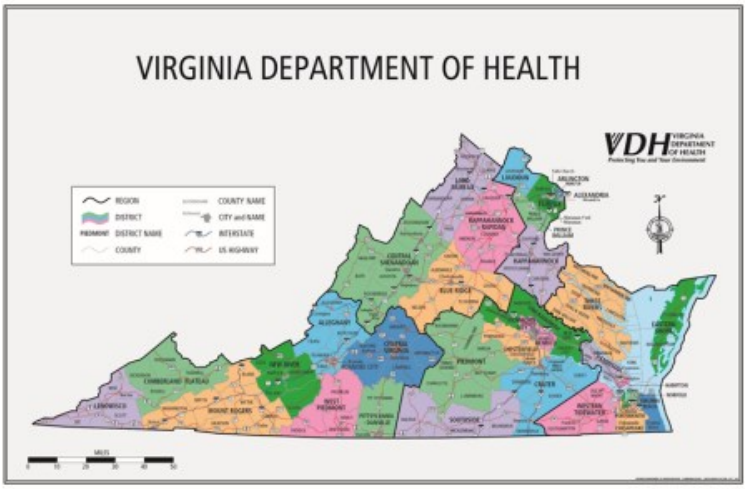
Population Density & Urbanization

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 202.6 per square mile. The largest independent cities are Virginia Beach (459,470), Chesapeake (249,422), Norfolk (238,005), the state's capital Richmond City (226,610) and Newport News City (186,247). 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 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 (482,204) 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 420,959 residents surpasses Chesterfield County in the Richmond MSA with its 364,508 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).

Race/Ethnicity

Among people reporting one race alone, 66.3% identified as White, 19.0% identified as Black, 0.3% American Indian and Alaska Native, 6.7% Asian, and 0.1% Native Hawaiian and Pacific Islander (2020: ACS 5-Year Estimates Data Profiles, Demographic and Housing Estimates). There were 9.5% of individuals that identified as Hispanic or Latine/x. 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 2020, with race and ethnicity composition consisting of 57.7% 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 11.5% Hispanic (any race) (2020 Virginia resident population estimates). The Virginia population, like that of the nation, is becoming more racially and ethnically diverse where 12.6% of the population are foreign-born (2020: ACS 5-Year Estimates Data Profiles, Selected Social Characteristics).

Age and Sex

There were 49.2% of the population identifying as male and 50.8% as female. The median age of Virginians is 38.4 years. Persons age 65 years and older represent 15.4% of the population. There were 22.0% of persons under 18 years, 6.0% under 5 years, and 96.8 males per 100 females. (2020: ACS 5-Year Estimates Data Profiles, Demographic and Housing Estimates). There were 186,643 grandparents, and among those, 35.2% were responsible for their grandchildren (2020: ACS 5-Year Estimates Data Profiles, Selected Social Characteristics).

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, 5.8% have a 9th to 12th grade education with no diploma, 23.9% are high school graduates or equivalent, 22.4% have a bachelor's degree, and 17.2% have a graduate or professional degree (2020: 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 nearly 4.4 million civilian workers, and 16.4% are in service occupations. The unemployment rate in Virginia was 4.6% as per ACS 2020, below the national rate of 5.4%. The median household income in Virginia is $76,398 compared to $64,994 in the U.S. (2020: ACS 5-Year Estimates Data Profiles, Selected Economic Characteristics).

Compared to the U.S. population, a lower percentage of Virginia families lived in households with incomes below the federal poverty level (6.8% vs. 9.1% for the U.S.) and also a lower percentage of children under age 18 lived in households with incomes below the federal poverty level (10.8% vs. 14.3% for the U.S.). However, wealth varies significantly across the state. The percentage of children living in poverty was 13.0% in 2020 (Talk Poverty). For the years 2019-2020, 13.7% of children with special health care needs lived in families with incomes less than 100% of the federal poverty level (2019-2020 National Survey of Children's Health (NSCH)). This is in comparison to children without special health care needs, of which 14.8% 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, 33.3% are rented. In renter-occupied units, nearly half (47.0%) pay 30 percent or more of their household income to rent (2020: 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 $1,257. The median home value for owner-occupied units in Virginia is $282,800 (2020) compared to $243,500 in 2014, a 16.1% 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, 658,470 people are facing hunger, and 1 in 10 are children (Feeding America). According to 2021 America's Health Rankings, 9.2% 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 2020, 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 2020 ACS 5-Year Estimates, 91.8% of Virginians have health insurance of some kind, where 75.8% were private and 29.1% were public. Among those under age 19, there were 5% without health insurance. Among the uninsured population, 13.8% are young adults age 26 to 34 (2020: ACS 5-Year Estimates Subject Tables, Selected Characteristics of Health Insurance). Others that are uninsured include 6.8% of those that identify as White compared to 8.4% of African Americans, 9.2% American Indian and Alaska Native, and 24.7% Hispanic or Latine/x. Twenty-one percent of those with less than a high school education were uninsured.

In 2021, the Bureau of Labor Statistics reported 4,060 Family Medicine Physicians in Virginia, and 500 obstetricians/gynecologists. There were 670 pediatricians, 4,880 dentists and 270 dental specialists or orthodontists, and 210 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 60 counties/census tracts in Virginia designated as Primary Care Health Professional Shortage Areas (HPSAs), 10 in Dental Care, 38 in Mental Health, and 223 counties/census tracts designated as medically underserved areas (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, nearly one-third 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 (79.5%) report that they have someone to turn to for day-to-day emotional support with parenting or raising children (NCHS 2019-2020). 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 (5.3%); insurance or Medicaid status (2.1%); weight (4.5%); and marital status (2.9%). Among those reporting discrimination or harassment due to their race, ethnicity or culture, 16.6% were Black and 6.8% 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.

NPM 13.1: Preventive Dental Visit During Pregnancy – Data from the Pregnancy Risk Assessment Monitoring System (PRAMS) showed that 50.9% of moms had a preventive dental visit during pregnancy (2020). Preventive dental care in pregnancy is recommended by the American College of Obstetricians and Gynecologists (ACOG) to improve lifelong oral hygiene habits and dietary behavior for women and their families.

SPM 4: Pregnancy Intention: Mistimed or Unwanted Pregnancy – The percentage of women reporting that they wanted to become pregnant later or never was 25.1% (2020 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, 45.4% of pregnancies were described by women as being 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 23.7 per 100,000 among White women and 49.1 per 100,000 among Black women (2016-2020). The Black/White Maternal Mortality Ratio was 2.1 (SOM 2).

NOM 2: Severe Maternal Morbidity – The rate of severe maternal morbidity in Virginia is 66.9 per 10,000 delivery hospitalizations, where hemorrhage accounts for 32.1 per 10,000 (2019). Disparities exist among race/ethnicity (non-Hispanic Black – 95.1), health insurance (Medicaid – 72.2, Other Public – 74.5, Uninsured – 75.2), and maternal age (≥35 Years – 102).

SPM 6: Mental Health & Well-Being - The percentage of women who experience postpartum depressive symptoms following a recent live birth was 11.8% (Virginia PRAMS). 15 of 35 Local Health Districts have chosen mental health as a priority.

DOMAIN: Perinatal/Infant Health

According to America's Health Rankings (2020), Virginia ranks 25th 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 (2020) showed 86.5% of respondents ever breastfed, 22.4% breastfed for 1-10 weeks, and 53.3% were breastfeeding at the time of the survey. There were some differences observed in continuation by race, where by at the time of the survey 56.6% of White moms were breastfeeding at the time of the survey, 55.8% of Hispanic moms, and 33.6% 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 5.8 per 1,000 live births (Virginia Vital Statistics System, 2020). A significant disparity exists in infant deaths between racial groups in Virginia, where non-Hispanic Black women had an infant mortality rate of 10.7, 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 2.1 (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 120.4 per 100,000 live births (Virginia Vital Statistics System, 2020); with disparities among race/ethnicity (non-Hispanic Black – 273.3), health insurance (Medicaid – 256.1, Uninsured – 121.8), and maternal age (<20 Years – 170.7).

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 31.3% (2019-2020) in Virginia, compared to the U.S. at 36.9%. 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 95.1 per 100,000 in 2019. Among age groups, the annual indicator was 225.8 for children less than one year of age, 102.5 among children ages 1-4, and 64.3 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 57.5% of children age 1-5 years and 87.7% of children age 6-11 years had a preventive dental visit (2019-2020). 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 34 per 100,000 children ages 10-19 (NOM 16.1). The adolescent motor vehicle mortality rate was 9.6 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 173.7 per 100,000 in 2019. The annual indicator was 93.9 among aged 10-14 years and 251.2 among aged 15-19 years. Among these students, 39.1% considered attempting suicide, and 18.0% attempted suicide. LGBT students were more likely than heterosexual students to report feeling sad (27.6% vs 14.8%), as well as students who experienced cyberbullying (59.6%) (Virginia YRBS, 2019). The adolescent suicide rate was 12.4 per 100,000 adolescents ages 15-19 (NOM 16.3). Adolescent suicide is currently a focus of the State Child Fatality Review Team.

NPM 12: Transition (ages 12-17 years) – The NSCH (2019-2020) showed only 16.6% of adolescents received services necessary to make transitions to adult health care. Health care transition focuses on building independent health care skills – including self-advocacy, preparing for the adult model of care, and transferring to new providers.

NPM 13.2: Preventive Dental Visit (ages 12-17 years) – The NSCH (2019-2020) showed that 83.4% of adolescents had a preventive dental visit.

Pregnancy Intention – The teen pregnancy rate has been declining, with the rate in Virginia being 17.3 per 1,000 females

age 15 to 19 years (Virginia Vital Statistics System, 2020). Differences exist among race/ethnicity and regions within the state. Hispanic/Latine/x and non-Hispanic Black teens had the highest teen pregnancy rates in 2020 at 28.9 and 19.4 respectfully. The Southwest (22.6), Eastern (22.1), and Central (18.8) 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 18.0% (NSCH 2019-2020).

NPM 11: Medical Home (CSHCN ages 0-17 years) – The NSCH (2019-2020) showed that 46.4% of CSHCN had a medical home. Children with a stable and continuous source of health care are more likely to receive appropriate preventive care.

NPM 12: Transition (CSHCN ages 12-17 years) – The NSCH (2019-2020) showed that 17.4% 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 (2019-2020) showed that 67.7% of CSHCN were continuously and adequately insured. There were 29.5% of CSHCN that had public insurance, 65.2% private insurance, and 1.0% uninsured.

DOMAIN: Cross-Cutting/Systems Building

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 provide dedicated space, technical assistance, and learning opportunities that advance racial equity among MCH workforce.

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.

Section 32.1-283.1 codifies the Child Fatality Review Team (since 1994), while Section 32.1-283.8 codifies the Maternal Mortality Review Team (since 2019).

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 has 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 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 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 stakeholders 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 new state health assessment (SHA) and state health improvement planning (SHIP) set to begin in 2023, 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 and workforce capacity training 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 policies, programs, and practices. The outcome is that family engagement and equitable collaboration become a core value across all MCH programs.

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 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 May 26, 2022 total cases in pregnant women totaled 9,354, with 528 hospitalizations and 1,173 among those noted as healthcare workers. Among children and adolescents aged 0 to 19 years, there have been 373,825 cases, 1,781 hospitalizations, and 15,216 outbreak associated cases.

Maternal/Infant Morbidity and Mortality

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).

In response to former 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 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.

Maternal Health: Maternal mortality in Virginia due to direct and indirect obstetric causes has continued on an upward trend. Preliminary data in 2021 indicate a maternal mortality rate of 48.9 per 100,000 live births, nearly three times higher than the rate in 2020 (17.9 per 100,000 live births). Increases continue to be driven by rates among non-Hispanic Black birthing people. Late maternal deaths due to obstetric causes have also continued to increase, with preliminary data indicating a rate of 16.3 per 100,000 live births. This latter indicator provides insight into deaths occurring in the 4th Trimester and helps to inform efforts related to postpartum care.

Infant Health: In 2020, the top five most prevalent causes of infant mortality in Virginia included congenital malformations/chromosomal abnormalities, disorders related to short gestation and low birth weight, sudden infant death syndrome (SIDS), newborn affected by maternal complications of pregnancy, and unintentional injuries. 543 infants died before their first birthday in Virginia, making the overall infant mortality rate across all races 5.7 per 1,000 live births. This is a decline from an infant mortality rate of 5.9 in 2019. Since 2011, the overall infant mortality numbers have remained relatively constant, with a slight downward trend apparent in recent years. However, this rate varies by race and ethnicity. For example, the infant mortality rate among the non-Hispanic white population was 4.9, while the rate among non-Hispanic Black infants was 10.8, making the black/white infant mortality ratio to be 2.2.

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.

Substance Use: In 2020, almost five Virginians died by drug overdose approximately every day. Virginia has seen a 32% increase in the number of drug overdose deaths from 2016-2020; approximately eight out of 10 drug overdose deaths each year (2016-2020) involved opioids. However, it is also important to note that drug overdose deaths involving psychostimulants or cocaine also saw marked increases from 2016 to 2020, at 450% and 80%, respectively. There were also an average of over 7,800 nonfatal drug overdose hospitalizations among Virginians each year from 2016-2020; in 2020 alone, nonfatal drug overdose hospitalizations cost an average of over $35,000 and a length of stay of over four days per hospitalization, with a total cost of over $267 million.

Maternal opioid use is also a public health issue, as this can lead to withdrawal symptoms and opioid dependency of the newborn, known as neonatal abstinence syndrome (NAS). In 2020, there were 7.7 maternal opioid related diagnoses (MOD) per 1,000 delivery hospitalizations and 5.8 NAS cases in Virginia per 1,000 birth hospitalizations. Higher MOD and NAS rates were seen in the Southwest health region and among the non-Hispanic White population.

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 also leads Project Patience Version 2.0, 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 FY23, under the direction of the Maternal Infant Consultant, coordination and implementation of the plan will begin.

Self harm: On average from 2016-2020, suicide was the 10th leading cause of death in Virginia. Suicide dropped to the 11th leading cause of death in Virginia in 2020, solely due to COVID-19 rising to the top three causes of death statewide. The average number of deaths by suicide in Virginia from 2011-2020 was 1,115 deaths each year, with an increase of 8% from 2011 to 2020. In 2020, deaths by suicide among Virginians resulted in 33,388 years of potential life lost. Self-harm is also a public health issue, as self-harm and suicidal ideation remains a significant risk factor for suicide death. There were an average of 2,964 nonfatal self-harm hospitalizations each year in Virginia from 2016-2020, costing an average of over $34,000 and a length of stay of almost four days per hospitalization, with a total cost of over $525 million.

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).

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. In addition, the MCH Epidemiologist Lead and IVPP Senior Epidemiologist have been selected for the 20/20 Mom Governmental Maternal Mental Health Fellows Program, representing the Virginia Department of Health. This 12-months-long learning collaborative brings fellows from agencies across the nation in order to assist localities in closing gaps in maternal mental health using a multi-agency approach.

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.).

Click on the links below to view the previous years' needs assessment narrative content:

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2019		2020	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$12,128,653	$12,287,553	$12,287,553	$11,750,864
State Funds	$9,097,551	$9,215,665	$9,215,665	$6,169,903
Local Funds	$0	$0	$0	$0
Other Funds	$1,125,000	$1,618,704	$1,618,704	$1,625,174
Program Funds	$1,427,400	$1,852,807	$2,086,819	$1,547,972
SubTotal	$23,778,604	$24,974,729	$25,208,741	$21,093,913
Other Federal Funds	$16,914,458	$0	$16,989,838	$14,682,649
Total	$40,693,062	$24,974,729	$42,198,579	$35,776,562

	2021		2022	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$12,287,553	$12,375,275	$12,457,398	
State Funds	$9,215,665	$9,282,539	$6,092,387	
Local Funds	$0	$0	$0	
Other Funds	$1,618,704	$1,702,690	$1,702,690	
Program Funds	$2,086,819	$1,707,091	$1,547,972	
SubTotal	$25,208,741	$25,067,595	$21,800,447	
Other Federal Funds	$0	$14,300,655	$17,859,944	
Total	$25,208,741	$39,368,250	$39,660,391	

	2023	
	Budgeted	Expended
Federal Allocation	$12,457,398	
State Funds	$5,933,268	
Local Funds	$0	
Other Funds	$1,702,690	
Program Funds	$1,707,091	
SubTotal	$21,800,447	
Other Federal Funds	$13,734,376	
Total	$35,534,823	

III.D.1. Expenditures

Form 2

In FY21, Virginia received a total federal allocation of $12,375,275.

During the same period:

- The program expended $12,375,275 of federal funds and $9,282,539 of State MCH funds.
- A total of $1,702,690 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 $1,707,091 in program income was generated and reinvested in delivery of Title V services.

FY21 expenditures for the state-federal Title V partnership totaled $13,821,149.

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 $12,692,320 (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 FY19 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 FY23 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 1,702,690 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 of 1,707,091 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 FY23 budget complies with both the state match and MOE mandates, as below:

FY23 Anticipated Federal Allocation: $12,457,398

FY23 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's Title V Purpose and Design

Virginia's Title V Program provides collaborative public health leadership that supports and strengthens systems for the health and well-being of Virginia's children, families, and communities. VDH's Division of Child and Family Health serves as the state level administrator of the Title V MCH Block Grant, ensuring that the responsibilities set forth by HRSA's Maternal and Child Health Bureau are met.

Organizationally, Virginia's Title V Program, including the CSHCN Program, is housed in the Division of Child and Family Health (DCFH), which is part of the Office of Family Health Services (OFHS). The Office of Population Health Data (DPHD), which provides data and evaluation support to Title V programs, is also housed in OFHS, ensuring shared values, goals, and strong cross-office relationships. Virginia's Title V Family Delegate is the Director of the Center for Family Involvement and Associate Director of Partnership for People with Disabilities, which is located in Virginia Commonwealth University.

Virginia Title V Core Leadership Team includes:
Vanessa Walker-Harris, MD – Director, Office of Family Health Services (OFHS)
Jennifer Macdonald, MPH, BSN, RN – Director, Division of Child and Family Health (DCFH)
Cindy deSa, MPH, MSW, LCSW - Maternal and Child Health/Title V Director (DCFH)
Marcus Allen, MPH - CYSHCN Director (DCFH)
Meagan Robinson, DrPH – Director, Division of Population Health Data (DPHD)
Dane De Silva, PhD, MPH – MCH Epidemiologist Lead (DPHD)
Dana Yarbrough, MS, MA – Virginia Title V Family Delegate
Toni Pintavalle, BS, MEd – Fiscal Grant Manager

Virginia's Title V Core Leadership Team places great value on its partnerships and leverages its relationships to accomplish many of the goals outlined in its State Action Plan. Title V serves as a catalyst to internal VDH relationships, such as reproductive health (Title X), MIECHV, developmental screening, injury prevention, school nurse program, dental health, as well as external collaboration and partnerships. Title V serves as a hub, bridging and synthesizing relationships for common purpose.

Virginia's Framework for Improving Outcomes for MCH Populations

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 Title V Program incorporates the following principles into efforts to improve systems for Virginia's women, children and families:

- *Trauma-informed*: Understanding the significant role that trauma plays in the lives of the MCH population, while also acknowledging community resiliency and capacity.
- *Social ecological model*: Considering the complex interplay between individual, relationship, community, and societal factors.
- *Data-driven:* Making strategic decisions based on data analysis and interpretation, acknowledging that within certain spaces where no data exists, community or individual knowledge or experience bears considerable weight.
- *Evidence-based and informed practices:* Using the best evidence possible to shape practices or programs.
- *Family and community driven:* Building not only on the strengths of the child and the family, but also on the strengths

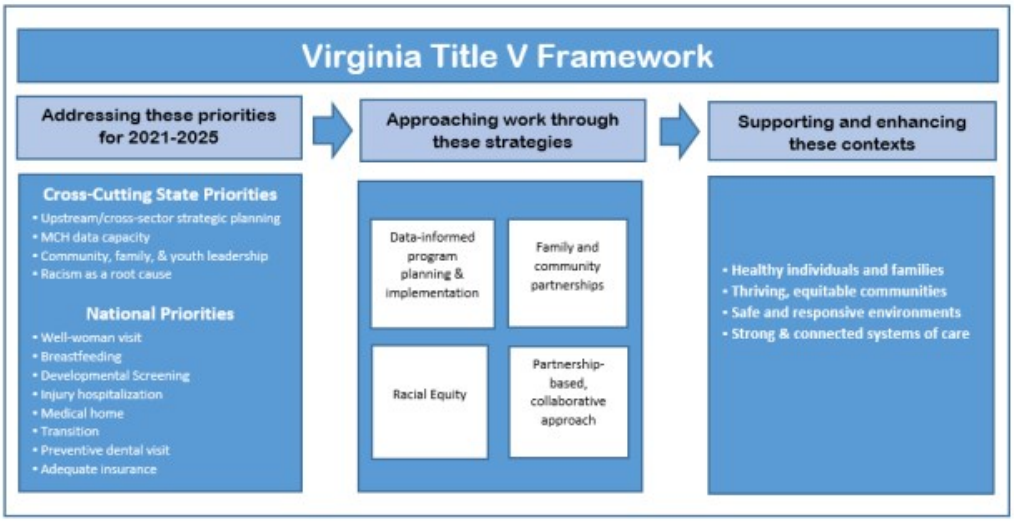
of the community in which the family resides.

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 include 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

VDH's 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**	**Updates**
Director, Division of Child and Family Health		
MCH/Title V Director		
CYSHCN Director	Program Support Blood Disorders Program Coordinator Care Connection Staff (9)	
NEWBORN SCREENING		
Birth Defects Surveillance Program Coordinator	Birth Defects Program Specialist*	***Vacant**
Early Hearing Detection and Intervention (EHDI) Program Coordinator	cCMV Follow-up Coordinator EHDI Program Support	
MATERNAL AND INFANT HEALTH		
Maternal and Infant Health Consultant		
EARLY CHILD HEALTH		
Early Child Health Supervisor/MIECHV Director	Early Child Health Consultant	
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)	***Vacant**

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

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

DIVISION OF PREVENTION AND HEALTH PROMOTION		
Position	**Direct reports**	**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 Supervisor	Injury & Violence Prevention Health Systems Coordinator Statewide Safety Seat Program Manager	

DIVISION OF POPULATION HEALTH DATA		
Position	**Direct reports**	**Updates**
Director, Division of Population Health Data	Division Support	
MCH EPIDEMIOLOGY		
MCH Epidemiologist Lead	*MCH Epidemiology Coordinator Newborn Screening & Birth Defects Epi Reproductive & Perinatal Health Epi Dental Health Epi Program Evaluator	***Vacant (New FY23)**
PREVENTION AND HEALTH PROMOTION EPIDEMIOLOGY		
Injury & Violence Prevention Epidemiologist	*Substance Use Epi	***Vacant**

OFFICE OF INFORMATION MANAGEMENT		
Position	**Direct reports**	**Updates**
*Director, Center for Public Health Informatics		***Vacant**

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

RECRUITMENT AND RETENTION

Virginia's Title V Program is strongest when the MCH workforce values are equity centered, relationship based, and strategic focused. Because there are many initiatives led by Title V that impact both state and community policies and systems, these values are paramount for programmatic success and sustainability. The focus has been on recruiting (and retaining) the right people who demonstrate a commitment and alignment to these values. Open position descriptions and interview questions have been updated to reflect the needs of the program, and to strengthen the interview process by

assessing for alignment with Title V's values. Annual professional development plans and opportunities support tailored growth beyond baseline VDH performance expectations.

STAFF TRAINING AND WORKFORCE DEVELOPMENT

The MCH/Title V Director hosts a monthly team meeting for all Title V-related staff. All sessions have an invited speaker – both internal team members and external stakeholders – whose topic aligns with the Title V state action plan. This is followed by a data presentation from our MCH Epidemiologist Lead, and then time for conversation, connection and reflection with all team members.

The Office of Family Health Services supports professional development for all staff. Annual goals for professional development and annual performance reviews are part of all staff positions. Staff professional development opportunities range from internal support to participating in national conferences and trainings.

MCH Staff, including members of both Division of Child and Family Health and Division of Population Health Data, participate in several national learning collaboratives, including AMCHP, CityMatCH, and the National MCH Workforce Development Center.

LOCAL HEALTH DISTRICTS

Title V provides funding to each of Virginia's 35 Local Health Districts (LHDs). The LHD MCH workforce has faced many challenges since the onset of the pandemic in March 2020, and almost all LHDs have reported staffing shortages due to reassignment, staff burn-out, high turnover rates, and unfilled, long-term vacancies. The majority of the LHDs reported having to shift staffing from MCH activities to COVID-19 response. As such, staff morale has suffered, increased stress has been endured, and the burden of the pandemic continues to weigh heavily on the emotional and mental health of those still working at the local level. Restrictions are being lifted, and the LHD MCH workforce is returning to pre-pandemic operations; however, it is imperative to create the supportive structures to ensure that the LHD workforce remains in alignment with the Title V mission and receives enhanced support, education and TA for their success. In order to meet this goal, intentional restructuring of the relationship between Title V and the LHD MCH staff is underway. This includes reformatting of LHD annual work plans that are strategically aligned with Title V's state action plan, utilizing measurable goals and objectives, aggregating activities in such a way that targeted technical assistance can be provided, cross-district work groups can be formed to address shared goals, and local measurements can be obtained. Additionally, each LHD will have the opportunity to participate in MCHSmart, a year-long asynchronous learning opportunity offered by the National Center for Education in Maternal and Child Health at Georgetown University. This opportunity will offer a post-covid re-centering of the MCH Leadership competencies for local MCH professionals, defining their specific knowledge, skills, personal characteristics, and MCH leadership values, and lay out a roadmap for future MCH planning and activities. The revisioned approach to LHD MCH workforce support and development will begin with FY 2023, with rollout and orientation scheduled for the LHD staff in late August 2022.

INVESTMENT IN FUTURE MCH WORKFORCE

CSTE Applied Epidemiology Fellowship Program: In March 2021, the Division of Population Health Data's application was accepted to serve as a host site for the Class XIX CSTE Applied Epidemiology Fellowship. Modeled after the Centers for Disease Control and Prevention (CDC) EIS program, the fellowship is designed to give recent public health graduates on-the-job training at health departments in preparation for a career as an epidemiologist at the state or local level. In September of 2021, we welcomed Ksenia Primich to the MCH Epidemiology team to complete her fellowship assignment within the Maternal and Child Health subject area. Prescribed fellowship activities and projects support Virginia's Title V MCH priorities and ongoing needs assessment activities, which include building an infant mortality dashboard, assessing food insecurity and birth outcomes, assessment of historical redlining and health outcomes, and evaluating surveillance systems. The Fellowship is a two-year on-the-job training experience and Fellows are supported by funding from CDC.

National MCH workforce Development Center Internship Program

In Summer 2022, Virginia's Title V Program sponsored two student internship projects through the National MCH workforce

Development Center at University of North Carolina. The eight-week long internships provided opportunity for four students, paired virtually, to work on projects of high importance to the advancement of maternal and child health in Virginia. Recommendations from both projects have been incorporated in the state action plan and are detailed in the FY23 Application year reports in the Cross-cutting/Systems Building doman (Project 1) and Perinatal/Infant Health domain (Project 2).

PROJECT #1: Moving towards Equitable Family Engagement in Virginia

Title V Preceptors: Dr. Bethany Geldmaker, HRSA VMAP Project Director and Dana Yarbrough, Associate Director,Partnership for People with Disabilities and Virginia Title V Family Delegate)

Interns: Pooja Deshpande, MPH Student at UNC Chapel Hill Gillings School of Global Public Health and Ashley Zuniga, BSW Student at East Carolina University and MCH-Step Scholar in ECU's LEAP Program

Project details: The interns explored definitions of equitable family engagement, collaboration and leadership through conducting family focus groups, and key informant interviews of Title V staff as well as national organization staff members. Themes of equitable family engagement were identified. Recommendations were then developed regarding collaborative definitions of equitable engagement with families, as well as ways in which current practices can be improved or modified to increase equitable engagement with families through Title V at the state level.

PROJECT #2: Evaluation of Virginia's BabyCare Program

Title V Preceptors: Cindy deSa, MCH/Title V Director, and Dr. Dane De Silva, MCH Epidemiologist Lead

Interns: Candace Jarzombek, MPH Student at Boston University School of Public Health, and Leslie Osorio Pascual, BSPH East Carolina University and MCH-Step Scholar in ECU's LEAP PRogram

Project details: Through examination of the two largest programs in the state, interns explored Virginia's BabyCare program, comparing it to the evidence-based home visiting programs currently available in Virginia. Through literature reviews and interviews with several stakeholders, an evaluation tool was developed, and key informant interviews were conducted. The interns identified how BabyCare complements the current home visiting landscape in Virginia, explored similarities and differences,and provided recommendations back to Title V for strengthening BabyCare as it currently exists, and offered suggestions for leveraging the program in other places across the state that is not currently being served by an evidence-based home visiting program.

Graduate Students in Epidemiology Program (GSEP)

In Summer 2022, Virginia's MCH Epi Unit also sponsored a student internship project through AMCHP's Graduate Students in Epidemiology Program. The ten-week long virtual internship provided the opportunity for a student to learn more about MCH Epidemiology and work on projects of high importance to the Title V and MCH Epi team.

PROJECT: Racial Disparities in the Rate of Severe Maternal Morbidity (SMM) Before and During the COVID-19 Pandemic

Title V Preceptors: Dr. Dane De Silva, MCH Epidemiologist Lead

Interns: Deidra Clermont, MPH Student at Boston University School of Public Health

Project details: Severe maternal morbidity (SMM) continues to be on the rise in the United States and varies by states, which is why it remains a Title V NOM. Although overall rates of SMM did not increase significantly between 2019 and 2020 in Virginia, disparities by race/ethnicity continue to persist. Given cancellations due to lockdowns and the disproportionate burden of COVID-19 on populations of color, the purpose of this project was to analyze the rate of severe maternal morbidity (SMM) before and after the start of COVID-19 pandemic, using an interrupted time series design to examine the impact of the pandemic on SMM and racial disparities.

TITLE V TRAINING MODULES: PROMOTING HEALTHY COMMUNITIES

Title V partners 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. Bimonthly meetings are held between UVA and representatives from each program to review content, enrollment, and opportunities for advertisement/dissemination of training opportunities.

Currently, Promoting Healthy Communities offers 12 continuing education modules in three categories. An additional learning module is currently under development. This module will be aimed at school nurses, developing and supporting their skills, knowledge, and competency regarding suicide prevention, intervention and postvention.

	Module Name	Enrollment Totals 7/1/20– 6/30/21	Enrollment Totals 7/1/21– 6/30/22
www.bfconsortium.org	Breastfeeding Training	2,362	969
	Breastfeeding Refresher	203	48
	Breastfeeding Performance Improvement	97	32
www.newbornscreeningeducation.org	Critical Congenital Heart Disease Screening	193	140
	Critical Congenital Heart Disease Screening – What Parents Need to Know	93	92
	Introduction to Virginia's Early Hearing Detection & Intervention	8	70
	Newborn Dried Blood Spot Screening	425	263
	Newborn Screening SMA & X-ALD	NA	18
www.promotinghealthycommunities.org	Healthcare Transition for Healthcare - Providers	49	14
	Healthcare Transition for Healthcare - Family	43	3
	Medical Home for Healthcare – Providers	43	11
	Medical Home for Healthcare – Family	20	0

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 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, to name a few.

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 14 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 14 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**. Five parents co-facilitated the **EHDI Learning Communities** in their region that met 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. Funds were provided to support three local **family support groups** providing unbiased information to families whose young children are deaf/hard of hearing. And, over 20 families participated in surveys and a **focus group on the impact of COVID-19** on EHDI systems. Two **fotonovelas** were created for Latinx families on the importance of screening and diagnosing their child's hearing by 3 months of age and referral to early intervention services by 6 months of age. Over 500 copies of both fotonovelas were disseminated to birth hospitals and audiology clinics.
- 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.
- Establishment of **Genetic Navigator** program. Co-led by Ms. Yarbrough and OFHS' director of newborn screening, this year was a state team comprised of geneticists, families and Title V representatives. Through facilitated discussion, a Genetic Navigator program was conceived to act as a safety net for ensuring children and families are aware of, and have access to, genetic services throughout the Commonwealth.
- 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.

The **Early Childhood Comprehensive Services project** has four family leaders serving on its state advisory committee. Several of the family leaders presented or facilitated small breakout discussions at Learn the Signs Act Early ECHO sessions related to family resilience and cultural considerations. Family leadership development is a key goal of the ECCS project and leadership behaviors will be addressed through formal family leadership training, a virtual insight panel who provide feedback as needed on key OFHS projects, social media influencers who package messaging to young families, and equity-focused roundtable discussions.

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 Virginia Beach Special Education Advisory Committee, 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, to name a few. Additionally, the parent representatives serve as Medicaid Waiver Mentors, participate in the CHKD High Cost/High Risk Case Management meetings and the Unite Us Referral Committee.

Care Connection for Children located at Virginia Commonwealth University contracts with Parent to Parent of Virginia for family support. Through this relationship, families have access to emotional support and a Latinx support group. Parent to Parent of Virginia staff are working on the 5th edition of the *Care Coordination Notebook: Financing your Child's Health Care and Long Term Care Services.*

Emerging Issues

From surveys and focus groups with families about the COVID-19 pandemic, OFHS has heard that families and systems continue to have questions about, and access issues related to, **telehealth, tele-intervention, and tele-education**.

There is an 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 and Evaluation 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 MCH Epidemiology Coordinator (senior epidemiologist), Reproductive and Perinatal Health (RPH) Epidemiologist and a Newborn Screening (NBS) Epidemiologist. The team also consists of a Dental Epidemiologist/Evaluator, supporting the state Dental Health Program within the OFHS Division of Health Promotion and Prevention, as well as two program evaluators supporting the MCH programs regarding home-visiting (i.e. Healthy Start, MIECHV), and child and adolescent health. There is additional cross-cutting collaboration with the Injury and Violence Prevention (IVP) Epidemiologist and Substance Use Prevention Epidemiologist within the DPHD Prevention and Health Promotion Unit, 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.

Dane De Silva, PhD – 0.75 FTE MCH Epidemiologist Lead/Unit Supervisor; SSDI Coordinator	
Funding	State Systems Development Initiative (SSDI); Title V MCH Block Grant; Virginia Neonatal Perinatal Collaborative (General Funds)
Education and Training	PhD (Maternal and Child Health), University of Maryland MPH (Maternal-Child Health and Epidemiology), University of British Columbia BMLSc, University of British Columbia
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).

Vacant – 1 FTE MCH Epidemiology Coordinator (Epidemiologist Senior)	
Funding	Title V MCH Block Grant; State Systems Development Initiative (SSDI)
Education and Training	Preferred qualifications: A master's degree from an accredited college or university in public health, science or social science with concentration in epidemiology, biostatistics or related field. Demonstrated ability to lead & direct the work of others either in a supervisory or project management capacity. Experience in Maternal and Child Health, including using public health surveillance or database management systems for population-based disease data or other conditions of public health significance.
Roles and Responsibilities	• Serves as liaison to Title V MCH Programs regarding technical, epidemiologic and statistical analyses, and health planning support. • Coordinates data for Virginia's Title V Federal Block Grant, State System Development Initiative Grant, and Home Visiting Initiatives (MIECHV, Healthy Start). • Support projects related to data linkages regarding pregnancy-related case surveillance.

Parker Brodsky, MPH – 0.35 FTE Newborn Screening Epidemiologist	
Funding	Early Hearing Detection and Intervention (EHDI); Title V MCH Block Grant; Sickle Cell Data Collection Program
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 – 0.50 FTE Reproductive and Perinatal Health Epidemiologist	
Funding	Title X Family Planning; Title V MCH Block Grant
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.

Kalu Onwuchekwa, 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 (Epidemiology), Eastern Virginia Medical School MBBS, University of Nigeria
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 – 0.20 FTE Program Evaluator	
Funding	Sexual Risk Avoidance Education (SRAE); Healthy Start; 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	CDC Overdose Data to Action, CDC Rape Prevention and Education, Title V MCH Block Grant, SAMHSA Garrett Lee Smith Youth Suicide Prevention, CDC Core State Injury Prevention Program
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 – 0.25 FTE Substance Use Prevention Epidemiologist (Epidemiologist Mid-Level)	
Funding	Title V MCH Block Grant; CDC Overdose Data to Action
Education and Training	Preferred qualifications: A master's degree from an accredited college or university in public health, science or social science with concentration in epidemiology, biostatistics or related field. Experience in injury and violence epidemiology, including using public health surveillance or database management systems for population-based disease data or other conditions of public health significance.
Roles and Responsibilities	• Analyzes, performs quality assurance, and disseminates substance use data used by internal and external stakeholders to support program planning efforts, grant applications, and ongoing implementation of federally funded substance use (IVP) initiatives. • Supports the VDH MCH team re: NAS surveillance and other IVP/substance use/ and MCH cross-cutting topics.

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 in 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 Epidemiologist Lead/Unit Supervisor reports to the DPHD director and is also a part of the Title V Leadership team. The dental, NBS, and RPH epidemiologists, and program evaluators report to the MCH Epidemiologist 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 summary 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. For example, the MCH Epidemiologist Lead has recently implemented a cross-unit journal club to discuss papers and methods, and to encourage collaborations across epidemiology units within DPHD. The MCH Epidemiology Unit staff 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, 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 currently limited to no linkage capability. However, through awarded opportunities with the Council of State and Territorial Epidemiologists (CSTE) Data Science Team Training (DSTT) program and the Association of State and Territorial Health Officials (ASTHO) PRAMS Multi-Jurisdiction Learning Community, teams within DPHD and the VDH Center for Public Health Informatics are working with VHI to obtain code to unscramble SSN in VHI hospitalization datasets for the possibility of linkage projects.

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 epidemiologist coordinates with the PRAMS Coordinator/Epidemiologist to draw the monthly PRAMS sample. During the current PRAMS grant year, VA PRAMS initiated a web-based survey module, allowing mothers to participate online using a QR code or passcode. The final birth file is prepared annually and forwarded to CDC PRAMS for weighting. Through collaboration between VA SSDI, VA PRAMS, and the OIM, we have been able to submit this file earlier in the year (submitted around November/December in previous years, now submitted July/August in 2019 and 2020), resulting in timelier receipt of the annual PRAMS dataset from CDC.

Title V Assessment, Monitoring, & Reporting

VA SSDI is actively involved in ensuring that VA MCH meets requirements of the Title V performance measurement framework. The program participates in and leads assessment, monitoring, reporting, and evaluation activities, where the SSDI Project Director (DPHD Director) provides oversight, the SSDI Coordinator (MCH Epidemiologist 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 epidemiological supports (e.g., Population Health Surveys Unit, SHA/SHIP Director) provided support throughout the 2020 statewide MCH needs assessment process and ongoing support 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 information 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. As the LiveStories contract has ended, the team is currently assessing other platforms, such as mySidewalk, to build out a public-facing visualization/dashboard as an ongoing needs assessment tool that will be updated annually.
Data Reporting	MCH Epidemiology under SSDI has established a contract with a data visualization expert to create a more efficient system for data visualization,

	extraction, and management of 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, develop an Infant Mortality report/visualization, and work with the VDH Center for Public Health Informatics to ensure accessibility and feasibility of visualizations created/posted. 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 aged 0 to 21, which can be filtered by age groups. MCH Epidemiology support has led and collaborated on multiple projects that have been presented at or submitted to conferences (CSTE, CityMatCH, SPER) and are in the process of developing several manuscripts. In September 2021, the DPHD onboarded a CSTE Fellow whose focus is MCH Epidemiology. The fellow recently completed an evaluation of Neonatal Abstinence Syndrome surveillance in the Commonwealth and presented at the 2022 CSTE Conference, and will be presenting work related to food insecurity and birth outcomes at the CityMatCH 2022 conference. The RPH epidemiologist recently presented a project titled “Association between Delivery Type and Breastfeeding Initiation” at the 2022 SPER Conference. The NBS epidemiologist will be presenting work related to prenatal care utilization and loss to follow-up in the VEHDI program at the CityMatCH 2022 conference.

Other MCH Data Capacity Efforts

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

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, Injury and Violence, Cancer, CYSHCN and Sickle Cell.

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. In addition, the MCH Epidemiologist Lead implemented a cross-unit journal club within DPHD to discuss papers and methods, and encourage collaboration across epidemiology units by facilitating new projects using existing data sources and identifying research gaps. The DPHD also has discussions to update health surveys, as necessary. For example, Virginia legalized marijuana in the state as of July 1, 2021, and our population health surveys made provisions to add marijuana-related supplements/questions to the surveys, with PRAMS starting the marijuana supplement in 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 first Task Force meeting launched in March 2022. The MCH Epidemiologist Lead serves as a subject matter expert/member on this Task Force, and the DPHD Director serves as an ex officio member.

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.

Fatality Review: As the Maternal Mortality Review Team (MMRT) and Child Fatality Review Team (CFRT) are housed under the Division of Death Prevention in the Office of the Chief Medical Examiner (OCME), DPHD maintains a relationship for data sharing and expanded data capacity related to maternal and child mortality and health disparities. Data come from the Maternal Mortality Surveillance Program and Child Fatality Surveillance Program, and include expanded information on precipitants of and circumstances surrounding the death, demographics, and social determinants of health.

Virginia House Bill 1950 (2021) directed the OCME to convene a work group to assess the feasibility of implementing the

Fetal Infant Mortality Review Team (FIMRT), in which the Director of Child and Family Health served as a member. Implementation of the FIMRT has the potential to expand data capacity related to fetal deaths, and although a report was published with the findings and recommendations from this work group, a bill was not submitted in the most recent legislative cycle to allow for its implementation at this time.

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

COMMONWEALTH OF VIRGINIA EMERGENCY PLANNING AND PREPAREDNESS

The Governors' Executive Order Number 42, signed on 9/3/2019, updated the Commonwealth of Virginia Emergency Operations Plan, naming Virginia Department of Emergency Management (VDEM) as the state agency responsible for the activation and maintenance of the Plan. This plan 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. A Revision Appendix was added in October 2021, adding a Recovery Section that houses Recovery Support Functions (RSFs), facilitating short, interim, and long-term recovery from a disaster to rebuild businesses and develop new economic opportunities with the goal of creating and sustaining more resilient, economically viable communities.

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 if an individual has access or a 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. The OFHS COOP Plan establishes a line of succession for key leadership positions. 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)

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.

Link to Commonwealth of Virginia Emergency Operation Plan:
https://www.vaemergency.gov/wp-content/uploads/2021/07/2021-COVEOP-Final-APPROVED-102021-1.pdf

Virginia Title V Public and Private Partnerships and Key Collaborations

Other MCHB Investments	
State Systems Development Initiative (SSDI)	Virginia's SSDI grant enables the MCH Epidemiology and Evaluation Team in VHD's Division of Population Health Data, working in collaboration with Title V staff, to build and expand MCH data capacity to support Title V program efforts and contribute to data driven decision-making.
Maternal, Infant and Early Childhood Home Visiting (MIECHV)	MIECHV and Title V collaborate to strengthen the home visiting system in Virginia, develop the home visiting workforce, and expand evidence-based home visiting services, including the three funded home visiting programs in Virginia: Healthy Families, Parents as Teachers, and Nurse-Family Partnership.
Healthy Start Grants	Virginia has two Healthy Start sites, locally known as Healthy Start Loving Steps. The site at Eastern Virginia Medical School serves Norfolk and Portsmouth, and the site at City of Hopewell serves Hopewell and Petersburg.
Other Federal Investments	
Nutrition Program for Women, infants & Children (WIC)	The WIC Program is co-located with Title V in the Office of Family Health Services. WIC collaborates and coordinates with Title V at both the state and local levels.
Early Hearing Detection and Intervention Program (EHDI)	Virginia's EHDI Program provides information and referral to families regarding newborn hearing screening, follow-up testing, and early intervention services. Title V funds support EHDI staff as well as programmatic activities and education modules.
Virginia Congenital Anomalies Reporting and Education System (VaCARES)	VaCARES, solely funded by Title V, is a registry of children under the age of two with birth defects. VaCARES partners with Title V, CSHCN Care Connection for Children Clinics to support affected children and their families with information, resources, and referrals. The Critical Congenital Heart Disease program is also under this umbrella.
Pregnancy Risk Assessment Monitoring System (PRAMS)	Located in VDH's Division of Population Health Data, Virginia PRAMS provides data support and strategic collaboration to Title V.
Early Childhood Comprehensive Systems (ECCS)	Funding supports Virginia Early Child Foundation's efforts to roadmap early childhood success by informing and advocating for policy and budget decisions, stewarding equity, providing research-based expertise, and nurturing innovation. VECF forges public and private partnerships at the state and regional levels that build and sustain capacity for equitable opportunities for early childhood success.
Pediatric Mental Health Care Access (PMHCA)	Virginia Mental Health Access Program is a statewide initiative that helps health care providers take better care of children and adolescents with mental health conditions through provider education and increasing access to child psychiatrists, psychologists, social workers, and care navigators.
Sexual Risk Avoidance Education (SRAE)	Virginia's Sexual Risk Avoidance Education (SRAE) Program works to prevent unintended pregnancies among adolescents by funding abstinence-based, evidence-based positive youth development interventions.
Learn the Signs Act Early	The CDC-funded program is housed in Virginia Commonwealth University's Center for Family Involvement, and collaborates with CYSHCN programs.

Professional education programs and Universities
Title V partners with Virginia Commonwealth University, University of Virginia, James Madison University, George Mason University, University of Richmond, Eastern Virginia Medical School. Title V provides internship and field placement opportunities to graduate and undergraduate students, and partners with university faculty on research and community programming. Title V actively engages with VCU and UVA's LEND Programs.

Boards, Councils, Committees, Collaboratives, Teams, and Work Groups		
Name of Group	**MCH Team Representation**	**Population Impacted**
Children's Health Insurance Program Advisory Board (CHIPAC)	Director, Division of Child & Family Health (DCFH)	Perinatal/Infant Health Child Health Adolescent Health CYSHCN
Rare Disease Council	Director, DCFH Birth Defects Surveillance Program Supervisor	Perinatal/Infant Health
Task Force on Maternal Health Data and Quality Measures	Director, Div. of Population Health Data (DPHD) MCH Epidemiologist Lead	Women/Maternal Health
EHDI Advisory Board	Newborn Screening and Birth Defects Surveillance Program Manager EHDI Program Supervisor	Perinatal/Infant Health
Newborn Screening Advisory Committee	Newborn Screening and Birth Defects Surveillance Program Manager Newborn Screening Dried Blood Spot Program Supervisor	Perinatal/Infant Health CYSHCN
Virginia Interagency Coordinating Council (VICC)	Early Childhood Health (ECH) Consultant	Child Health
Early Impact Virginia	ECH Team	Perinatal/Infant Health Child Health Adolescent Health CYSHCN
Virginia School Nurse Association	School Health (SH) Nurse Consultant	Child Health Adolescent Health CYSHCN
Annual Meeting of Virginia Chapter of the American Academy of Pediatrics (VA-AAP)	SH Nurse Consultant Adolescent Health (AH) Coordinator	Child Health Adolescent Health
Summer Institute for School Nurses	SH Nurse Consultant	Child Health Adolescent Health
March of Dimes Committee (MOD)	Maternal Infant Health (MIH) Consultant MCH Epidemiologist Lead Director, DPHD	Perinatal/Infant Health
5 Star Breastfeeding Program	Director, DCFH MCH/Title V Director MIH Consultant	Women/Maternal Health Perinatal/Infant Health
Contraceptive Access Workgroup	Reproductive Health Unit Supervisor	Women/Maternal Health Adolescent Health
Department of Education (DOE) Early Childhood Advisory Committee	Director, DCFH SH Nurse Consultant	Child Health
Virginia Neonatal Perinatal Collaborative (VNPC)	Director, DCFH MCH/Title V Director MIH Consultant	Women/Maternal Health Perinatal/Infant Health
Head Start Collaborative	ECH Team	Child Health
Advisory Board and Head Start State Health Advisory Committee	ECH Consultant	Child Health

Early Childhood Mental Health Advisory Board	ECH; MIECHV Project Director	Child Health
Infant Toddler Specialist Network Advisory Board	ECH	Child Health
Maternal Mortality Review Team	Director, Office of Family Health Services (OFHS)	Women/Maternal Health
Child Fatality Review Team	Director, DPHP	Perinatal/Infant Health Child Health Adolescent Health
Virginia Food Security Leadership Team	Director, DPHP Director, DCFH	Women/Maternal Health Perinatal/Infant Health Child Health Adolescent Health CYSHCN
Sister Agency Monthly Team	Director, DCFH Director, DPHD MCH/Title V Director MCH Epidemiologist Lead MIH Consultant MIECHV Director Reproductive Health (RH) Unit Supervisor Maternal Mortality Projects Manager	Women/Maternal Health Perinatal/Infant Health Child Health Adolescent Health CYSHCN
Doula Task Force	Director, DCFH RH Unit Supervisor Resource Mothers Supervisor	Women/Maternal Health Perinatal/Infant Health
Youth Advisory Council	AH Coordinator Youth Advisors	Adolescent Health CYSHCN
Virginia Catalyst (Oral Health)	Dental Health Programs Manager	Women/Maternal Health Child Health Adolescent Health CYSHCN
Unite Us Virginia Committee	MCH/Title V Director	Women/Maternal Health Perinatal/Infant Health Child Health Adolescent Health CYSHCN
Learning Communities/Collaboratives		
National Academy for State Health Policy (NASHP) MCH Policy Innovations Program (PIP) Project	Director, DCFH RH Unit Supervisor AH Coordinator	Women/Maternal Health Perinatal/Infant Health
AMCHP Healthy Beginnings with Urban Baby Beginnings	Director, DCFH MCH/Title V Director MIECHV Director Resource Mothers Supervisor OFHS Policy Analyst	Women/Maternal Health Perinatal/Infant Health
City MatCH Learning Collaborative – Alignment for Action Learning	Director, DCFH Blue Ridge Health District	Women/Maternal Health Perinatal/Infant Health
PEW Charitable Trust: Calling All Sectors	Director, DCFH MCH/Title V Director Director, DPHD	Women/Maternal Health Perinatal/Infant Health
MCH Workforce Development Center – Accelerating Equity Learning Community	Director, DCFH MCH/Title V Director MIECHV Director Resource Mothers Supervisor	Women/Maternal Health Perinatal/Infant Health
MCH Workforce Development Center – Family Engagement Transformation Cohort	ECH Consultant Family/Youth Leader	Child Health
2022-2023 cohort of the Maternal	MCH Epidemiologist Lead	Women/Maternal Health

Mental Health Government Agency Fellows program	IVPP Senior Epidemiologist	
CityMatCH – 2022 Training Course in Maternal and Child Health Epidemiology	MCH Epidemiologist Lead	Women/Maternal Health Perinatal/Infant Health Child Health Adolescent Health CYSHCN
AMCHP Leadership Lab 2021-2022	MCH/Title V Director (participant) CYSHCN Director (mentor) Director, DPHD (mentor)	Women/Maternal Health Perinatal/Infant Health Child Health Adolescent Health CYSHCN

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

Title V – Medicaid Memorandum of Understanding

Updated last in 2015, the Title V-Medicaid MOU (attached to this application) includes information on the responsibilities of both parties inherent to this collaboration. In early 2022, members of both VDH and DMAS convened to review the current MOU sections related to maternal and child health and CYSHCN. Efforts are currently underway to update and strengthen the agreement.

Virginia's Medicaid Program

Virginia Department of Medical Assistance Services (DMAS) plays an essential role in the Commonwealth's health care system by offering lifesaving healthcare coverage to approximately 2 million individuals and is delivered to individuals through two models: fee-for-service (10% of enrollees) and managed care (90% of enrollees). Approximately 27% (527,901) of Virginian children ages 0-19,[1] and 36.4% of children with special healthcare needs[2] receive services through Virginia's Medicaid program. Virginia Medicaid covers a broad group of people and provides services beyond the minimum standards set in federal law, including expanding coverage to higher-income children through the CHIP Program, and covering long-term care in the home and community instead of an institutional setting. In 2020, Virginia Medicaid covered approximately 37,300 births.[3]

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.

VDH and DMAS Coordination

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:** Virginia is the 4th state in the nation to offer community doula services as a benefit for Medicaid members. Leaders from both DMAS and VDH collectively provided input and

direction into both the state certification and reimbursement processes. Both initiatives went into full effect in early 2022.

2. **National Academy for State National Academy for State Health Policy (NASHP) Maternal and Child Health Policy Innovation Program:** DMAS applied for, and was awarded to work on a two-year policy academy which will advance innovative policy initiatives and build state capacity, 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 2021/2023) Program focused on addressing maternal mortality for Medicaid eligible pregnant and parenting women. More specifically, this program aimed to increase awareness of the community doula benefit and expansion of Postpartum Coverage to both members and providers.
3. **CMS Affinity Group:** The focus of this group is to Improve Maternal Health by Reducing Low-Risk Cesarean Delivery (LRCD). Slated to begin in September 2022, this group will be led by DMAS and VDH Title V will participate with other state partners to work on strategies to reduce LRCD and related issues.
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.
5. **BabyCare Program:** Virginia's BabyCare Program is Medicaid's case management program that 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 postpartum 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.

Medicaid expansion updates that impact Title V population

MEDICAID EXPANSION: In January 2019, new Virginia Medicaid expansion eligibility rules went into effect, with more than 500,000 new Medicaid members enrolled in health coverage. During the first year of expansion (2018-2019) there was a decrease of the overall uninsured rate from 12.3% to 11%. 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% during the same time period.

MEDICAID DENTAL BENEFITS EXPANSION: Effective July 1, 2021, Virginia's nationally recognized Smiles For Children program added coverage to adults with Medicaid, in addition to dental benefits to pregnant women and children age 20 and below. 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 July 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.

Virginia Medicaid Covid Response

The Families First Coronavirus Response Act (FFCRA) directed states to maintain Medicaid health coverage for individuals enrolled on or after March 18, 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: Suspension of co-pays for Medicaid or FAMIS-covered services for the duration of the public health emergency; Outreach to high-risk members to review critical needs; Expanded telehealth options; Routine prescriptions supplied at 90-day intervals; Safeguard for coverage lapse due to processing delay.

[1] ACS 2020 5 year estimate

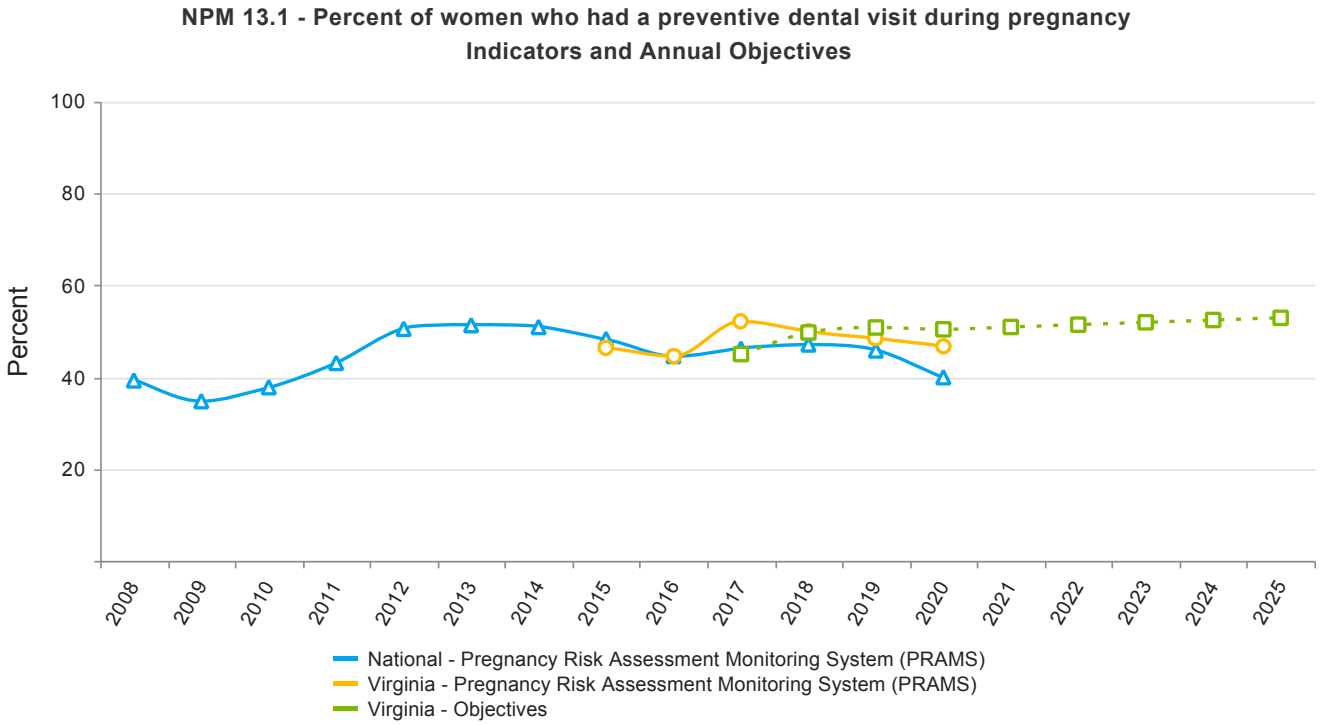
[2] NSCH – 2019-2020

[3] BabySteps VA Maternal Health Annual Report 2021 - https://www.dmas.virginia.gov/media/4638/dmas-maternity-report-2021.pdf

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

Women/Maternal Health

National Performance Measures



Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	45	49.7	50.8	50.4	50.9
Annual Indicator	46.5	44.7	49.9	48.4	46.7
Numerator	44,225	42,882	46,558	43,840	41,629
Denominator	95,088	95,839	93,304	90,596	89,193
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2016	2018	2019	2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	51.4	51.9	52.4	52.9

Evidence-Based or –Informed Strategy Measures

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

Measure Status:				Active	
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			6	6	6
Annual Indicator		3	4	8	7
Numerator					
Denominator					
Data Source		VDH Oral Health Program documentation	VDH Oral Health Program documentation	VDH Oral Health Program documentation	VDH Oral Health Program documentation
Data Source Year		2018	2019	2020	2021
Provisional or Final ?		Final	Final	Final	Final

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

State Performance Measures

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			23.8
Annual Indicator	25.3	27.1	25.1
Numerator			
Denominator			
Data Source	VA PRAMS	VA PRAMS	VA PRAMS
Data Source Year	2018	2019	2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	23.3	22.8	22.3	21.8

SPM 6 - Promotion and strengthening of optimal mental/behavioral health and well-being through partnerships and programs

Measure Status:	Active

Annual Objectives			
	2023	2024	2025
Annual Objective	48.6	51.4	54.3

State Outcome Measures

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

Measure Status:	Active

State Provided Data				
	2018	2019	2020	2021
Annual Objective			2.8	2.4
Annual Indicator	1.9	2.2	2.7	2.1
Numerator	52.6	32.4	38.2	49.1
Denominator	27.7	14.5	14.1	23.7
Data Source	National Vital Statistics System	National Vital Statistics System	National Vital Statistics System	National Vital Statistics System
Data Source Year	2013-2017	2014-2018	2015-2019	2016-2020
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	2.1	1.8	1.5	1.2

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 2025, increase the percent of women who had a dental visit during pregnancy from 49.9% (PRAMS 2018) to 52.4%	
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	
Continue to foster a network of 6 regional Oral Health Alliances to conduct regional needs assessments and implement systems change and data-sharing initiatives to improve the oral health of all Virginians, with emphasis on pregnant women, and children and adolescents ages 1-17	
Convene statewide groups focused on targeted oral health issues and facilitate collaboration and work plan development, and provide leadership and oversight to guide initiatives	
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

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

By 2025, reduce the rate of mistimed pregnancies from 25.3% (PRAMS 2018) to 21.8%

Strategies

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

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

Priority Need

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

SPM

SPM 6 - Promotion and strengthening of optimal mental/behavioral health and well-being through partnerships and programs

Objectives

By 2025, reduce the percent of women who reported loss of interest or feeling depressed (post-partum depression) from 14.43% (PRAMS 2019) to 13.71%

Strategies

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

Local Health District (LHD): Strengthen early identification, supports, and referrals for women's mental and behavioral health needs

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

Priority Need

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

SOM

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

Objectives

By 2025, decrease the disparity in Black-White maternal mortality disparity ratio from 2.1 (2017) to 1.23 (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 Title V representation in selected workgroups

Local Health District (LHD): Develop, mobilize, and participate in strong interagency, multisector, and community partnerships to address disparities in maternal and infant mortality rates

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

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

By 2025, decrease the disparity in Black-White maternal mortality ratio from 2.1 (2017) to 1.23 (2025)

Strategies

Sustain state maternal mortality and child fatality review programs, engaging with cross-sector partners and addressing social determinants of health in development of MMRT and CFRT recommendations

Convene Maternal Health Data and Quality Measures Task Force as mandated by HB2111 to evaluate maternal health data collection processes

WOMEN/MATERNAL HEALTH DOMAIN
SUMMARY/OVERVIEW
FY21 ANNUAL REPORT

DOMAIN CONTRIBUTORS

Maternal and Infant Health (MIH) Consultant – Division of Child and Family Health
Reproductive Health Unit – Division of Child and Family Health
MCH Epidemiology – Division of Population Health Data
Division of Death Prevention – Office of the Chief Medical Examiner (OCME)
Dental Health Program – Division of Prevention and Health Promotion
VDH Local Health Districts

MATERNAL AND INFANT HEALTH (MIH) CONSULTANT: The MIH Consultant 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. The MIH Consultant position was vacated in February 2020; however, a new consultant has been hired and will start in late August 2022.

REPRODUCTIVE HEALTH UNIT: This unit is 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.

DIVISION OF DEATH PREVENTION: The Division of Death Prevention, located in the Office of the Chief Medical Examiner, is responsible for several epidemiological surveillance and fatality review programs, including the Maternal Mortality Review and Child Fatality Review Teams. 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.

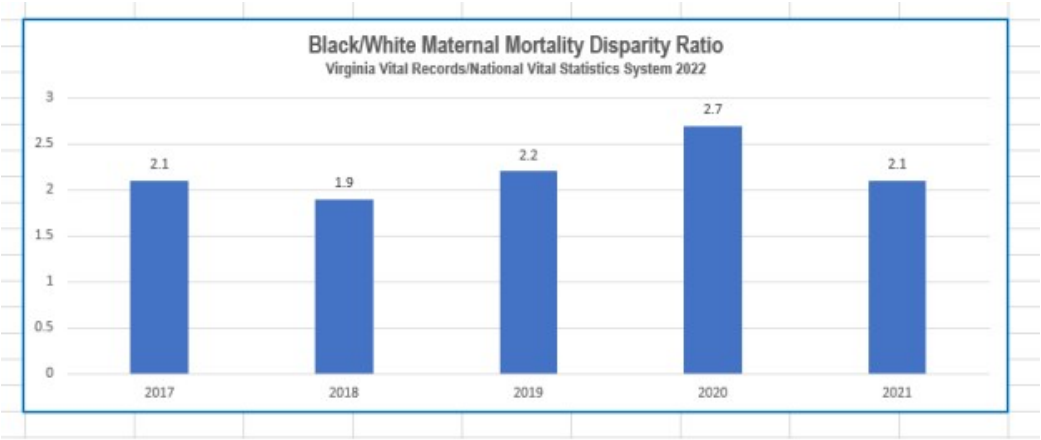
MCH EPIDEMIOLOGY: The MCH Epidemiology and Evaluation Unit is a centralized epidemiology unit within the Division of Population Health Data headed by the MCH Epidemiology Supervisor who serves as the Lead Epidemiologist for Title V. The team has additional capacity available through a Reproductive and Perinatal Health (RPH) Epidemiologist and a Newborn Screening (NBS) Epidemiologist, a Dental Health Epidemiologist/Evaluator, and two program evaluators supporting MCH programs regarding home-visiting (i.e., Healthy Start, MIECHV), and child and adolescent health. Additional cross-cutting support is provided by the Injury and Violence Prevention Epidemiologist.

VDH LOCAL HEALTH DISTRICTS: Each of VDH's 35 local health districts (LHDs) receive Title V funds to drive and support maternal and child health programmatic initiatives at the local level.

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

PRIORITY 1: Maternal and Infant Mortality Disparity: Eliminate the racial disparity in maternal and infant mortality rates by 2025



OBJECTIVE	By 2025, decrease the disparity in black-white maternal mortality disparity ratio from 2.1 (2017) to 1.2 (2025).
OUTCOME MEASURE	SOM 2: Maternal Mortality Disparity: Black/White Maternal Mortality Ratio

Review of maternal mortality data from 2018 indicates that Virginia's maternal mortality rate of 15.6 per 100,000 pregnancies largely mirrors the national mortality rate of 17.4 per 100,000; however, the maternal mortality rate of black women (47.2) is over two times higher than that for white women (18.1). PRAMS data from the same period indicated that Black women were more likely to report chronic conditions like hypertension and depression, and more likely to report experiencing

discrimination or harassment due to their race/ethnicity or insurance or Medicaid status. Additionally, the 2019 Maternal Mortality Review Team (MMRT) report showed that Black women with at least one chronic condition had a maternal mortality rate over twice that of their white counterparts (51.4 versus 25.1, respectively). When combined with rising rates of pregnant women with substance use disorder, and an unplanned pregnancy rate of almost 50%, Virginia's 2019 Maternal Health Strategic Plan (attached document) sets an ambitious yet imperative goal of eliminating the racial disparity in maternal mortality by 2025. This plan outlines six specific focus areas with strategies and recommendations for achieving this goal. The focus areas are: Insurance coverage, healthcare environment, criminal justice and child welfare response, community-based services, contraception, and data collection. Title V's strategies in the Women/Maternal Health Domain complement and advance the recommendations made in the Maternal Health Strategic Plan.

Strategy 1: Work with stakeholders to increase access to doula services among women of color

During the 2020 General Assembly Session, Virginia legislators tasked VDH with establishing a State Doula Certification Program in order to make doula services more accessible to all people, but specifically to Black women, who experience the highest maternal mortality rates 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 Department of Medical Assistance Services (DMAS), Virginia's Medicaid Program. VDH and DMAS worked in concert so that when the doula certification program is launched in FY22, certified doulas will then be able to apply to become a Medicaid provider. Medicaid coverage for doulas will open access to low-income families and help to address the racial maternal mortality disparity in Virginia

An official Doula Task Force convened in FY21 to provide the opportunity for doulas, providers, consumers, and payers to provide continuous feedback to the State Doula Certification Program throughout program implementation. The purpose of this task force is to assist with the promulgation of regulations and the certification process of doulas, as well as to serve as an informational resource for policy-related matters for VDH. The task force consists of fifteen members representing the following areas of expertise:

- Three individuals who are not doulas and who received doula services during their previous pregnancies
- Seven representatives who are doulas working independently, as part of a collective, or as part of a private or community-based provider organization
- Three representatives who are clinical providers, including at least one OB/GYN and one certified nurse midwife
- One representative of a professional organization for hospitals
- One legislative member with a demonstrated interest in maternal and child health
- VDH and DMAS representatives serve as ex-officio members

Strategy 2: Maintain Title V representation on the Virginia Neonatal Perinatal Collaborative (VNPC) Steering and Executive committees, and Title V representation in selected workgroups.

Beginning February 2020, the Virginia Neonatal Perinatal Collaborative (VNPC) moved to Virginia Commonwealth University through a contract with VDH providing contract administration, epidemiological support, and is represented on all VNPC committees. In collaboration and coordination with Virginia's 54 birth hospitals, VNPC is currently focusing on three quality improvement (QI) projects 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. Virginia is one of three states to pilot the 4th trimester bundle, with 51 birth hospitals currently participating in the bundle. Title V participates in VNPC's Sister Agency Monthly call, alongside MCH representation from all state-level agencies. VNPC facilitates a perinatal cannabis workgroup, which formed in response to Virginia's July 2021 marijuana legalization legislation. Title V is active in this workgroup, which is focusing on awareness and education at both the provider and community levels. VNPC offers a monthly webinar series for state perinatal stakeholders which are well attended each month. VNPC also hosts two annual summits, both of which were virtual during FY21. The 4th Annual VNPC Summit was held on October 4, 2020, themed around "respectful care".

The Perinatal and Infant Mortality Summit occurred on March 2, 2021. Both summits had over 100 attendees from state, district and local community organizations.

Strategy 3: Strengthen and expand MCH capacity at the local health district level

Thirteen of 35 local health districts prioritized maternal and infant mortality disparity in their annual work plans. Local activities include: Conducting local area environmental scans and gap analyses of maternal and infant mortality; strengthening community partnerships to increase referrals for the Black and Hispanic birthing population to home visiting programs; collaborating with community partners, including FQHCs, to develop stronger referral processes for appointments and care coordination of women with chronic medical conditions and those at risk of poor outcomes, including focuses on health literacy and health system navigation; partnering with local housing and food bank resources to strengthen community-centered support; strengthening of current educational resources provided to women who utilize current LHD clinics.

PRIORITY 2: MCH data capacity: Maintain and expand state MCH data capacity, to include ongoing needs assessment activities, program evaluation, and modernized data visualization and integration

OBJECTIVE	By 2025, decrease the disparity in black-white maternal mortality ratio from 2.1 (2017) to 1.2 (2025)
OUTCOME MEASURE	SOM2: Maternal mortality disparity: Black/white maternal mortality ratio

Strategy 1: Sustain state maternal mortality and child fatality review programs, engaging with cross-sector partners and addressing social determinants of health in development of MMRT and CFRT recommendations

Activities of the Maternal Mortality Programs included the coordination and facilitation of 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 Team successfully implemented virtual review team meetings. After each review team meeting, data from the review team meeting was entered into the MMRIA system by the Maternal Mortality Programs Manager and Maternal Mortality Research Assistant. The Programs Manager also maintained and reviewed the recommendations from each review meeting for applicability and appropriateness based on the review topic and current data trends.

Additionally, in an effort to disseminate the findings and recommendations of the Maternal Mortality Review Team, Dr. Melanie Rouse participated in several dissemination activities. These activities include the following:

- Dr. Melanie Rouse was an invited speaker during a Virginia Children's Health Insurance Program Advisory Committee meeting, December 2020.
- Dr. Rouse was the guest speaker and discussion facilitator regarding racial disparities in maternal mortality during a Grand Rounds on Maternal Mortality and Morbidity for OBGYN students at Virginia Commonwealth University, February 2021.
- Dr. Rouse was an invited speaker at the Virginia Neonatal Perinatal Collaborative Perinatal, Maternal and Infant Mortality Summit regarding maternal mortality and racial disparities in Virginia, March 2021.

The Maternal Mortality Programs Manager collaborated with the VNPC to develop a shared vision plan which aims to improve maternal and infant health across the Commonwealth through data-driven, evidenced 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.

Using data from the Maternal Mortality Surveillance Program, the OCME provided data to 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 DPHD once developed and before dissemination of materials.

The Maternal Mortality Review Team contributed to consumer and family engagement and partnership through the continued efforts in reducing maternal mortality. The impacts of maternal mortality are far reaching, including links to reduce mental health and other socioeconomic disparities that greatly influence a person's wellbeing. Additionally, the work of the MMRT has identified key risk factors that affect maternal mortality and the higher the number of risk factors, the greater the likelihood of a fatal event. Risk factors include:

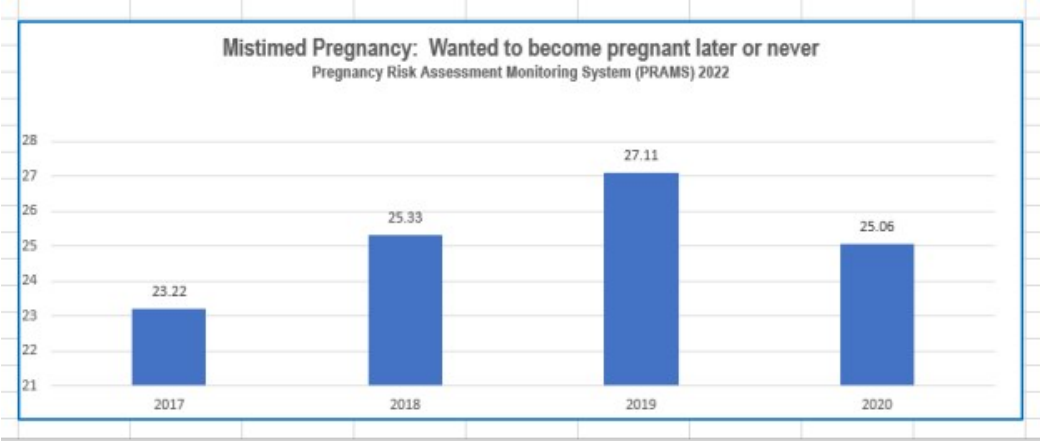
- Chronic diseases
- Chronic mental illness
    - Depression
    - Anxiety
- Chronic substance use disorder
- Intimate partner violence

The addition of a MMRT Research Associate allowed for the expansion of the MMRT program to include more in-depth data collection and analysis. The hiring of this research associate also allowed for a new tool to be developed so that the 2015-2017 backlogged data could be collected and allow for a more comprehensive database in future years. Additionally, the addition of the MMRT Research Associate gave the Maternal Mortality Programs Manager more ability to focus efforts on data analysis, policy development, and data dissemination, as the research associate is responsible for many administrative tasks formerly managed by the Programs Manager.

Strategy 2: Convene the Maternal Health Data and Quality Measures Task Force as mandated by HB2111 to evaluate maternal health data collection processes

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. With representation from multiple disciplines and organizations, the provisions of the bill require the Task Force to monitor and evaluate relevant stakeholder data, including third-party payer claims and mandated sources, to examine quality of care with regard to race, ethnicity, and demographic, as well as the impact of social determinants of health on outcomes. The first Task Force meeting was held in March 2022. The MCH Epidemiologist Lead serves as a subject matter expert/member on this Task Force, and the DPHD Director serves as an ex officio member.

PRIORITY 3: Reproductive justice and support: Promote equitable access to choice-centered reproduction-related services, including sex education, family planning, fertility/grief support, and parenting support



OBJECTIVE	By 2025, reduce the rate of mistimed pregnancies from 25.3% (PRAMS 2018) to 21.8%
PERFORMANCE MEASURE	SPM 4 – Pregnancy Intention: Mistimed or Unwanted pregnancy (wanted to become pregnant later or never)

Strategy 1: Work with stakeholders to remove policy, financial, and training barriers to contraceptive access

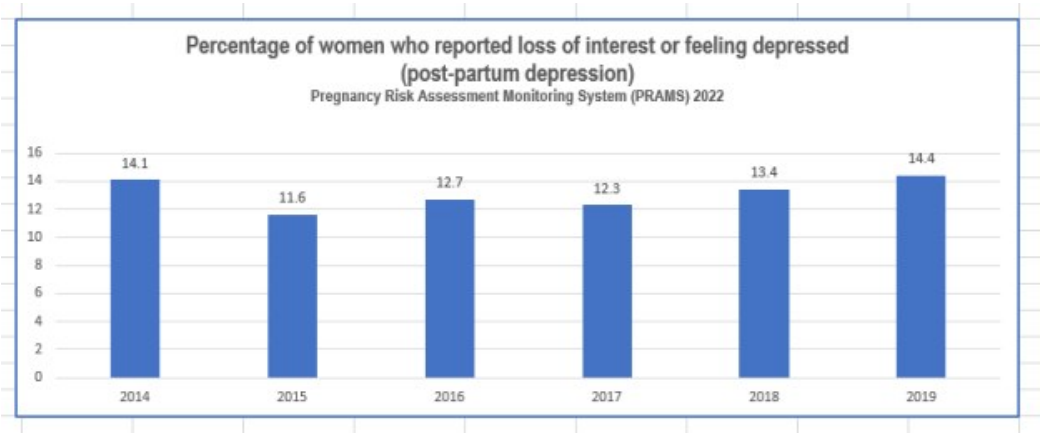
VDH's Reproductive Health Unit includes several programs dedicated to Title V populations and priorities, including the Contraceptive Access Network, the Virginia Contraceptive Access Initiative, the Title X Family Planning Program, the Adolescent Health Program, Resource Mothers, the Doula Certification Program and Task Force, and the Pregnancy Loss Services Initiative.

The Contraceptive Access Network is a group of agencies working to reduce unintended pregnancies among people 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 health. 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.

The Contraceptive Access Network collaborated to successfully advocate for the Virginia LARC Initiative, a two-year pilot program designed to increase access to hormonal LARCs (long acting reversible contraceptives) among uninsured, low-income patients that began in 2018. 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 its two year pilot period (October 2018-July 2020), the Virginia LARC Initiative provided approximately 3,986 no-cost visits to eligible patients. In July 2020, the Virginia General 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. During SFY 21 (July 1, 2020-June 30, 2021), the expanded program provided 6,785 no-cost visits to eligible patients, representing an enormous increase in patients served. Title V funds support VDH staff time spent administering this program.

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

PRIORITY 4: Mental Health



OBJECTIVE	By 2025, reduce the percent of women who reported loss of interest or feeling depressed (postpartum depression) from 14.4% (PRAMS 2019) to 13.7%
PERFORMANCE MEASURE	SPM 6 - Promotion and strengthening of optimal mental health and well-being through partnerships and programs

Perinatal mental health (PMH) conditions, including perinatal mood and anxiety disorders or PMADS, are one of the most common complications in pregnancy, affecting 1 in 7 birthing individuals in the United States; however, PMH affects birthing individuals who are members of vulnerable groups, marginalized and underserved communities are affected at a much higher rate. PMH conditions impact the mother-baby dyad in significant ways: less engagement in medical care, preterm delivery, low birthweight and NICU stays, lactation challenges, bonding and attachment issues, cognitive and motor delays in the baby, and adverse partner relationships. We also know that 100% of pregnancy-related mental health deaths were preventable. Before COVID-19, the CDC estimated that one in eight women experienced postpartum depression, and about five to seven percent experienced major depressive symptoms. Two COVID-19 studies which collected survey data on maternal mental health and breastfeeding during the pandemic indicated that a third of women screened positive for depression and one-fifth for major depression. One in five who screened positive for postpartum depression reported thoughts of harming themselves. In the state of Virginia, 11.77% of 2020 PRAMS respondents indicated that they “often” or “always” felt down, depressed, or hopeless or having little interest or little pleasure in doing things they usually enjoyed since delivery.

Strategy 1: Explore opportunities for providing support to families seeking fertility services and families experiencing miscarriage

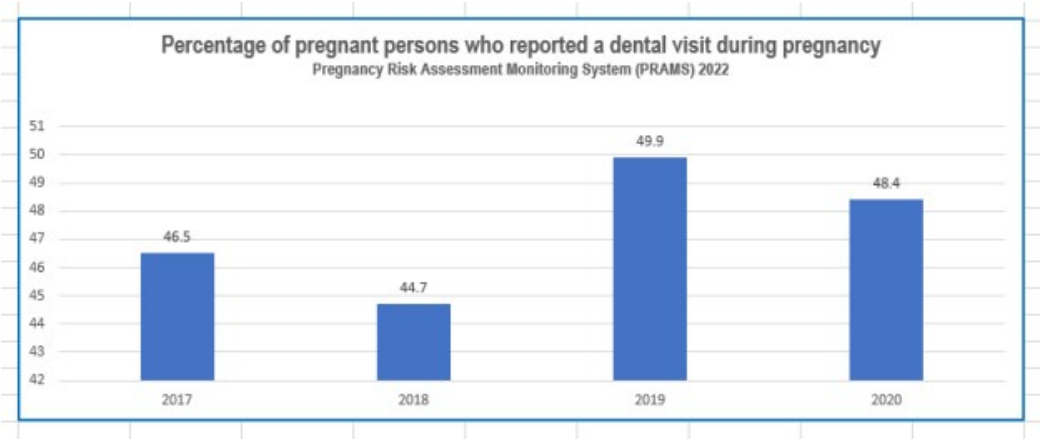
During FY21, VDH laid the foundation for the Pregnancy Loss Services Initiative. The purpose of VDH's Pregnancy Loss Services Initiative is to build the capacity of community organizations to provide pregnancy loss support and education services to individuals and groups (including families) who have experienced pregnancy loss, including but not limited to miscarriage (including molar and ectopic pregnancy), termination for medical reasons, stillbirth and neonatal death, and sudden, unexpected death of an infant. While pregnancy loss is defined differently throughout the world, the World Health Organization (WHO) defines a miscarriage as a baby who dies before 28 weeks of pregnancy and a stillbirth as a baby who dies at or after 28 weeks. An estimated 10% to 20% of known pregnancies end in miscarriage, and an additional 1% end in stillbirth. Research suggests that even after the birth of a healthy child, some parents who have experienced pregnancy loss continue to grieve for much longer than previously thought by health care professionals. Pregnancy loss may affect future

pregnancies, the ability of a parent to care for their other children, and may lead to the development of mental health issues (e.g. anxiety, depression, and post-traumatic stress disorders). By increasing access to pregnancy loss support services among Virginians, VDH aims to help individuals and families heal, thus resulting in positive health outcomes for children, adults, families, and communities. During this reporting period, VDH released a Request for Applications and recommended funding five community agencies to provide pregnancy loss services. Services were launched in FY22.

Strategy 2: Strengthen and expand supportive capacity regarding perinatal mental health at the local health district level

Fifteen of 35 local health districts (LHDs) prioritized mental health in their annual work plans. Local activities include: hiring a social worker with experience in mental health counseling to assess all mothers enrolling for prenatal or postpartum MCH services; strengthening the mental health skills of the LHD personnel through evidence-based trainings and continuing education; strengthening the internal screening, referral, and follow-up process; increasing connections with community providers.

PRIORITY 5: Oral Health



OBJECTIVE	By 2025, increase the percent of women who had a dental visit during pregnancy from 49.9% (PRAMS 2018) to 52.4%.
PERFORMANCE MEASURE	NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy
EVIDENCE-BASED or -INFORMED STRATEGY MEASURE	ESM 13.1.1 - Number of Regional Oral Health Collaborative Projects that implemented work to increase dental visits among pregnant women

The Dental Health Program (DHP) partners widely across both internal Virginia Department of Health programs as well as externally through 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 to focus on HPV prevention and oral cancer education, and vaping concerns for the adolescent population.

Strategy 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

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 continues this work and identifies 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 continues 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.

Specific activities in FY21 (October 1, 2020 – September 30, 2021) include:	
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

VDH continues to partner with the Virginia Health Catalyst (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.

Specific activities in FY21 (October 1, 2020 – September 30, 2021) include:	
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

VDH continues its partnership 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 convenes 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. VHC continues 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. VHC also engages other clinical expertise as needed, to offer additional technical assistance and guidance to the workgroup. HRSA Oral Health Workforce Grant funds are 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 VHC in convening 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 formed two workgroups, 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 also convenes the Early Dental Home (EDH) workgroup and collaborates with existing groups working on HPV to ensure oral health is integrated into their approach and goals. Additionally, the VHC has expanded community engagement and provides 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 has, for the second time, partnered 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).

Specific activities in FY21 (October 1, 2020 – September 30, 2021) include:	
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

During the 2020 General Assembly session, Virginia legislators passed a law to allow pharmacists to dispense contraception to low-risk patients over 18 years of age. VDH's Reproductive Health Unit Supervisor worked with the Board of Pharmacy and other stakeholders to develop protocols for dispensing contraception, but pharmacists were tasked with COVID-19 vaccination activities and were unable to implement the new protocols. VHD's Reproductive Health Team intends to work with pharmacy partners during the upcoming reporting period to launch this program. VDH anticipates that this policy change will ultimately lead to increased access for contraception to vulnerable communities, particularly people living in communities with few or no family planning providers. While not funded by Title V, this work will complement the work done by both the Title V and Title X grants and help reduce unintended pregnancy rates in Virginia.

WOMEN/MATERNAL HEALTH DOMAIN

FY23 APPLICATION YEAR

The following programmatic strategies and activities will continue as methods to advance and improve outcomes in each of the identified priority areas.

PRIORITY 1	Maternal and Infant Mortality Disparity: Eliminate the racial disparity in maternal and infant mortality rates by 2025
OBJECTIVE	By 2025, decrease the disparity in black-white maternal mortality ratio from 2.1 (2017) to 1.2 (2025).
OUTCOME MEASURE	SOM2: Maternal mortality disparity: Black/white maternal mortality ratio

Strategies:

1. **Work with stakeholders to increase access to doula services among women of color**
   In order to advance the Doula Certification Program, VDH intends to continue to manage the State Doula Certification Program and provide administrative support to the Virginia Doula Task Force during the upcoming funding period. This task force will meet quarterly and guide the Doula Certification Program, Medicaid reimbursement of doulas, and promote doula access among vulnerable populations.

2. **Maintain Title V representation on the Virginia Neonatal Perinatal Collaborative (VNPC) Steering and Executive committees, and Title V representation in selected workgroups**
   VDH staff, including DCFH Director, Title V/MCH Director, Maternal/Infant Consultant, and MCH Epi team members will maintain active representation in VNPC committees and workgroups regarding Fourth Trimester, Perinatal Cannabis, and Eliminating Bias in the Dyad Care.

3. **Local Health District (LHD) Strategy: Develop, mobilize, and participate in strong interagency, multisector, and community partnerships to address disparities in maternal and infant mortality rates**
   LHDs that are working on efforts within this strategy will receive ongoing TA from Title V and MCH Epidemiology Teams to develop, expand, and strengthen the doula communities in their districts, supporting doulas towards their efforts to becoming certified and thereby eligible for Medicaid reimbursement, and ensuring that the birthing community has access to doula support if desired.

PRIORITY 2	MCH data capacity: Maintain and expand state MCH data capacity, to include ongoing needs assessment activities, program evaluation, and modernized data visualization and integration.
OBJECTIVE	By 2025, decrease the disparity in black-white maternal mortality ratio from 2.1 (2017) to 1.2 (2025).
OUTCOME MEASURE	SOM2: Maternal mortality disparity: Black/white maternal mortality ratio

Strategies:

1. **Sustain state maternal mortality and child fatality review programs, engaging with cross-sector partners and addressing social determinants of health in development of MMRT and CFRT recommendations**
   Coordination and facilitation of bi-monthly MMRT meeting: Activities under this activity include case selection for each meeting, requesting records from health, social, and community based agencies that will be used in the review, review of those records, and determination of inclusion or exclusion in the review, as well as scanning the record for additional information that could be collected from other providers for use. After each review team meeting, data from the review team meeting is entered into

the MMRIA system by the Maternal Mortality Programs Manager and MMRT Research Associate. The Programs Manager is also responsible for maintaining the recommendations from each review meeting and compiling and reviewing the recommendations quarterly for applicability and appropriateness based on the review topic and current data trends.

Conduct epidemiological surveillance: Activities under this activity will include collection of comprehensive data using the MMRT data tool. The research associate will be responsible for collecting data using the tool and entering the data in the MMRT Surveillance Database. They will also work with the Programs Manager to identify data trends, conduct data analysis, and evaluate the tool and the data for quality assurance purposes.

MCH Data Capacity: Using data from the Maternal Mortality Surveillance Program, the OCME will provide data to Title V, community-based, and Virginia Department of Health partners 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, when requested.

Community Leadership: The OCME will engage the community through multidisciplinary workgroups, review team meetings, and other activities where appropriate. This work is done through the Maternal Mortality Review Team. The team is chaired by Virginia's Office of the Chief Medical Examiner and Office of Family Health Services and the team includes representation from education, social service and community service boards, psychiatry, injury prevention, health promotion, obstetrics and gynecology, maternal fetal medicine, and other relevant agencies. The purpose of the team is to review topic specific cases and work to provide policy and programmatic recommendations to address the studied topic. Furthermore, the Maternal Mortality Programs Manager sits on a variety of community boards and workgroups addressing child death. The OCME will also develop a proof of concept paper that will systematically explore the efficacy and feasibility of including patient or family interviews in the review process. There is value in hearing from those that may be personally affected by maternal death and interviewing individuals or families could be beneficial to the program. Since this is not an activity that has not been done before and due to statutory limitations, this concept must be explored to understand feasibility and efficacy. The proof of concept paper will also explore how to partner with agencies such as the Virginia Neonatal Perinatal Collaborative or Citizens Review Panel to address equity and work to address health disparities in infant and child death.

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

Maternal/Infant Mortality Disparity: The OCME will collaborate with sister agencies to identify drivers of disparities in maternal and infant mortality. This work will include working with the VNPC to evaluate the implementation of past recommendations and explore how to move recommendations into action. The Maternal Mortality Surveillance Program will assist with identification of barriers to community-based organizations (CBOs) delivering preventive, evidence-informed interventions to reduce maternal/infant health disparities.

2. Convene the Maternal Health Data and Quality Measures Task Force as mandated by HB2111 to evaluate maternal health data collection processes.

During FY23, the Maternal Health Data and Quality Measures Task Force will continue to convene bi-monthly to address the following mandated goals:

- Monitor progress and evaluate all data from state-level stakeholders with regard to race, ethnicity, and other demographic and clinical outcome data;
- Monitor progress and evaluate all data from state-level sources mandated for maternal care, including new Healthcare Effectiveness Data and Information Set (HEDIS) measure updates;
- Examine barriers preventing the collection and reporting of timely maternal health data from all stakeholders;
- Examine current maternal health benefit requirements and determine the need for additional benefits to protect the health of birthing people;
- Evaluate the impact of Social Determinants of Health (SDoH) screening on pregnant women and its impact on outcomes data;
- Collect and analyze data one year after delivery; and
- Develop recommendations for standard quality metrics on maternal care.

PRIORITY 3	Reproductive justice and support: Promote equitable access to choice-centered reproduction-related services, including sex education, family planning, fertility/grief support, and parenting support
OBJECTIVE	By 2025, reduce the rate of mistimed pregnancies from 25.3% (PRAMS 2018) to 21.8%
PERFORMANCE MEASURE	SPM 4 – Pregnancy Intention: Mistimed or Unwanted pregnancy (wanted to become pregnant later or never)

Strategies:

1. **Work with stakeholders to remove policy, financial, and training barriers to contraceptive access**
   During FY23, 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. VDH's Reproductive Health Unit also intends to work with partners to encourage pharmacists to dispense contraception in areas with limited access to family planning services. VDH will revisit the scope of the Contraceptive Access Network to explore more opportunities for collaboration regarding this new state policy.

2. **Title V, in partnership with VDH's Reproductive Health Unit, will create a joint Statement of Commitment that reflects internal consensus to women's reproductive health**
   In response to the landmark Supreme Court decision, Dobbs v Jackson Women's Health Organization, it is imperative that the disproportionate impact to the maternal health population be fully articulated. It is also critical that the responsibility of the impact of this does not land fully on the shoulders of our Reproductive Health partners. In an effort to assure necessary surveillance, programming and communication, Title V and VDH's Reproductive Health will further strengthen the existing partnership in a way that reflects cohesion and commitment to the full spectrum of reproductive health care for Virginia's women. This Statement of Commitment will then serve as a guide for both programs to support maternal health, advance equitable outcomes, and centering actions to protect human rights.

PRIORITY 4	Mental Health
OBJECTIVE	By 2025, reduce the percent of women who reported loss of interest or feeling depressed (postpartum depression) from 14.4% (PRAMS 2019) to 13.7%
PERFORMANCE MEASURE	SPM 6 - Promotion and strengthening of optimal mental/behavioral health and well-being through partnerships and programs

Strategies:

1. **Explore opportunities for providing support to families seeking fertility services and families experiencing miscarriage**
   Funding permitted, VDH intends to continue the Pregnancy Loss Support program in FY23. VDH partners with five community-based agencies to offer support services, including grief counseling, to families experiencing pregnancy loss, and evaluate any data (quantitative or qualitative) available from the first year of implementation.

2. **Local Health District (LHD): Strengthen early identification, supports, and referrals for women's mental and behavioral health needs**
   LHDs who indicate that they are working on this strategy will receive TA from Title V regarding strengthening their capacity and processes regarding screenings, patient education, referrals for services, community provider relationship building, staff education regarding perinatal mental health disorders, and ensuring that all LHD patients are informed of the maternal mental health hotline.

PRIORITY 5	Oral Health
OBJECTIVE	By 2025, increase the percent of women who had a dental visit during pregnancy from 49.9% (PRAMS 2018) to 52.4%
PERFORMANCE MEASURE	NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy
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

Strategies:

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

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**

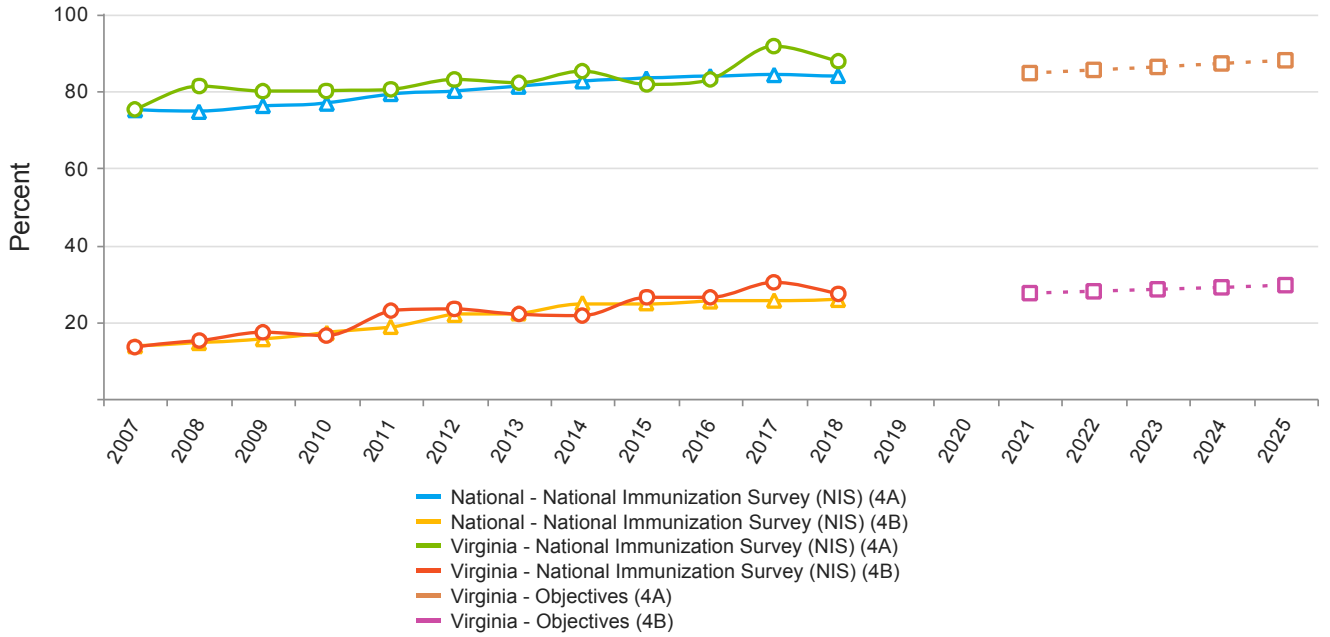
3. **Convene statewide groups focused on targeted oral health issues and facilitate collaboration and work plan development, and provide leadership and oversight to guide initiatives**

Perinatal/Infant Health

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**	**2021**
Annual Objective			84.6
Annual Indicator	82.9	91.7	87.5
Numerator	73,338	84,128	78,142
Denominator	88,459	91,769	89,302
Data Source	NIS	NIS	NIS
Data Source Year	2016	2017	2018

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

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

Federally Available Data			
Data Source: National Immunization Survey (NIS)			
	2019	**2020**	**2021**
Annual Objective			27.5
Annual Indicator	26.4	30.4	27.5
Numerator	22,710	27,265	23,681
Denominator	85,942	89,656	85,967
Data Source	NIS	NIS	NIS
Data Source Year	2016	2017	2018

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

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			Yes
Annual Indicator			No
Numerator			
Denominator			
Data Source			OFHS MCH Program Documentation
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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	2021
Annual Objective			1.8	2.1
Annual Indicator	2.2	2	2.3	2.2
Numerator	9.6	9.7	10.6	10.7
Denominator	4.4	4.9	4.7	4.8
Data Source	VDH Division of Health Statistics	VDH Division of Health Statistics	VDH Division of Health Statistics	VDH Division of Health Statistics
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	1.9	1.7	1.5	1.2

State Action Plan Table

State Action Plan Table (Virginia) - Perinatal/Infant Health - Entry 1	
Priority Need	
Maternal and Infant Mortality Disparity: Eliminate the racial disparity in maternal and infant mortality rates by 2025.	
NPM	
NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	
Objectives	
Decrease the Black/White infant mortality ratio from 2.0 to 1.0 by June 30, 2025	
Strategies	
Maintain Title V representation on the Virginia Neonatal Perinatal Collaborative (VNPC) Steering and Executive Committees, and Title V representation in selected workgroups	
Develop and mobilize strong interagency, multisector, and community partnerships to address infant mortality due to preventable injury	
Develop, coordinate, and implement an action plan for substance-exposed infants based on the 2020 Report to the General Assembly	
Local Health Districts (LHD): Develop, mobilize, and participate in strong interagency, multisector, and community partnerships to address disparities in maternal and infant mortality rates	
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

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

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

Coordinate and expand Five-Star Breastfeeding-Friendly Hospital Recognition Program

Local Health District (LHD) strategy: Identify the LHD capacity to successfully implement 10 Steps to Breastfeeding-Friendly Health Department

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 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

Decrease the disparity in Black-White infant mortality ratio from 2.0 (2019) to 1.2 (2025)

Strategies

Sustain state maternal mortality and child fatality review programs, engaging with cross-sector partners and addressing social determinants of health in development of MMRT and CFRT recommendations

Create a system through which data from existing BabyCare programs is synthesized and pulled into Tableau

PERINATAL/INFANT HEALTH DOMAIN
SUMMARY/OVERVIEW
FY21 ANNUAL REPORT

DOMAIN CONTRIBUTORS

DOMAIN CONTRIBUTORS:
Maternal and Infant Health (MIH) Consultant – Division of Child and Family Health
Injury and Violence Prevention Program – Division of Prevention and Health Promotion
MCH Epidemiology – Division of Population Health Data
Division of Death Prevention – Office of the Chief Medical Examiner (OCME)
Local Health Districts

DOMAIN OVERVIEW

MATERNAL INFANT HEALTH (MIH) CONSULTANT: The MIH Consultant 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, the state Child Fatality Review Team, and the Five-Star Breastfeeding Friendly Hospital Program. The MIH Consultant position was vacated in February 2020; however, a new consultant has been hired and will start in late August 2022.

IINJURY AND 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. The program seeks to build solid infrastructure to improve the health of Virginias 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.

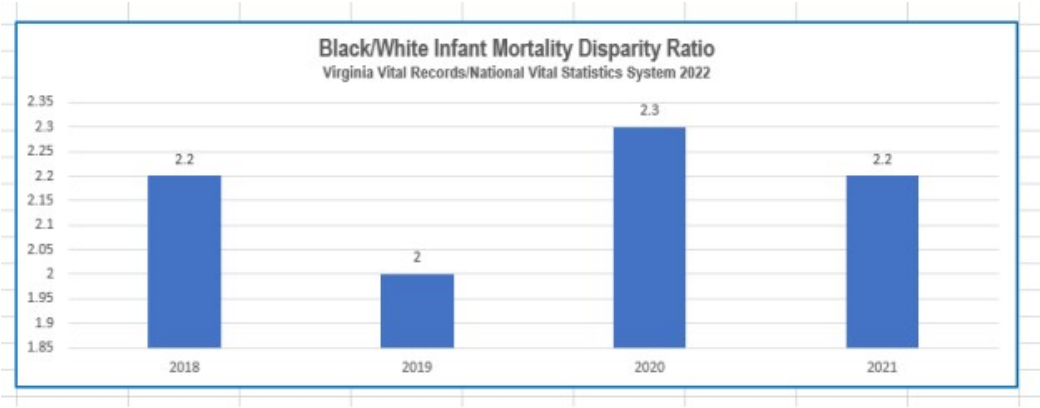
MCH EPIDEMIOLOGY: The MCH Epidemiology and Evaluation Unit is a centralized epidemiology unit within the Division of Population Health Data headed by the MCH Epidemiology Supervisor who serves as the Lead Epidemiologist for Title V. The team has additional capacity available through a Reproductive and Perinatal Health (RPH) Epidemiologist and a Newborn Screening (NBS) Epidemiologist, an Oral Health Epidemiologist, and 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. Additional cross-cutting support is provided by the Injury and Violence Prevention Epidemiologist.

DIVISION OF DEATH PREVENTION: The Division of Death Prevention, located in the Office of the Chief Medical Examiner, is responsible for several epidemiological surveillance and fatality review programs, including the Maternal Mortality Review and Child Fatality Review Teams.

LOCAL HEALTH DISTRICTS: The Commonwealth is divided into 35 Local Health Districts (LHD) which provide direct services and support tailored to the specific community needs.

STATE ACTION PLAN UPDATES

PRIORITY 1: Maternal and Infant Mortality Disparity: Eliminate the racial disparity in maternal and infant mortality rates by 2025



OBJECTIVE	Decrease the Black/White infant mortality ratio from 2.0 (2019) to 1.2 by 2025
OUTCOME MEASURE	SOM 1: Infant Mortality Disparity: Black/White Maternal Mortality Ratio

Infant mortality is a hallmark of overall health status of a population, which is why it has remains an objective of both Healthy People 2030 and Virginia's Title V. In 2020, 543 infants died before their first birthday in Virginia, making the overall infant mortality rate across all races 5.7 per 1,000 live births. This is a decline from an infant mortality rate of 5.9 in 2019. Since 2011, the overall infant mortality numbers have remained relatively constant, with a slight downward trend apparent in recent years. However, this rate varies by race and ethnicity. For example, the infant mortality rate among the non-Hispanic white population was 4.9, while the rate among non-Hispanic Black infants was 10.8, which has remained stable in recent years. This disparity in infant mortality rates shows that Black infants were 2.2 times more likely to experience mortality than their White counterparts. As such, one of Virginia's State Outcome Measures is to decrease the black/white infant mortality ratio to 1.2.

Strategy 1: Maintain Title V representation on the Virginia Neonatal Perinatal Collaborative (VNPC) Steering and Executive committees, and Title V representation in selected workgroups

Virginia is one of three states to pilot the 4th trimester bundle, with 51 birth hospitals currently participating in the bundle. This care bundle addresses the first three months after birth – which is a time of significant adjustment for both the newborn outside the womb, and the mother, who is adjusting to new parenthood and hormonal shifts. The bundle provides strategic and anticipatory guidance for both the OB/GYN and Pediatric providers, focusing on preventive measures to address the gaps in postpartum care that have resulted in both maternal and infant morbidity and mortality.

VNPC offers a monthly webinar series for state perinatal stakeholders which are well attended each month. VNPC's Perinatal and Infant Mortality Summit occurred on March 2, 2021, and had over 100 attendees from state, district and local community organizations. Speakers were a mix of medical staff, academic faculty, VDH subject matter experts, and community organizations.

Strategy 2: Develop and mobilize strong interagency, multisector, and community partnerships to address infant mortality due to preventable injury

Injury Prevention Projects/Education for Families:
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 that will helpful in 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.

Partially funded Title V IVPP staff and In-kind contribution of time and effort of non MCH-IVPP staff supports this effort.

During the reporting period, IVPP underwent a transition to development of an Injury Prevention Education virtual room visual platform by partnering with a state approved audio/visual vendor. All modules have been created. During the remaining part of the MCH fiscal year, IVPP staff will work directly with hospitals to embed the program into Baby TV. The program also presented this concept to the Library of Virginia Youth Services. LOVA Youth Services is working with the IVPP to survey youth librarians for another fiscal year to determine utilization of the program and resources needed to serve families. This education package will also provide resources/linkages of care for available public health services/available statewide benefits for families that promote healthy outcomes and reduction of injuries and violence, and will continue to promote UniteUs and Bridges2Resources.

Strategy 3: 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.

There were two significant disruptions to the progress of this plan in FY21 - COVID-19 and the vacancy of the Maternal and Infant Health Coordinator position, which continued vacant throughout FY21 and FY22. Once this position is filled, this work will resume and be prioritized.

Strategy 4: Strengthen and expand MCH capacity at the local health district level

Thirteen of 35 local health districts prioritized maternal and infant mortality disparity in their annual work plans, with a strong focus on SUIDS prevention. Local activities include: strengthening the maternal and infant care coordination for high risk pregnant women and infants, partnering with the local community, including WIC offices, area pediatrician offices, and housing communities and area food banks for car seat distribution and education, pack-n-play/cribette distribution, sleep sacks, and safe sleep education. One LHD, Prince William, utilized Title V funding to support a WIC breastfeeding peer counselor to provide follow-up education and support for prenatal and breastfeeding women.

PRIORITY 2: MCH data capacity: Maintain and expand state MCH data capacity, to include ongoing needs assessment activities, program evaluation, and modernized data visualization and integration

OBJECTIVE	By 2025, decrease the disparity in black-white infant mortality ratio from 2.1 (2017) to 1.2 (2025).
OUTCOME MEASURE	SOM1: Infant mortality disparity: Black/white infant mortality ratio

Strategy 1: Sustain state maternal mortality and child fatality review programs, engaging with cross-sector partners and addressing social determinants of health in development of MMRT and CFRT recommendations

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

- *Ryan M. Diduk-Smith PhD, MPH, CHES* (Director, Division of Death Prevention) oversees the Office of the Chief Medical Examiner's Maternal Mortality Review Team and Child Fatality Review Team. She is responsible for administration, staff oversight, and supports the data abstraction, collection, and analysis of maternal mortality and child fatality data.
- *Melanie J. Rouse, PhD* (Maternal Mortality Programs Manager) is responsible for the implementation of the Maternal Mortality Review Team and related projects. She is responsible for the coordinating and facilitating the review team, data analysis, data entry in to CDC's MMRIA system, report writing, and data dissemination.

- *Tricia Smith* (Family Violence Programs Manager) is responsible for the implementation of the Child Fatality Review Team and related projects. She is responsible for coordinating and facilitating the CFRT, child fatality surveillance activities, report writing, data analysis and dissemination.
- *Vacant* (Maternal Mortality Research Associate) is responsible for data collection, preliminary data analysis, data cleaning, and administrative support for all maternal mortality programs, including the Maternal Mortality Review Team.
- *Sydney Wooten, MS* (Child Fatality Research Assistant) is responsible for data collection, preliminary data analysis, data cleaning, and administrative support for the infant and child fatality programs, including the Child Fatality Review Team.

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

The Infant and Child Fatality data collection tool was revised and implemented into the REDCap system. This tool allows for the in-depth collection of all deaths of children, 0-17, living in Virginia, with future linkage to the Maternal Mortality Surveillance Database. The CFRT provided data and recommendations from the Citizens Review Panel to the Department of Social Services for their 2022 report.

Child Fatality Review Team:

- The CFRT is currently reviewing adolescent suicides with a report of recommendations to be planned for late 2022 for the 2023 General Assembly Session. Currently there 6 remaining cases to review.
- The Infant and Child Fatality data collection tool was revised and implemented in REDCap, to support its in-depth collection of all deaths of children, 0-17, living in Virginia. Currently 2017 data is being collected.
- The CFRT provided data and recommendations from the Citizens Review Panel to the Department of Social Services for their 2022 report.

Child Fatality Review Team

Coordination and facilitation of bi-monthly CFRT meetings: Activities under this activity include case selection for each meeting, requesting records from health, social, and community based agencies that will be used in the review, review of those records, and determination of inclusion or exclusion in the review, as well as scanning the record for additional information that could be collected from other providers or agencies. After each review team meeting, data from the 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.

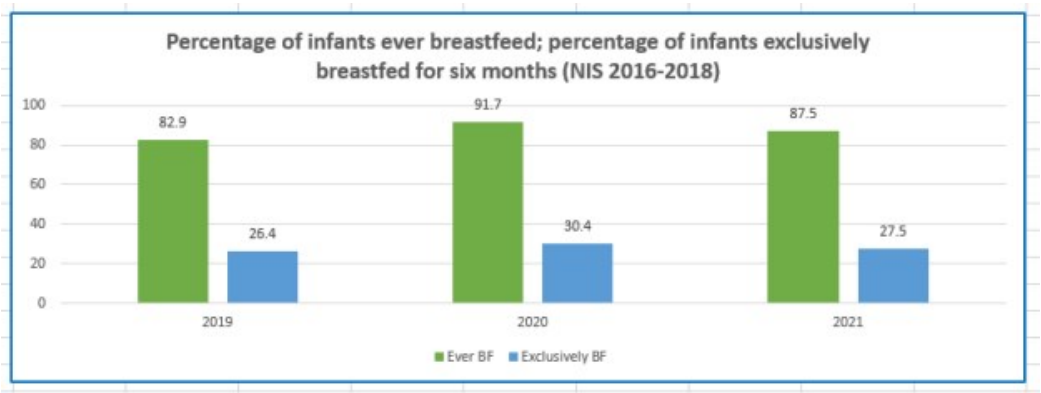
The OCME continued to engage the community through multidisciplinary workgroups, review team meetings, and other activities where appropriate, through the Child Fatality Review Team. The team is chaired by Virginia's Office of the Chief Medical Examiner and includes representation from education, social service and community service boards, psychiatry, injury prevention, health promotion, pediatrics, and other relevant agencies. The purpose of the team is to review topic specific cases and work to provide policy and programmatic recommendations to address the studied topic. Additionally, the Family Violence Programs Manager sits on a variety of community boards and workgroups addressing child death, including the Child Welfare Advisory Committee, FACT Child Abuse and Neglect Advisory Committee, Suicide Prevention Interagency Advisory Group, and Injury & Violence Prevention Collaborative.

Conduct epidemiological surveillance: Activities under this activity include collection of comprehensive data using the re-developed Infant and Child Fatality Surveillance Tools. The Family Violence Research Assistant is responsible for collecting data using the tool and entering the data in 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.

PRIORITY 3: Upstream/Cross-Sector strategic planning: Eliminate health inequities arising from social, political, economic, and environmental conditions through strategic, nontraditional partnerships

OBJECTIVE	By 2025: A. Increase the percentage of infants ever breastfed from 82.9% (NIS 2016) to 87.9% B. Increase the percentage of infants exclusively breastfed through 6 months of age from 26.4% (NIS 2016) to 29.6%
PERFORMANCE MEASURE	NPM4: A) Percent of infants who are ever breastfed; B) percentage of infants exclusively breastfed through 6 months of age
Evidence-based or –informed strategy measures	ESM4.1: Development of a coordinated action plan of gap-filling activities for breastfeeding programming across VDH divisions.



Strategy 1: Coordinate and expand the Five-Star Breastfeeding Friendly Hospital Program

In 1991, the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) launched the Baby-Friendly Hospital Initiative (BFHI), which is a global program that encourages the broad-scale implementation of Ten Steps to Successful Breastfeeding and the International Code of Marketing of Breast-milk Substitutes, and generating widespread understanding and enthusiasm for best practice infant feeding care. Baby-Friendly USA is the national authority and the accrediting body for the Bay Friendly Hospital Initiative in the United States. In Virginia, the Five-Star Breastfeeding Program supports birthing facilities in building their capacity to receive the Baby-Friendly USA Designation. This program housed and administered in VDH's Office of Family Health Services – with staff from Division of Child and Family Health providing programmatic support for this role in collaboration with the State Breastfeeding Coordinator, housed in the Division of Community Nutrition.

COVID challenged the birthing facilities' ability to engage in the program, and position vacancies and COVID-related conflicts across the Five-Star Committee slowed down the work and progress tremendously. In September 2021, the VDH's State Breastfeeding Coordinator, Title V Director, and Director of Child and Family Health met with the intention of revitalizing the Committee, subsequently reviewed the previous committee composition, reached out to members to assess for continued

commitment, and recovened the group to begin rebuilding the program. Committee members also serve as reviewers of the applications submitted for five-star designation. The committee has representation from professionals across the state, including OB/GYN and pediatric physicians, hospital and community IBCLC, breastfeeding educator, and a consumer. The Committee is currently reviewing existing processes, upgrading the application process, and planning a statewide re-launch educational event in late 2022.

PERINATAL/INFANT HEALTH DOMAIN
FY23 APPLICATION YEAR
The following programmatic strategies and activities will continue as methods to advance and improve outcomes in each of the identified priority areas.

PRIORITY 1	Maternal and Infant Mortality Disparity: Eliminate the racial disparity in maternal and infant mortality rates by 2025
OBJECTIVE	By 2025, decrease the Black/White infant mortality ratio from 2.0 (2019) to 1.2 by 2025
OUTCOME MEASURE	SOM 1: Infant Mortality Disparity: Black/White Maternal Mortality Ratio

Strategies:

Strategy 1: Maintain Title V representation on the Virginia Neonatal Perinatal Collaborative (VNPC) Steering and Executive committees, and Title V representation in selected workgroups
VDH staff, including DCFH Director, Title V/MCH Director, Maternal/Infant Consultant, and MCH Epi team members will maintain active representation in VNPC committees and workgroups regarding Fourth Trimester, Perinatal Cannabis and Eliminating Bias in the Dyad Care.

Strategy 2: Develop and mobilize strong interagency, multisector, and community partnerships to address infant mortality due to preventable injury
IVPP will continue the dissemination of Project Patience into FY23, 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 FY23, 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.

Strategy 3: Develop, coordinate, and implement an action plan for substance-exposed infants based on the 2020 Report to the General Assembly
The Maternal and Infant Health Consultant position will be filled starting August 2022, and this strategy will be prioritized and reorganized throughout FY23.

Strategy 4: Local Health District (LHD) Strategy: Develop, mobilize, and participate in strong interagency, multisector, and community partnerships to address disparities in maternal and infant mortality rates
LHDs working on selected efforts within this strategy will receive ongoing TA from Title V and MCH Epidemiology Teams to develop, expand, and strengthen the doula communities in their districts, supporting doulas towards their efforts to becoming certified and thereby eligible for Medicaid reimbursement, and ensuring that that the birthing community has access to doula support if desired.

PRIORITY 2	MCH data capacity: Maintain and expand state MCH data capacity, to include ongoing needs assessment activities, program evaluation, and modernized data visualization and integration
OBJECTIVE	By 2025, decrease the disparity in black-white infant mortality ratio from 2.1 (2017) to 1.2 (2025)
OUTCOME MEASURE	SOM1: Infant mortality disparity: Black/white infant mortality ratio

Strategy 1: Sustain state maternal mortality and child fatality review programs, engaging with cross-sector partners and addressing social determinants of health in development of MMRT and CFRT recommendations
Coordination and facilitation of bi-monthly 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 the 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 will continue to engage the community through multidisciplinary workgroups, review team meetings, and other activities where appropriate, through the Child Fatality Review Team. The team is chaired by Virginia's Office of the Chief Medical Examiner and includes representation from education, social service and community service boards, psychiatry, injury prevention, health promotion, pediatrics, and other relevant agencies. The purpose of the team is to review topic specific cases and work to provide policy and programmatic recommendations to address the studied topic. Additionally, the Family Violence Programs Manager sits on a variety of community boards and workgroups addressing child death, including the Child Welfare Advisory Committee, FACT Child Abuse and Neglect Advisory Committee, Suicide Prevention Interagency Advisory Group, and Injury & Violence Prevention Collaborative.
Conduct epidemiological surveillance: Activities under this activity include collection of comprehensive data using the re-developed Infant and Child Fatality Surveillance Tools. The Family Violence Research Assistant is responsible for collecting data using the tool and entering the data in 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.

Strategy 2: Create a system through which data from existing BabyCare programs is synthesized and pulled into Tableau
In Summer 2022, VDH's Title V program sponsored two interns through the National MCH Workforce Development Center Summer Internship program. The interns, Candace Jarzombek (MPH 2023, Boston University), and Leslie Osorio-Pascual (BSPH 2023, East Carolina University) conducted an evaluation of Virginia's BabyCare Program. BabyCare is a case management and home visiting program for at-risk, Medicaid- or FAMIS-eligible pregnant and postpartum people and their infants. BabyCare is practiced differently across Virginia's local health districts (LHDs), with some districts fully providing the full spectrum of BabyCare's services, some providing parts but not all, and others not participating if there are no maternity services offered in their district. BabyCare, in its current form, is not an evidence-based program, which offers flexibility and variability to its use across the LHDs. Two questions were raised to the Interns: What is the difference between BabyCare and the evidence-based home visiting programs; how would BabyCare benefit by becoming evidence-based? The Interns evaluated the BabyCare programs in Mount Rogers and Chesapeake LHDs, the two largest programs in the state, providing approximately 500 home visits every month. They conducted key informant interviews with BabyCare nurses in each LHD, reviewed the existing BabyCare program guidelines, tools, and standards for districts, and then compared findings to existing evidence-based programs in Virginia. The Interns provided several recommendations back to Title V, including the creation of a unified data system across all existing BabyCare programs through which client-related data can be synthesized and assessed which would demonstrate measurable outcomes in those areas that are shared

with the existing evidence-based home visiting programs. The LHDs all utilize the same medical records system, which will ease facilitation of data sharing into a common system for synthesis and evaluation.

PRIORITY 3	Upstream/Cross-Sector strategic planning: Eliminate health inequities arising from social, political, economic, and environmental conditions through strategic, nontraditional partnerships
OBJECTIVE	By 2025: (A) Increase the percentage of infants ever breastfed from 82.9% (NIS 2016) to 87.9%; (B) Increase the percentage of infants exclusively breastfed through 6 months of age from 26.4% (NIS 2016) to 29.6%
PERFORMANCE MEASURE	NPM4: A) Percent of infants who are ever breastfed; B) percentage of infants exclusively breastfed through 6 months of age
Evidence-based or –informed strategy measures	ESM4.1: Development of a coordinated action plan of gap-filling activities for breastfeeding programming across VDH divisions.

Strategy 1: Coordinate and expand the Five-Star Breastfeeding Friendly Hospital Program

Continued organization, coordination, and restructuring over FY22 will result in re-launch of the Five-Star program in FY23. Hospitals will receive updated guidance, and a streamlined application process. Committee members will undergo training regarding application reviews, and two review cycles will be scheduled each year going forward.

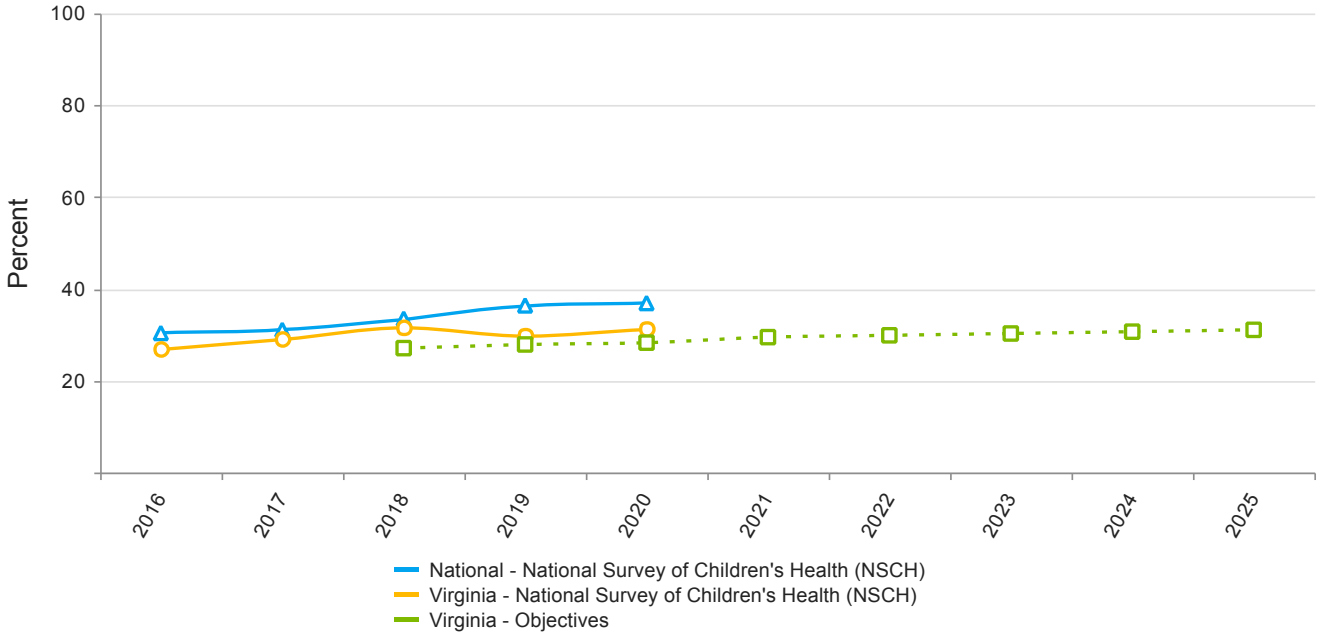
Strategy 2: Local Health District (LHD) Strategy: Identify the LHD capacity to successfully implement 10 Steps to Breastfeeding-Friendly Health Department

In August 2022, VDH's Health Commissioner challenged each local health district to implement the "10 Steps to Breastfeeding-Friendly Health Department" program. Title V will assist Virginia's WIC State Breastfeeding Coordinator in assessing the LHD capacity

Child Health

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		27.1	27.9	28.3	29.5
Annual Indicator	26.8	29.1	31.4	29.9	31.3
Numerator	67,562	59,469	54,036	67,406	73,254
Denominator	252,334	204,083	171,987	225,762	234,340
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

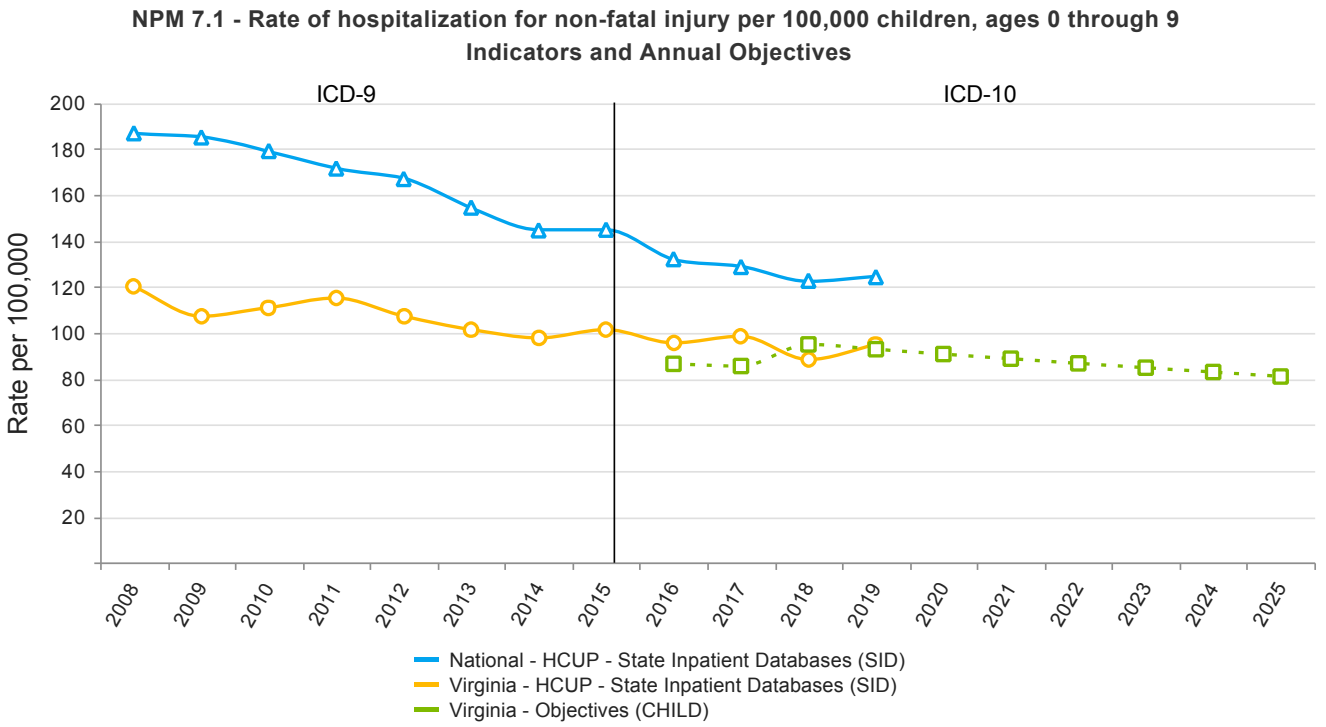
Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	29.9	30.3	30.7	31.1

Evidence-Based or –Informed Strategy Measures

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

Measure Status:				Active	
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	7	15	20	25	35
Annual Indicator	15	30	30	30	50
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	VDH Division of Child and Family Health
Data Source Year	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	50.0	100.0	100.0	100.0



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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	85.5	94.9	92.8	90.7	88.7
Annual Indicator	101.5	95.4	98.6	88.4	95.1
Numerator	785	982	1,013	906	970
Denominator	773,528	1,029,557	1,026,897	1,025,381	1,020,363
Data Source	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	86.7	84.8	82.9	81.0

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	2021
Annual Objective		
Annual Indicator	14	16
Numerator		
Denominator		
Data Source	VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program
Data Source Year	2020	2021
Provisional or Final ?	Final	Final

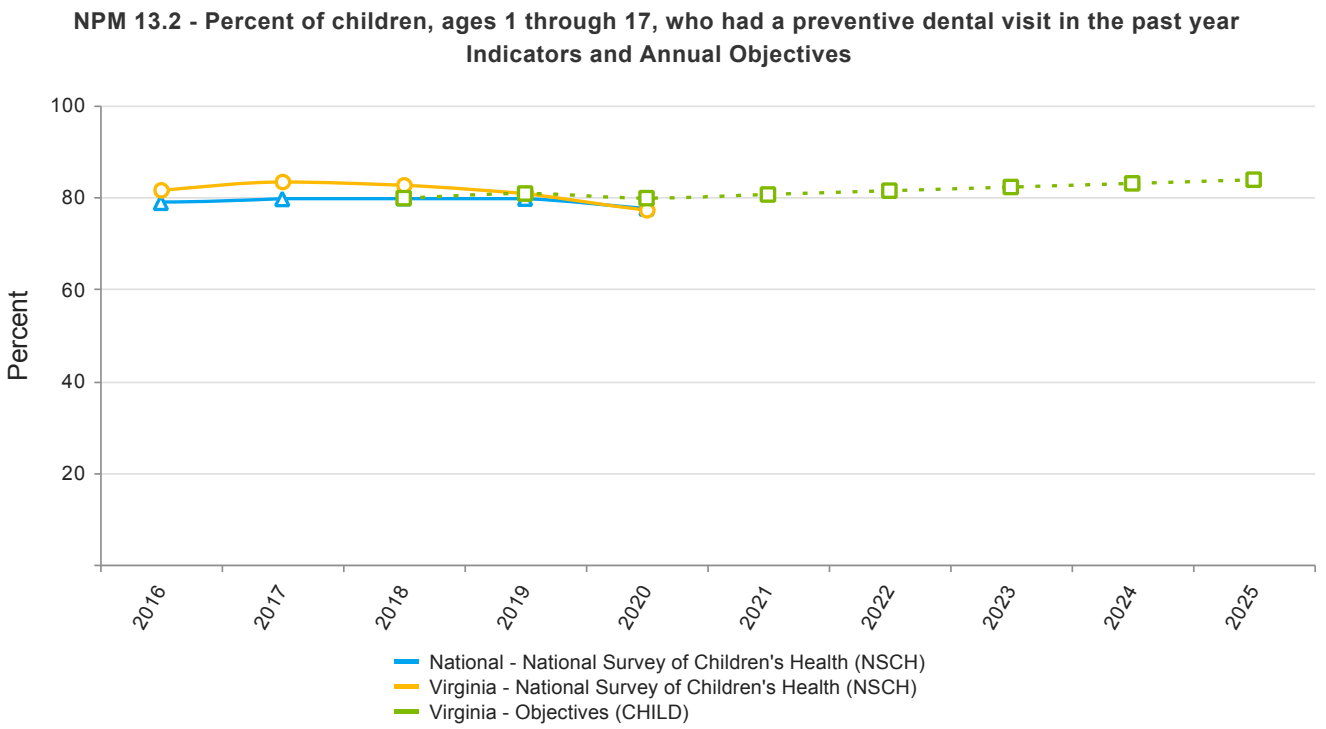
Annual Objectives				
	2022	2023	2024	2025
Annual Objective	16.0	17.0	18.0	19.0

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

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective			2,549	2,549	2,549
Annual Indicator		2,596	1,560	1,738	426
Numerator					
Denominator					
Data Source		VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program
Data Source Year		2018	2019	2020	2021
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		93.2	94.3	89.1	80.5
Annual Indicator	81.4	83.1	82.4	80.5	77.1
Numerator	1,407,907	1,448,110	1,463,318	1,432,504	1,360,700
Denominator	1,729,004	1,741,839	1,775,616	1,778,464	1,763,868
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective		79.7	80.7	79.7	80.5
Annual Indicator	75.7	78.4	78.9	77.6	74
Numerator					
Denominator					
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	81.3	82.1	82.9	83.7

Evidence-Based or –Informed Strategy Measures

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

Measure Status:				Active	
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			6	6	6
Annual Indicator		3	4	8	9
Numerator					
Denominator					
Data Source		VDH Oral Health Program documentation	VDH Oral Health Program documentation	VDH Oral Health Program documentation	VDH Oral Health Program documentation
Data Source Year		2018	2019	2020	2021
Provisional or Final ?		Final	Final	Final	Final

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

State Action Plan Table

State Action Plan Table (Virginia) - Child Health - Entry 1	
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 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 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 3

Priority Need

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

NPM

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

Objectives

By June 30, 2025, increase the percent of children (ages 1 through 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

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

Priority Need

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

NPM

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

Objectives

By 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 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

CHILD HEALTH DOMAIN
SUMMARY/OVERVIEW
FY21 ANNUAL REPORT

DOMAIN CONTRIBUTORS

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

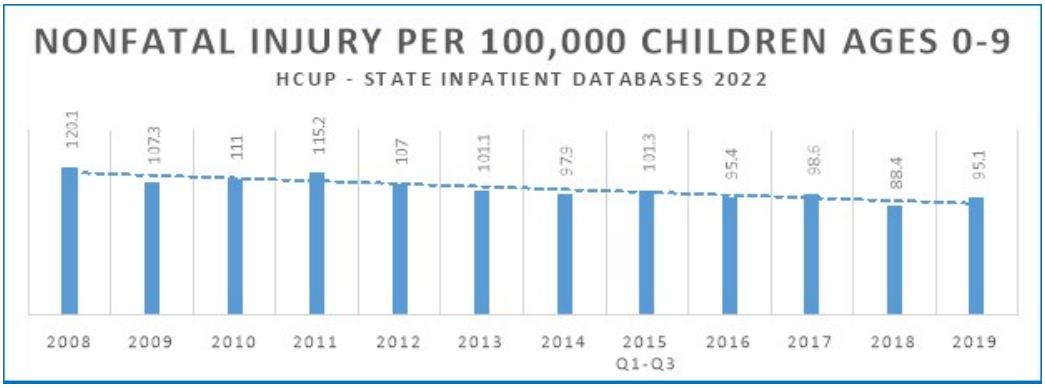
- Increase screening using a parent-administered evidence-based tool (ASQ, ASQ SE)
- Engage local partners to collaborate and coordinate local screening and referral processes
- Lead community awareness campaigns about healthy child development and the importance of developmental screening

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

PRIORITY 1: Finances as a root cause: Increase the financial agency and well-being of MCH populations.

OBJECTIVE	Decrease the rate of hospitalization for nonfatal injury per 100,000 children ages 0-9 from 101.5 (HCUP-State Inpatient Databases (SID) – 2015) to 81.0.
PERFORMANCE MEASURE	NPM 7.1: Rate of hospitalization for non-fatal injury per 100,000 children, ages 0-9.
Evidence-based or – informed strategy measures	ESM7.1.2- Number of child safety seats disseminated through the LISSDEP network



Strategy 1: 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 (LISSDEP).

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 proper usage and installation of programmatic safety seats and booster seats

Families are provided a no cost safety seat after receiving education and training in proper installation and usage. Families must demonstrate proficiency in skills mastered. As LISSDEP continues to address the challenges imposed by the Commonwealth's amplified response to COVID-19 and the inability to host on site trainings, the program is anticipated to again re-emerge in robust dissemination of safety seats this upcoming year. A special emphasis is placed on disparate populations.

In kind contribution of time and effort of non MCH-IVPP staff supports this effort.

IVPP was able to use non-MCH funded staff time to mitigate program challenges due to the continued presence of COVID-19. Local health departments continued to play a lead role in community vaccinations and boosters which posed a barrier to

completing LISSDEP activities. The vast majority of LISSDEP distribution sites suspended or greatly reduced the issuance of safety seats. Additionally, local health departments faced staffing shortages, which further limited their ability to resume normal activities. Active sites continued to adopt strategies to limit group sizes, leveraging other required contact appointments for LISSDEP distribution, and providing education in its entirety outside in parking lots. IVPP LISSDEP continues to provide coordinator and educator training and technical support to move sites towards becoming fully operational. A total of 340 convertible safety seats and 86 booster seats, totaling 426 restraints were distributed in FY21. IVPP completed a strategic needs/asset assessment plan to help identify strategies gaps and opportunities to direct future activities. Addressing site administrative burden and recognizing the value of family voice and choice in LISSDEP operations were two key takeaways from this effort to increase enrollment and broaden the program reach. This document will guide strategies to strengthen site capacity and service execution. Additionally, a CPS strategic communication plan was developed to support the distribution of seats in localities without LISSDEP sites and assist in building targeted partnerships with entities to improve equitable access to seats by high-risk groups (i.e. minority, non-English speaking, rural, and low-income populations). This document will guide recruitment strategies for community based partners towards increasing enrollment and reaching disparate, and underserved populations.

Virginia Broadcast Solutions (VBS) serves as Virginia's sole source partner in the delivery of health education to the public through the Public Education Partnership (PEP) agreement. VBS works through the NCSA program to delivery health education messaging, which is designed to help organizations that operate in the public interest, such as non-profits and state agencies, get their messages heard in an organized manner. The agency provides pre-recorded spots that the VAB distributes to its member stations. The agency then receives advertising time donated by VAB broadcast stations. Station affidavits confirm when and where the message has aired. As Child Passenger Safety Week annually provides the opportunity to heighten the awareness of the public in safe transportation for Children, VBS supported the VDH Child Passenger Safety team to launch a communication campaign during this period. A partnership with VBS to launch an awareness campaign during 2021 CPS was completed and executed. Regions included South West Virginia, Rockingham/Orange County, and Coastal or Eastern Virginia. Regions were selected based on having low seatbelt use and presence of a safety seat check station. Communication mediums used were radio, digital ads, and social media ads consistent with the media preferences of the targeted audience age group (caregivers aged 20-45) . While evaluation metrics were implemented for digital and social media ads, there was no rigorous evaluation measure for radio outside of the anticipated broadcast reach. Results for digital and social media ads exceeded expectations in number of impressions (934,388 SM, 1,335,413 D), clicks (6,919 SM, 1,682 D), and click through (0.74% compared to 0.60% for similar SM campaigns, 0.13% compared to 0.06% for similar campaigns). The campaign materials were additionally shared with 36 Safety Seat Check Sites serving 57 localities. Web hits reached 340 unique users with 428 resource items downloaded. The number of safety seats checked by the VDH SSCS Network increased from 229 in October 2021 to 253 in November 2021.

In other areas of Child Passenger Safety and Pedestrian Safety, the IVPP provides in kind contribution of time and effort of non MCH-IVPP staff to serve on pedestrian safety interagency teams focused on the intersection between child health and transportation, as facilitated by the Virginia Department of Motor Vehicles, Department of Transportation, Virginia State Police, along with other state agencies and non-profits.

Strategy 2: Work in tandem with interagency teams in partnership with IVPP to focus on the intersection between child health and transportation.

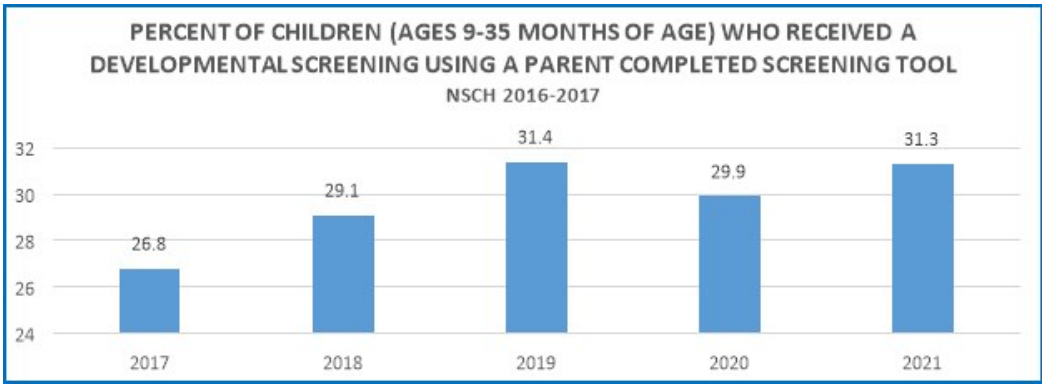
As proposed within the FY21 narrative by the Title V Director, the activity “The VDH IVP Program will work in tandem with the Title V Director on an interagency team focused on the intersection between child health and transportation”, was unable to be completed due to the Title V Director vacancy in FY21. However, VDH 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 began the creation of a feasibility plan in pedestrian safety and bicycling behavior initiatives in the reporting period.

PRIORITY 2: 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)

OBJECTIVE	By June 30, 2025, increase the percent of children (ages 10-71 months) receiving a developmental screening using a parent-completed screening tool from 29.1% (NSCH 2016-2017) to 31.1%
PERFORMANCE MEASURE	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.
Evidence-based or –informed strategy measures	Number of LHDs, community partners, and providers receiving developmental screening resources, training, or TA



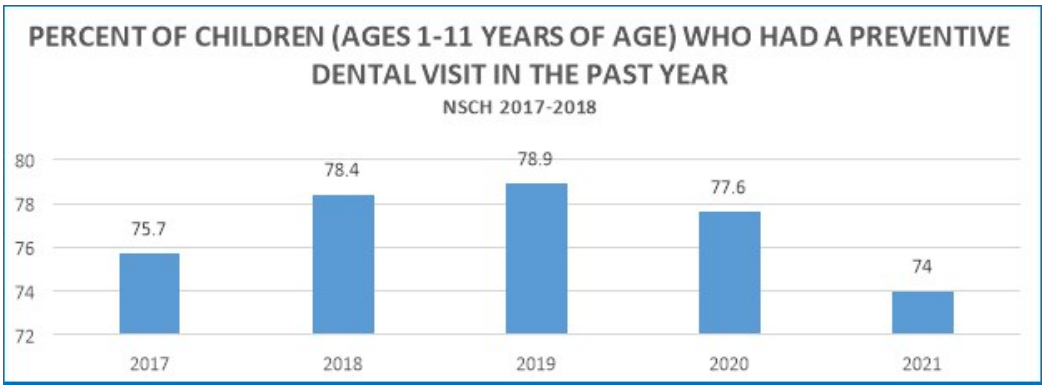
Strategy 1: Support the development of high functioning community/regional partnerships led by 6 Ready Region 'Hubs' that coordinate and improve local developmental screening and referral systems improvements.

The developmental screening initiative is a strong example of programmatic success and impact across state, regional and community partnerships. Virginia has nine regional early childhood hubs (Ready Regions) supported through the Virginia Early Childhood Foundation (VECF). This work supports a major objective to integrate health into these and other P-3 systems and programs. In partnership with VDH and through the use of Title V funding, VECF has engaged partners, through a competitive process, in six communities across the Commonwealth to serve as "Developmental Screening Initiative" (DSI) Hubs. Utilizing their established role as conveners of ECE partners, DSI Hubs serve as learning laboratories to spearhead better understanding and more comprehensive, coordinated screening and referral systems at the local level.

Hubs are charged with 1) coordination of screening and referral systems, 2) increasing messaging to parents and communities about child development, screening, and referral, and 3) building capacity of ECE partners to screen children birth to five. The DSI hypothesis that engaging the ECE sector to conduct screening and referral is grounded in recognition that this sector includes both 1) educators and 2) access to parents, both with vested interests in supporting healthy development. Ideally, this strategic investment will increase the number of screens that occur overall, thus increasing the likelihood that developmental delays are caught and referred early, producing better outcomes for children. This work builds local capacity for parent-engaged developmental monitoring. DSI Hubs work to build screening capacity within the sector by leveraging existing ECE mechanisms and by training childcare partners to screen and refer. Most screening partners in the DSI project are ECE providers, ranging in size from family day homes to Head Start and Early Head Start programs to public preschools. Several health integration efforts are underway that will continue to expand the partnership with VDH and DSI through other funding sources. Of interest is the return on investment using this model and developmental screening navigators with child care programs and physician offices. It is labor intensive work and requires extensive outreach and technical support to assist programs with entering screens into the centralized Brookes Enterprise system, which began functioning in quarter three. A total of 2,089 screens were conducted in FY21 quarter 4, nearly doubling the 1,148 screens documented in the previous quarter. Of the total 2,089 screens, 585 (28%) were in the monitoring zone, and 209 (10%) either resulted in referral or were flagged for referral. In addition, overall, partnerships increased slightly this quarter; only one Hub lost a partner, due to conflicting VKRP (Virginia Kindergarten Readiness Program) requirements requiring the use of a different assessment/screening tool. One hundred fifty-four (154) partners were identified in FY 21 Quarter 4 across the six Hubs, a gain of nine partners over the previous quarter. DSI Hubs report 57 MOUs (Memorandum of Understandings) in place with regional partners, with 22 pending. One hundred partners are administering screens, with an additional 32 planned in the future. Data sharing agreements are in place with 42 partners, with 19 pending. In summary, the strategy aligns with reporting measures (NPM,SPM, ESM).

PRIORITY 3: Oral Health

OBJECTIVE	By June 30, 2025, increase the percent of children (ages 1 through 11) who had a preventive dental visit in the past year from 78.9% (NSCH 2017-2018) to 83.7%
PERFORMANCE MEASURE	NPM 13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.
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 (12-17 years)



Strategy 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.

New programming specifically aimed at advancing the oral health of adolescents began in FY21. 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 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.

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 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.

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).

CHILD HEALTH DOMAIN
FY23 APPLICATION YEAR
The following programmatic strategies and activities will continue as methods to advance and improve outcomes in each of the identified priority areas.

PRIORITY 1	Finances as a root cause.
OBJECTIVE	Decrease the rate of hospitalization for nonfatal injury per 100,000 children ages 0-9 from 101.5 (HCUP-State Inpatient Databases (SID) – 2015) to 81.0.
PERFORMANCE MEASURE	NPM 7.1: Rate of hospitalization for non-fatal injury per 100,000 children, ages 0-9.

Strategies:

Strategy 1: 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 (LISSDEP).

IVPP LISSDEP will continue dissemination of child safety seats through the LISSDEP network in FY23 in support of income eligible families according to the IVPP Census Analysis and Strategic Communications Plan. Families are provided a safety seat at no cost to participants that complete an educational session in proper usage and installation. Families must demonstrate proficiency in skills mastered prior to issuance of restraint. This work supports geographical and racial disparities statewide. The Census Analysis and Strategic Communications Plan will continue to provide guidance with identifying strategic partners within high-risk communities to establish LISSDEP distribution partnerships. Priority will be placed on continuing to educate community based organizations and recruiting alternate partners and stand-alone distribution sites to increase program enrollment and address inequities and reach disparate populations. Strategic partners for collaboration will be non-profit organizations, birthing hospitals, refugee resettlement service groups, etc. Contractors will support the expansion of program enrollment by engaging identified strategic partners and/or reach disparate and underserved populations in both communities with and without LISSDEP distribution sites. In addition, efforts will continue to reduce enrollment barriers to access seats as identified in the strategic needs/asset assessment plan. All sites will have access in FY23 to the optional remote operations mode designed to address administrative burdens that may reduce enrollment and travel or time barriers for families. This will include the applicant screening, eligibility evidence collection, and modified recipient training components. Site coaching will continue to focus on engaging alternative partners to reach disparate communities and equity considerations, and inclusion of Family Voice and Choice to better serve clientele and increase seat issuance. Additional coaching will focus on utilizing the new operations model effectively.

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	October 2022-September 2023	IVP Supervisor; Transportation Safety Coord; 3 Non-MCH funded positions; Contractor company

PRIORITY 2	Upstream/cross-sector strategic planning: Eliminate the health inequities arising from social, political, economic, and environmental conditions through strategic, nontraditional partnerships
OBJECTIVE	Decrease the rate of hospitalization for nonfatal injury per 100,000 children ages 0-9 from 101.5 (HCUP-State Inpatient Databases (SID) – 2015) to 81.0.
PERFORMANCE MEASURE	NPM 7.1: Rate of hospitalization for non-fatal injury per 100,000 children, ages 0-9.

Strategies:

Strategy 1: Partner with IVPP to focus on the intersection between child health and transportation.

In FY23, VDH IVPP will continue to serve on interagency teams focused on the intersection between child health and transportation. In-kind contributions include 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), 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. VDH IVPP will implement one intervention in FY23 based on key findings from the feasibility study.

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.	October 2022-September 2023	Transportation Safety Coord
Complete one feasibility plan for implementation of pedestrian and bicycling safety activities	October 2022-September 2023	Transportation Safety Coord

PRIORITY 3	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).
OBJECTIVE	By June 30, 2025, increase the percent of children (ages 10-71 months) receiving a developmental screening using a parent-completed screening tool from 29.1% (NSCH 2016-2017) to 31.1%
PERFORMANCE MEASURE	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.

Strategies:

Strategy 1: Support the development of high functioning community/regional partnerships led by 6 Ready Region 'hubs' that coordinate and improve local developmental screening and referral systems improvements.

Communities are just beginning the process to emerge from under the pandemic. The need continues to support the work of providing training, TA and resources to improve developmental screening. The strategy is to continue to offer resources and technical support as programs begin to return to pre-pandemic functions. This is a collaborative partnership with the Ready Region hubs. Based on feedback from qualitative key informant interviews, it is too early to try to add additional ESMs to the work plan. Of interest, as we move forward over the upcoming year, is to explore what it takes to develop and train ready to go communities. As a training investment, it is unclear what inputs are needed to increase screening among providers. In addition, as the project works to build infrastructure and connect systems, we are examining what is will take to keep these systems in place for long term sustainability.

PRIORITY 4	Oral health
OBJECTIVE	By June 30, 2025, increase the percent of children (ages 1 through 11) who had a preventive dental visit in the past year from 78.9% (NSCH 2017-2018) to 83.7%
OUTCOME MEASURE	NPM 13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.

Strategies:

Strategy 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.

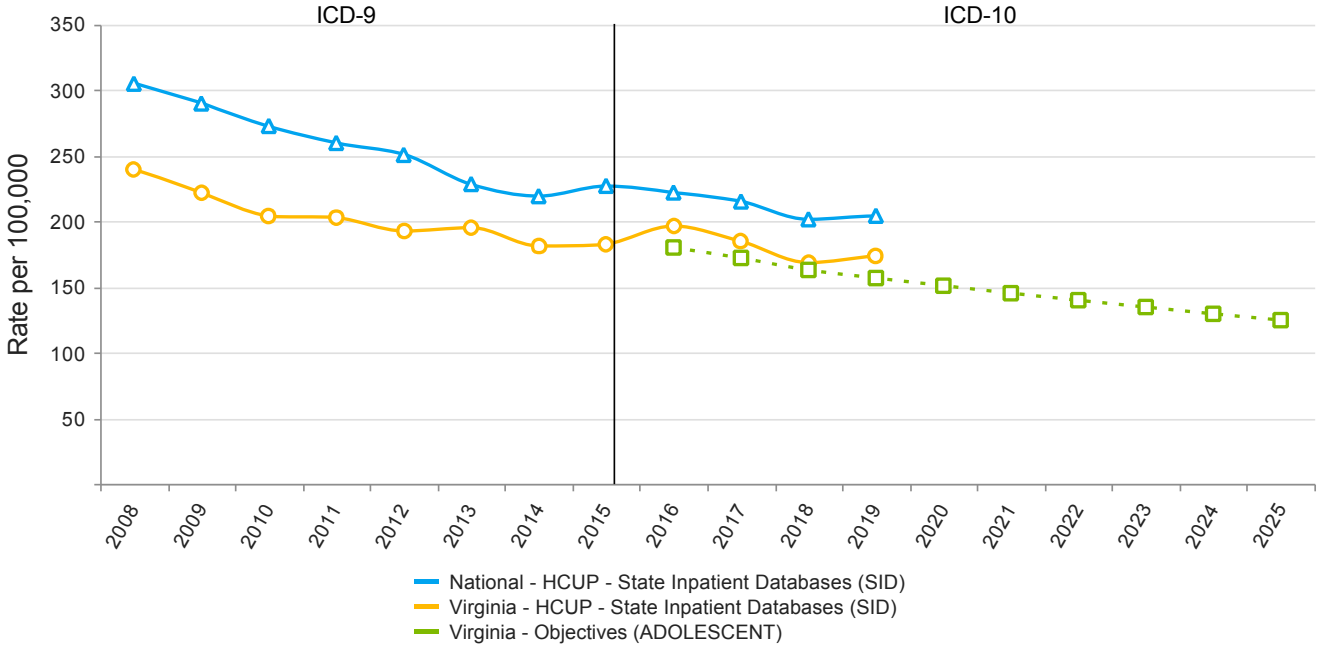
Strategy 2: Sustain network of regional Oral Health Alliances to foster regional efforts and initiatives throughout the Commonwealth and distribute mini-grants for implementation of systems change and data-sharing initiatives to improve the oral health of all Virginians, with emphasis on pregnant women, and children and adolescents ages 1-17.

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

Adolescent Health

National Performance Measures

NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19
Indicators and Annual Objectives



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

Federally Available Data					
Data Source: HCUP - State Inpatient Databases (SID)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	172	162.9	156.8	151	145.3
Annual Indicator	182.6	196.3	184.5	168.1	173.7
Numerator	1,451	2,087	1,964	1,800	1,854
Denominator	794,656	1,062,972	1,064,407	1,070,646	1,067,063
Data Source	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	139.9	134.7	129.6	124.8

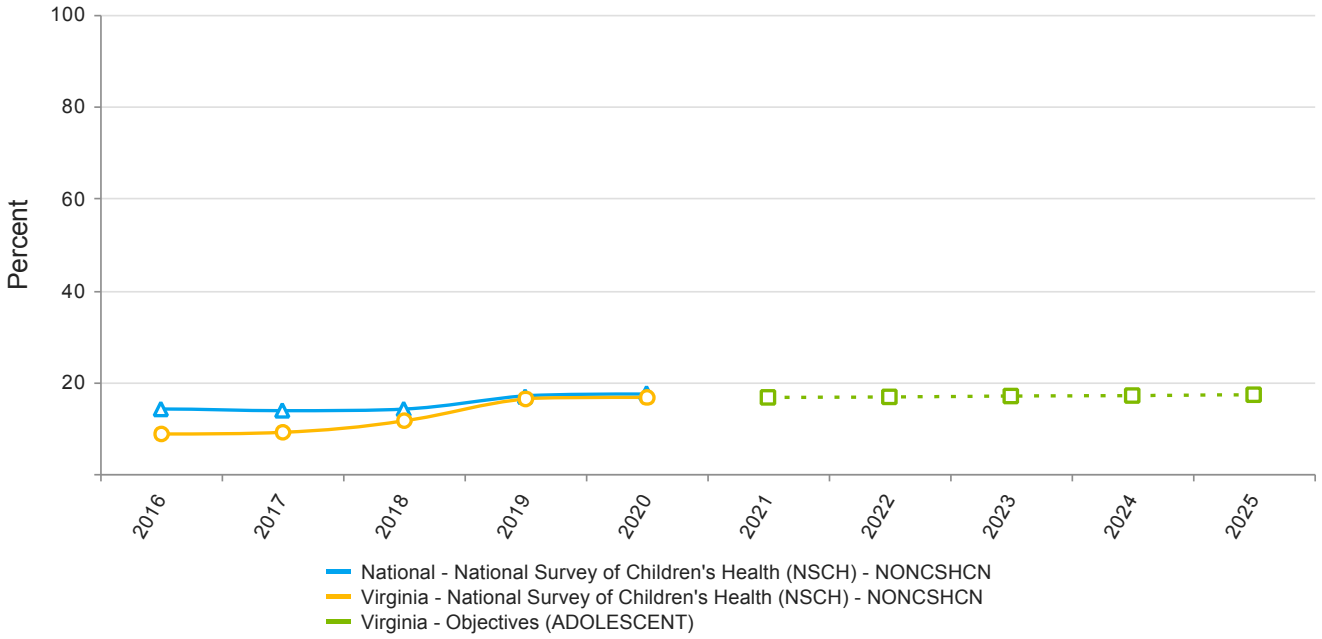
Evidence-Based or –Informed Strategy Measures

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

Measure Status:				Active	
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			10	20	250
Annual Indicator		102	195	237	501
Numerator					
Denominator					
Data Source		VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program
Data Source Year		2018	2019	2020	2021
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	300.0	350.0	400.0	600.0

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**	**2021**
Annual Objective			16.7
Annual Indicator	11.6	16.5	16.6
Numerator	56,684	71,210	75,517
Denominator	489,697	431,868	455,838
Data Source	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-NONCSHCN
Data Source Year	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	16.8	17.0	17.1	17.3

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					
	2017	2018	2019	2020	2021
Annual Objective	25	100	250	400	40
Annual Indicator	0	0	0	45	49
Numerator					
Denominator					
Data Source	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Provisional	Final	Final	Final

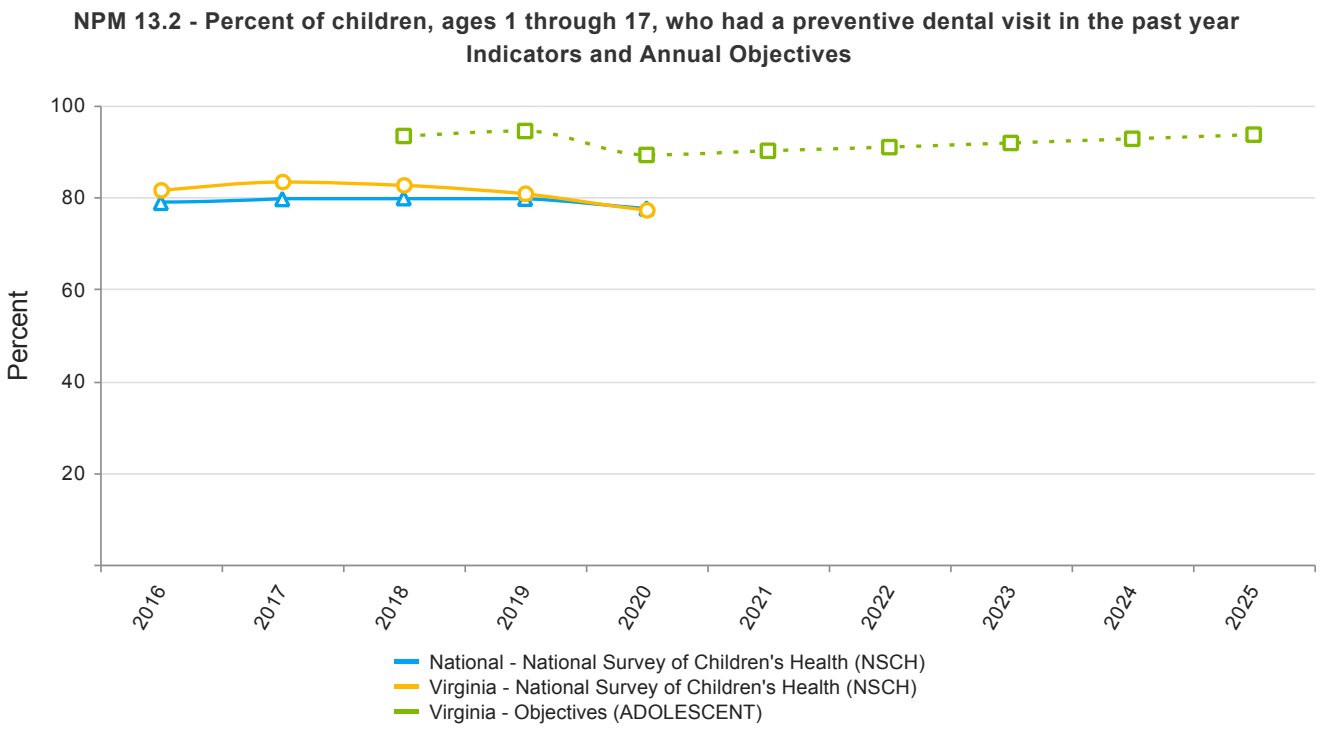
Annual Objectives				
	2022	2023	2024	2025
Annual Objective	45.0	50.0	55.0	60.0

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			75
Annual Indicator		68.2	68.2
Numerator		90	90
Denominator		132	132
Data Source		VDH and VDOE School Health Nurse Documentation	VDH and VDOE School Health Nurse Documentation
Data Source Year		2020	2020
Provisional or Final ?		Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	77.0	79.0	81.0	83.0



NPM 13.2 - Adolescent Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		93.2	94.3	89.1	90
Annual Indicator	81.4	83.1	82.4	80.5	77.1
Numerator	1,407,907	1,448,110	1,463,318	1,432,504	1,360,700
Denominator	1,729,004	1,741,839	1,775,616	1,778,464	1,763,868
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective		93.2	94.3	89.1	90
Annual Indicator	90.9	90.5	88.2	86.6	83.4
Numerator					
Denominator					
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	90.8	91.7	92.6	93.5

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective			6	6	6
Annual Indicator		3	4	8	9
Numerator					
Denominator					
Data Source		VDH Oral Health Program documentation	VDH Oral Health Program documentation	VDH Oral Health Program documentation	VDH Oral Health Program documentation
Data Source Year		2018	2019	2020	2021
Provisional or Final ?		Final	Final	Final	Final

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

State Performance Measures

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			23.8
Annual Indicator	25.3	27.1	25.1
Numerator			
Denominator			
Data Source	VA PRAMS	VA PRAMS	VA PRAMS
Data Source Year	2018	2019	2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	23.3	22.8	22.3	21.8

SPM 6 - Promotion and strengthening of optimal mental/behavioral health and well-being through partnerships and programs

Measure Status:	Active

Annual Objectives			
	2023	2024	2025
Annual Objective	48.6	51.4	54.3

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	
Provide suicide prevention trainings to professionals interacting with youth and adolescents	
ESMs	**Status**
ESM 7.2.1 - Number of gatekeepers trained in the prevention of suicide among youth	Active
NOMs	
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	

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

Priority Need

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

Provide resources and professional development opportunities to school nurses

Maintain data capacity for school health immunization data

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

Continue cross collaboration with school-based oral health programs

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

By 2025, reduce the rate of mistimed pregnancies from 25.3% (PRAMS 2018) to 21.8% by 2025

Strategies

Implement evidence-based comprehensive sexual education in areas of the state with disproportionately high rates of teen pregnancy and low access to sexual health information; Advocate for policy change that requires sex education in Virginia to be medically accurate, comprehensive, inclusive, and required

Assure Resource Mothers staff are trained in the Growing Great Kids curriculum, a skills-driven program designed to promote healthy child development and strengthen protective factors for families in a home visiting setting, and increase capacity of youth-serving agencies to implement AIM4TM, an evidence-based pregnancy prevention program designed for parenting teens

Local Health District (LHD) Strategy: Conduct community/environmental scan and gap analysis regarding adolescent reproductive health –assessing community, public and private partners that provide outreach, education, and appropriate reproductive health services to adolescents.

ADOLESCENT HEALTH DOMAIN
SUMMARY/OVERVIEW
FY21 ANNUAL REPORT

DOMAIN CONTRIBUTORS

DOMAIN CONTRIBUTORS:
Adolescent Health Program– Division of Child and Family Health - Repro Health Unit
Resource Mothers Program - Division of Child and Family Health - Repro Health Unit
Injury and Violence Prevention Program – Division of Prevention and Health Promotion
School Health - Division of Child and Family Health
Dental Health Program – Division of Prevention and Health Promotion
VDH Local Health Districts

DOMAIN OVERVIEW

ADOLESCENT HEALTH PROGRAM: 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.

RESOURCES MOTHERS PROGRAM: Resource Mothers (TANF, Title V): Adolescent health program providing support services to pregnant and parenting teens and their families 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.

YOUTH SUICIDE PREVENTION: The 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 updating the *Commonwealth of Virginia Suicide Across the Lifespan Prevention Plan.*

SCHOOL HEALTH PROGRAM: VDH School Health Nurse Consultant partners and collaborates closely with the Virginia Department of Education (DOE) and their School Health Nurse Consultant to serve elementary through high school students enrolled in public, private and parochial schools in the Commonwealth. The program aims to provide technical assistance and professional developmental training opportunities to the school systems, particular 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.

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

PRIORITY 1: Reproductive justice and support: Promote equitable access to choice-centered reproduction-related services, including sex education, family planning, fertility/grief support, and parenting support

OBJECTIVE	By 2025, reduce the rate of mistimed pregnancies from 25.3 (PRAMS 2018) to 21.8% by 2025
PERFORMANCE MEASURE	SPM4: Pregnancy intention: Mistimed or unwanted pregnancy (wanted to become pregnant later or never)

Adolescence and young adulthood are considered "critical periods" in the Life Course, and struggle with a wide range of health care needs related to social, economic, and environmental factors. Adolescents suffer from worsened health outcomes, particularly if they are of lower socioeconomic status, a minority background, and have unmet mental health needs. Providing appropriate and comprehensive health services to adolescents, particularly related to reproductive justice and support, are important.

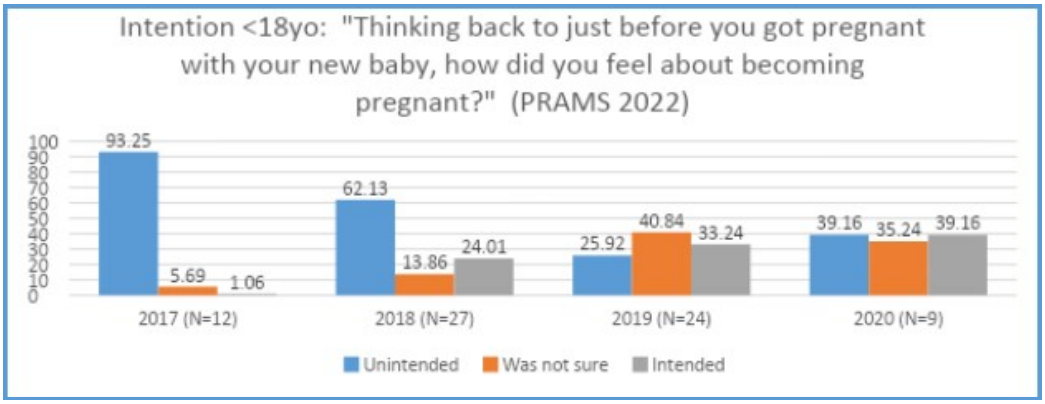
In Virginia, the 2020 adolescent birth rate is 13.1 per 1,000 births (National Vital Statistics System). According to PRAMS, many of these adolescent births among adolescents less than 18 are largely unintended; however, the trend in unintendeness among this age group is continuing to trend downwards in more recent years. Although maternal deaths are rare among this age group, when compared with births among women aged 20 and over, infants of adolescents have the highest rate of mortality, preterm birth, low birthweight, and maternal complications. In Virginia, 10.2% of preterm births were to mothers under the age of 18. Despite the declining birth rate for adolescents aged 15–19, differences continue to occur in the mortality of infants born to teenagers by race and ethnicity and cause of death.

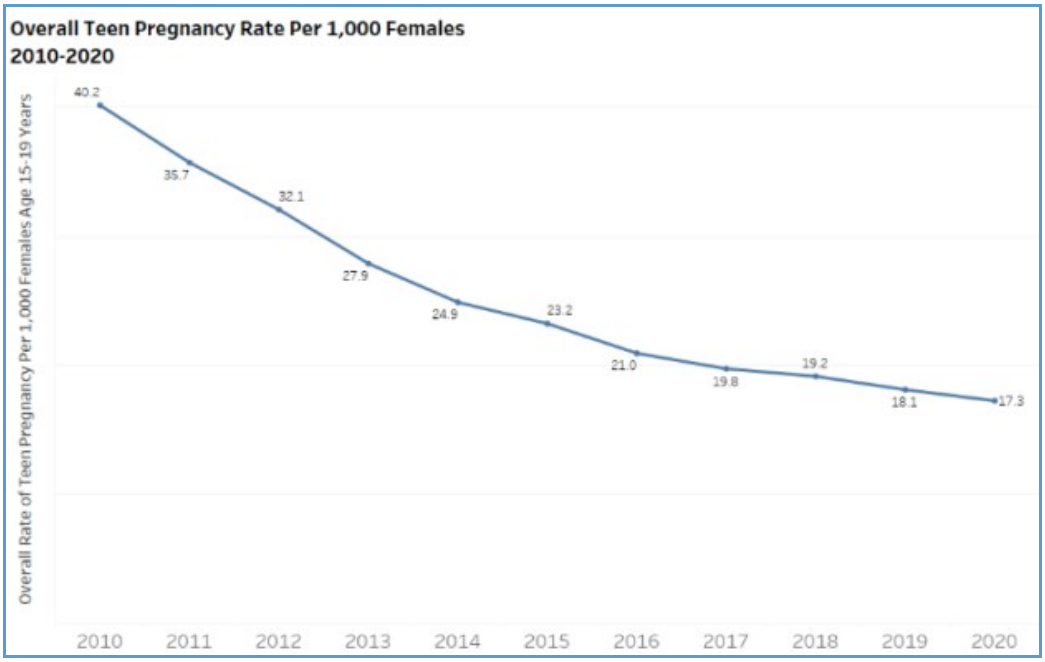
Current Virginia MMRT rates for adolescents - <18yo

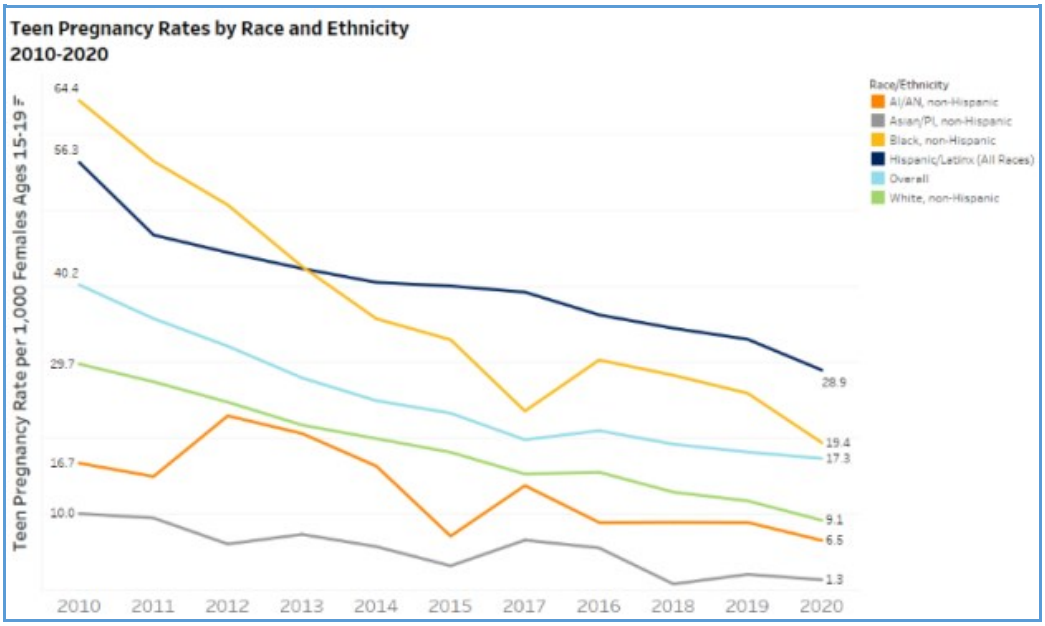
	White	Black	Other
2016	0	1	0
2018	1	0	1

Nationally, in 2017–2018, infants of teenagers aged 15–19 had the highest rate of mortality (8.77 deaths per 1,000 live births) compared with infants of women aged 20 and over. Mortality rates were highest for infants of non-Hispanic black teenagers (12.54) compared with infants of non-Hispanic white (8.43) and Hispanic (6.47) teenagers. The mortality rate of infants born to non-Hispanic black teenagers related to preterm birth and low birthweight (284.31 deaths per 100,000 live births) was more than double the rate of infants born to non-Hispanic white teenagers (119.18) and three times the rate of infants born to Hispanic teenagers (94.44).

The current workforce includes few adolescent health specialists that can engage and support interventions focused on risk assessment, health promotion, and fostering of positive youth development.







Strategy 1: Implement evidence-based comprehensive sexual education in areas of the state with disproportionately high rates of teen pregnancy and low access to sexual health information; Advocate for policy change that requires sex education in Virginia to be medically accurate, comprehensive, inclusive, and required

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

VDH's Adolescent Health Program includes evidence-based positive youth development programs. VDH receives federal Sexual Risk Avoidance Education (SRAE) funds to support programs at six program sites. SRAE funds support two evidence-based curricula: *Project AIM* and *Teen Outreach Program (TOP)*. VDH's SRAE program reach was limited during this reporting period because many youth-serving organizations halted in-person programming and local health department staff were pulled to help with COVID-related tasks. While some programs were able to pivot to the virtual environment, this took time and was not possible for all sites. The SRAE program served approximately 395 youth during this reporting period.

Title V funds are used to complement VDH's long-standing positive youth development programs by a supporting a comprehensive sex education curriculum called *Get Real: Comprehensive Sex Education that Work*s. During FY21, VDH established partnerships with two nonprofit organizations and a hospital system to implement this program. Launching a program during the COVID-19 pandemic was challenging and caused program numbers to be understandably lower than expected. Approximately 480 youth participated in *Get Real* during FY21. During this time, the VDH team also provided feedback to the Virginia Department of Education on meaningful ways to update the Virginia Standards of Learning Guidelines for Family Life Education. This feedback was combined with the feedback from other stakeholders, and currently rests with the Department of Education.

Strategy 2: Fund BrdsNBz, a free sexual health informational text line for teens operated by the American Sexual Health Association, statewide in Virginia

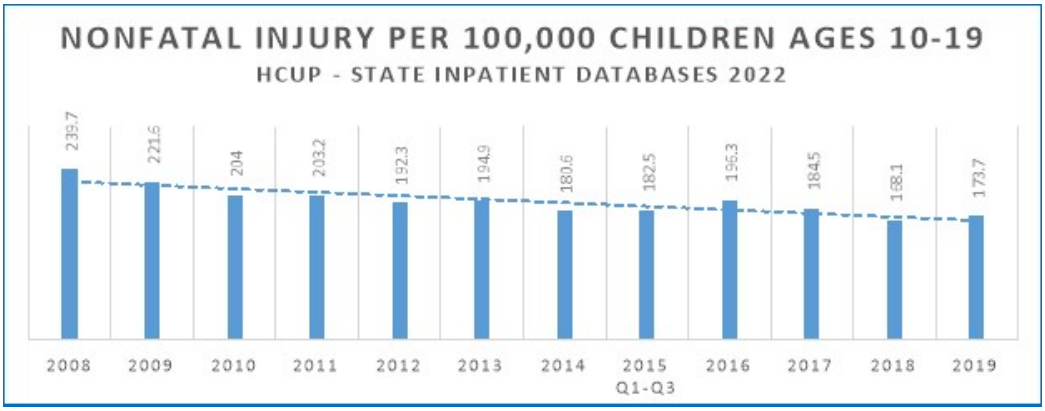
During FY21, VDH funded BrdsNBz, a pilot text information program designed to provide medically accurate information to young people with questions about sexuality. The program entailed partnering with the American Sexual Health Association (ASHA) to develop a Virginia-specific code for Virginia youth, disseminating information across the Commonwealth, and contracting with ASHA to staff the textline. Despite VDH's efforts to promote the program, utilization was very low, and VDH decided to discontinue the program. VDH's Youth Advisors provided valuable insight about why program utilization was low, and VDH intends to incorporate youth feedback from the beginning when planning such interventions moving forward.

Strategy 3: Assure Resource Mothers staff are trained in the Growing Great Kids curriculum, a skills-driven program designed to promote healthy child development and strengthen protective factors for families in a home visiting setting, and increase capacity of youth-serving agencies to implement AIM4TM, an evidence-based pregnancy prevention program designed for parenting teens

In addition to its pregnancy prevention programs, VDH's Reproductive Health Unit also provides support to young parents. Resource Mothers is an adolescent health program for pregnant and parenting teens. As part of this program, community health workers offer home visiting services to teens until their child reaches the age of one. During these visits, community health workers provide educational and emotional support to the client and her family. Resource Mothers uses two evidence based programs: Growing Great Kids and AIM4TM (AIM for Teen Moms). 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. Program reach was limited during the COVID-19 pandemic: community health workers enrolled 147 teens into the program, and supported 98 newborns during this reporting period, representing a significant decrease from previous years. Resource Mothers staff were required to stop most or all in-person programming for safety reasons, and they pivoted to virtual platforms such as Zoom for Healthcare Professionals to engage with teens and their families when possible. Title V funds are used to support curriculum-specific trainings for Resource Mothers staff, and these trainings were offered virtually during COVID. VDH offered one virtual GGK training to 9 community health workers and one virtual AIM4TM training to 8 community health workers during the FY21 reporting period.

PRIORITY 2: Mental health

OBJECTIVE	By June 30, 2025, decrease the rate of hospitalization for nonfatal injury per 100,000 children ages 10 to 19 from 182. 6 (HCUP – State Inpatient Databases (SID) 2015) to 124.79.
PERFORMANCE MEASURE	NPM 7.2: Rate of hospitalization for non-fatal injury per 100,000 children, ages 10-19.
Evidence-based or –informed strategy measures	ESM 7.2.1 – Number of gatekeepers trained in the prevention of suicide among youth.



Strategy 1: Provide suicide prevention trainings to professionals interacting with youth and adolescents

Reduction of suicide deaths is a continuing priority. However, death statistics vastly underestimate the burden of intentional self-harm injuries in youth. In 2001, the Virginia Department of Health (VDH) was designated as the lead agency for youth suicide prevention in Virginia pursuant to the Code of Virginia §32.1-73.7. The VDH Suicide Prevention Program is housed in the Division of Prevention and Health Promotion (DPHP), within the IVPP. Primary efforts to address youth suicide under this program have focused on training youth serving professionals and organizations to comprehensively screen for suicide risk and refer affected youth to immediate care.

During the reporting period, IVPP continued to coordinate gatekeeper trainings in partnership with James Madison University as the Campus Suicide Prevention Center of Virginia (CSPCVA) in the prevention of suicide among youth. “Recognizing and Responding to Suicide Risk” and “CAMS: Collaborative Assessment and Management of Suicidality” which equip clinicians with the skills to screen, assess, and refer for suicide risk, providing counseling in a flexible, empathetic, and non-judgmental way. Additionally, the Center facilitates and coordinates regular Mental Health First Aid, ASIST, and safeTalk trainings. Promoting suicide intervention skills training to directors of graduate programs in counseling, psychology and applies social work across Virginia continued during the project period. The IVPP and JMU recommended that first year students take ASIST and second year students take the CAMS 3-hour overview. The center currently has 7 programs that have made ASIST a part of their standard curriculum. During the reporting period, 501 gatekeepers across Virginia’s campuses and universities were trained by the CSPCVA.

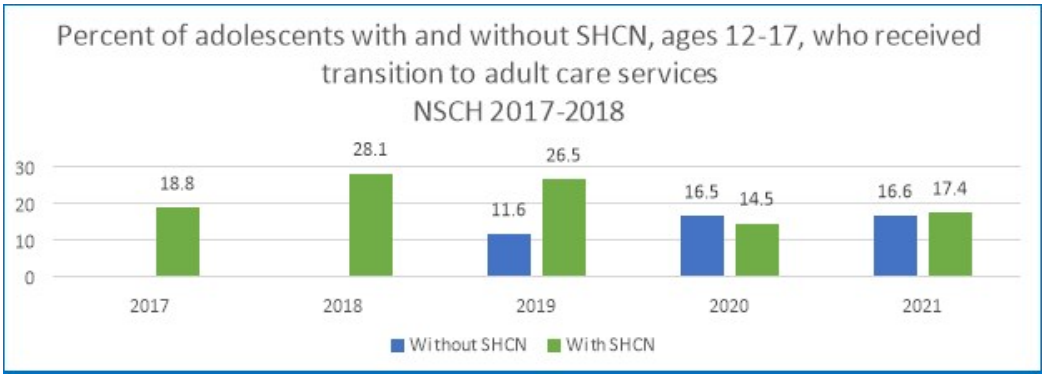
As written by the Title V Director in FY21, the activity “Partner with the Title V Director to enhance a strategic plan for suicide prevention among middle school students” and “Partner jointly with Title V Director to complete a needs/asset assessment and evaluation specific to interagency adolescent mental health activities, to include key accomplishments, identification of community-based organizations poised to serve as strategic partners, and assessment of 3-5 strategic needs” was unable to be completed due to the Title V Director vacancy.

However, during the project year, partially and non-funded Title V IVPP staff supporting ongoing suicide prevention efforts partnered with the Department of Education 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.

The IVPP Youth Suicide Prevention Program uses partially funded Title V staff time and effort to advance a comprehensive statewide suicide prevention program.

PRIORITY 3: 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)

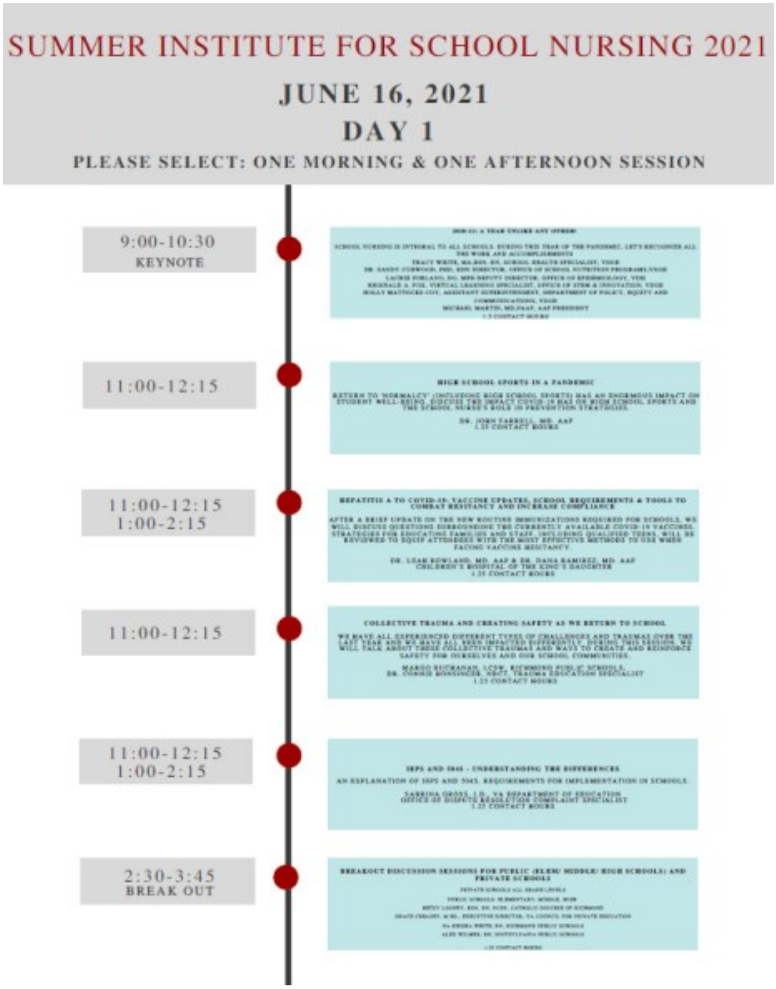
OBJECTIVE	By June 30, 2025, increase the proportion of adolescents, ages 12-17, in Virginia who are engaged in transition services to adult health care from 11.6% (NSCH 2017-2018) to 14.2%
PERFORMANCE MEASURE	NPM 12: Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care.
Evidence-based or – informed strategy measures	ESM 12.2: Percentage of Virginia school divisions reporting into the VDOE school health data system

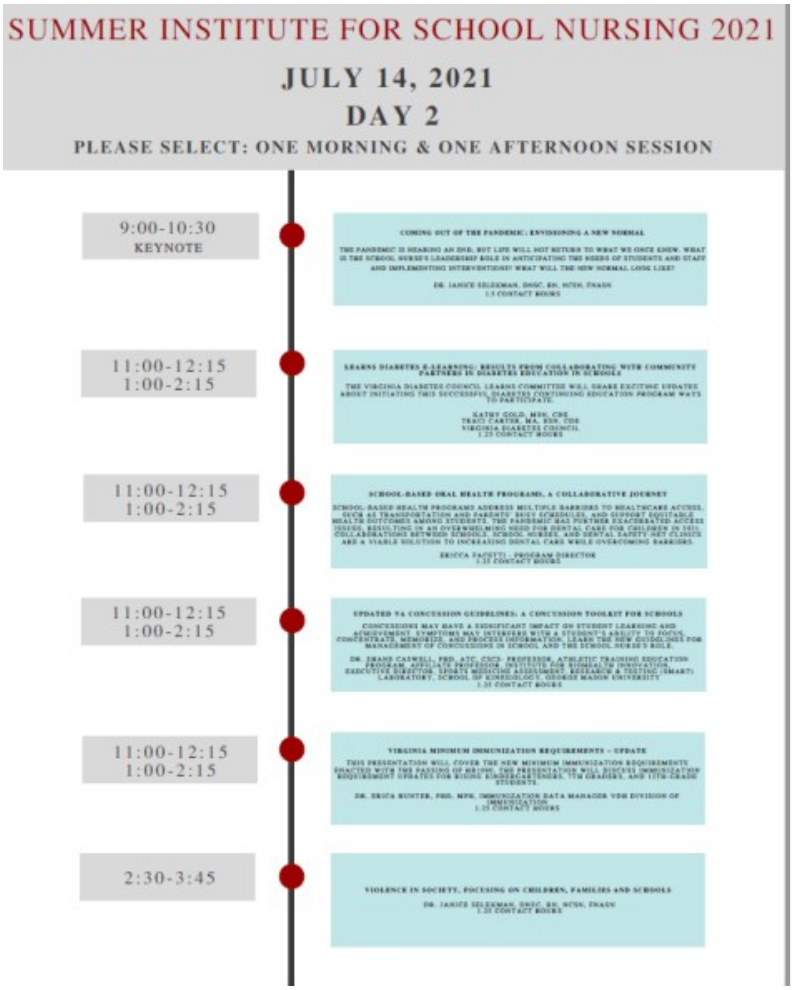


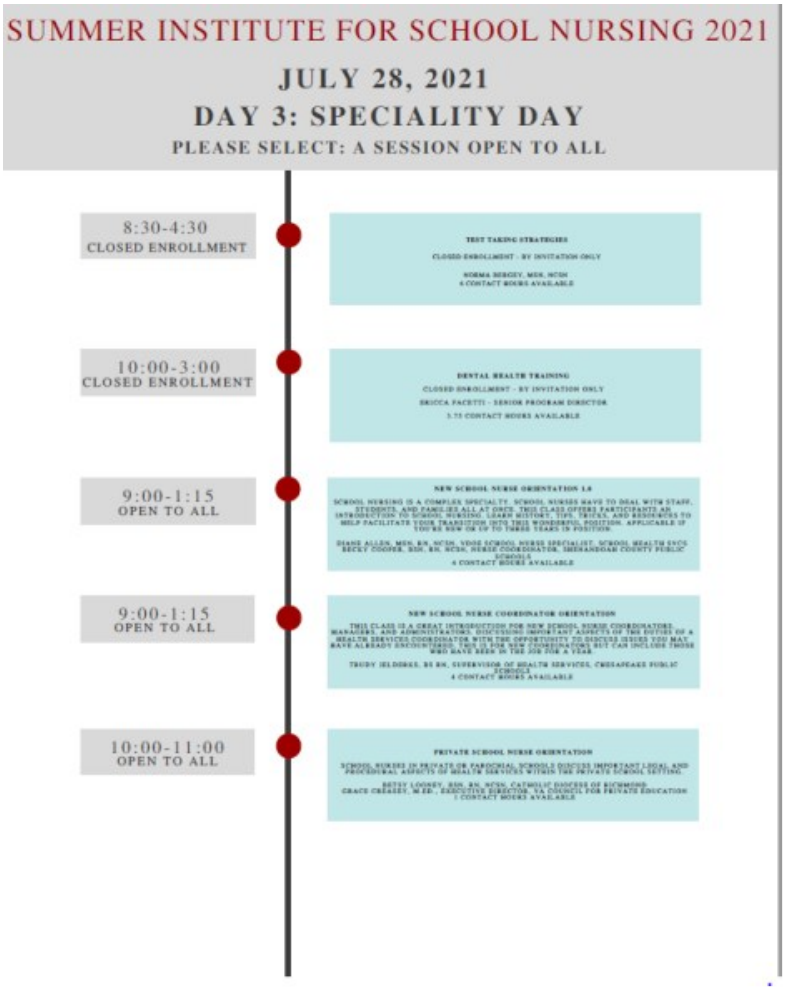
Strategy 1: Provide resources and professional development opportunities to school nurses

Cross collaboration between the Virginia Department of Education (VDOE), Virginia Department of Health (VDH) and Virginia School Nurses Association (VASN): The Summer Institute for School Nursing (SISN) 2021 expanded opportunities and empowered school nurses. SISN 2021 was held virtually and provided professional development opportunities to 465 school nurses from all over the Commonwealth. The SISN 2021 conference agenda is below and school nurses participated in a mental health professional development session by Dr. Connie Honsinger : "Collective Trauma and Creating Safety as We Return to School" designed to promote and strengthen mental health school programs (SPM6). Untreated mental health disorders have a serious impact on physical health and chronic diseases. The third day of SISN 2021 was a specialty day for school nurses and provided training. The VDH Title V Office of Family Health Services offered scholarships to 15 school nurses to become nationally certified school nurses. VDH received 25 applications from school nurses across the Commonwealth and 15 school nurses met the National Board for Certification of School Nurses criteria and were selected to participate in the scholarship program. All of the scholarship winners participated in a review course on the third day of SISN 2021, this review course prepared school nurses to take the Nationally Certified School Nurse (NCSN) exam during the summer or fall testing window. Unfortunately only 10 of the 15 school nurse scholarship winners

took the certification exam. Many of Virginia's school nurses were tasked with additional responsibilities responding to COVID-19 (contact tracing and case investigation efforts in partnership with their local health departments) in their schools and this proved to be a barrier. Overall the scholarship program provided an opportunity for 7 school nurses to become nationally certified school nurses.




SUMMER INSTITUTE FOR SCHOOL NURSING 2021
JULY 14, 2021
DAY 2
PLEASE SELECT: ONE MORNING & ONE AFTERNOON SESSION
9:00-10:30
KEYNOTE
COMING OUT OF THE PANDEMIC: ENVISIONING A NEW NORMAL
THE PANDEMIC IS SHAKING AN END, BUT LIFE WILL NOT RETURN TO WHAT WE ONCE KNEW. WHAT IS THE SCHOOL NURSE'S LEADERSHIP ROLE IN ANTICIPATING THE NEEDS OF STUDENTS AND STAFF AND IMPLEMENTING INTERVENTIONS? WHAT WILL THE NEW NORMAL LOOK LIKE?
DR. JANICE SELEKMAN, DNSC, RN, NCSN, FNASN
1.5 CONTACT HOURS
11:00-12:15
1:00-2:15
LEARNS DIABETES E-LEARNING: RESULTS FROM COLLABORATING WITH COMMUNITY PARTNERS IN DIABETES EDUCATION IN SCHOOLS
THE VIRGINIA DIABETES COUNCIL LEARNS COMMITTEE WILL SHARE EXITING UPDATES ABOUT INITIATING THIS SUCCESSFUL DIABETES CONTINUING EDUCATION PROGRAM WAYS TO PARTICIPATE.
KATHY GOLD, MSN, CDE
TRACI CARTER, MA, RDN, CDE
VIRGINIA DIABETES COUNCIL
1.25 CONTACT HOURS
11:00-12:15
1:00-2:15
SCHOOL-BASED ORAL HEALTH PROGRAMS, A COLLABORATIVE JOURNEY
SCHOOL BASED HEALTH PROGRAMS ADDRESS MULTIPLE BARRIERS TO HEALTHCARE ACCESS, SUCH AS TRANSPORTATION AND PARENTS' BUSY SCHEDULES, AND SUPPORT EQUITABLE HEALTH OUTCOMES AMONG STUDENTS. THE PANDEMIC HAS FURTHER EXACERBATED ACCESS ISSUES, RESULTING IN AN OVERWHELMING NEED FOR DENTAL CARE FOR CHILDREN IN 2021. COLLABORATIONS BETWEEN SCHOOLS, SCHOOL NURSES, AND DENTAL SAFETY-NET CLINICS ARE A VIABLE SOLUTION TO INCREASING DENTAL CARE WHILE OVERCOMING BARRIERS.
ERICCA FACETTI - PROGRAM DIRECTOR
1.25 CONTACT HOURS
11:00-12:15
1:00-2:15
UPDATED VA CONCUSSION GUIDELINES: A CONCUSSION TOOLKIT FOR SCHOOLS
CONCUSSIONS MAY HAVE A SIGNIFICANT IMPACT ON STUDENT LEARNING AND ACHIEVEMENT. SYMPTOMS MAY INTERFERE WITH A STUDENT'S ABILITY TO FOCUS, CONCENTRATE, MEMORIZE, AND PROCESS INFORMATION. LEARN THE NEW GUIDELINES FOR MANAGEMENT OF CONCUSSIONS IN SCHOOL AND THE SCHOOL NURSE'S ROLE.
DR. BRAND CASWELL, PHD, ATC, CSCS- PROFESSOR, ATHLETIC TRAINING EDUCATION PROGRAM, AFFILIATE PROFESSOR, INSTITUTE FOR BIOHEALTH INNOVATION, EXECUTIVE DIRECTOR, SPORTS MODELING ASSESSMENT, RESEARCH & TESTING (SMART) LABORATORY, SCHOOL OF KINESIOLOGY, GEORGE MASON UNIVERSITY
1.25 CONTACT HOURS
11:00-12:15
1:00-2:15
VIRGINIA MINIMUM IMMUNIZATION REQUIREMENTS - UPDATE
THIS PRESENTATION WILL COVER THE NEW MINIMUM IMMUNIZATION REQUIREMENTS ENACTED WITH THE PASSING OF HB1094. THE PRESENTATION WILL DISCUSS IMMUNIZATION REQUIREMENT UPDATES FOR RISING KINDERGARTENERS, 7TH GRADERS, AND 11TH GRADE STUDENTS.
DR. ERICA HUNTER, PHD, MPH, IMMUNIZATION DATA MANAGER VDH DIVISION OF IMMUNIZATION
1.25 CONTACT HOURS
2:30-3:45
VIOLENCE IN SOCIETY, FOCUSING ON CHILDREN, FAMILIES AND SCHOOLS
DR. JANICE SELEKMAN, DNSC, RN, NCSN, FNASN
1.25 CONTACT HOURS



Strategy 2: Continue cross-collaborative efforts with school-based stakeholders

Cross collaboration between the Virginia Department of Education (VDOE), Community Stakeholders, Virginia Chapter of the American Academy of Pediatrics (VA AAP), Virginia Department of Health (VDH) and Virginia School Nurses Association (VASN), and school nurses: Virginia has 132 school divisions but only 90 (68%) reported data to VDOE for the 2020-2021 school year, 90 Virginia schools reported having 55,165 students with an asthma diagnosis from a health care provider and 9,109 of those students provided the school with an Asthma Action Plan from a healthcare provider. The 2021 General Assembly passed HB2019, requiring schools to possess albuterol metered dose inhalers (MDI) and valved holding chambers and to administer undesignated stock albuterol to any student experiencing respiratory distress. The implementation of school policies and procedures for the emergency treatment of respiratory distress using undesignated stock albuterol is not intended to replace the individual Asthma Action Plan of a student with asthma. Instead, it should be used when an Asthma Action Plan and/or prescribed albuterol inhaler is not available or easily accessible. Schools were encouraged to assist families with any additional support services needed to effectively manage their child in the school setting. A workgroup consisting of VDH, VDOE, VA AAP, VASN, local health departments, community stakeholders, and school staff was tasked with developing a model policy, best practices, standing order template, respiratory distress algorithms, procurement process and training modules for schools. Guidelines for The Use of Undesignated Stock Albuterol in Schools Resource is available to school staff and can be found on the Virginia Department of Education website. Staff training modules were developed by the workgroup and are available here. Respiratory distress algorithm resources for school nurses and staff are available on the VDH school Health Website and the links are below:

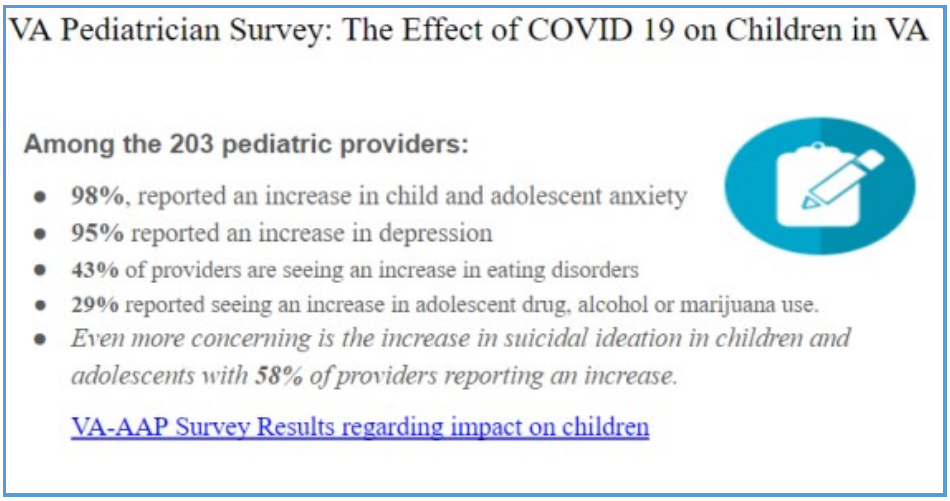
- Response to Mild to Moderate Respiratory Distress Algorithm

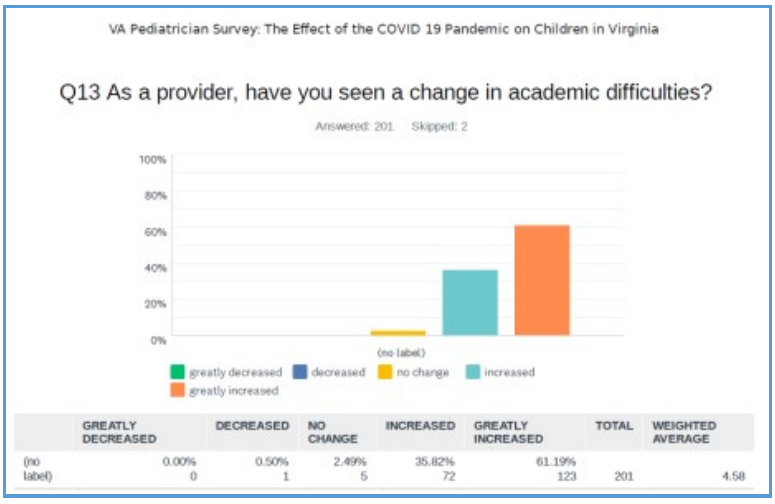
- Response to Moderate to Severe Respiratory Distress Algorithm

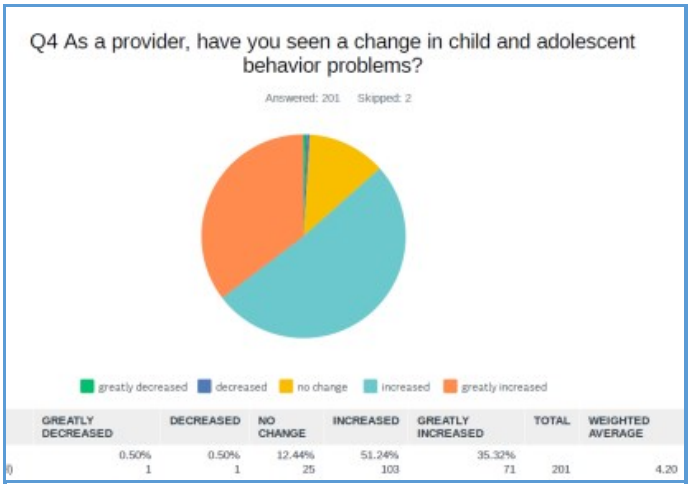
The purpose of the administration of undesignated stock emergency albuterol is to reduce the amount of time children spend away from the classroom and to make schools safer for all children.

The Virginia Chapter of the American Academy of Pediatrics, VDOE, VDH School Health and Division of Epidemiology partnered to establish the School Reopening Task Force. The School Reopening Task Force provides information, resources, expertise and support to school staff, teachers, families and students. The School Reopening Task Force coordinates care and connects families to community resources, collects and monitors data, and provides school divisions with guidance and updates to return safely to in person learning.
Since the beginning of the pandemic, the Virginia Chapter of the American Academy of Pediatrics has partnered with VDOE and VDH to provide a strong system of care by educating, supplying guidance and developing resources for Virginia healthcare providers, schools nurses, teachers, health departments, school administration and families about COVID 19, chronic conditions, immunizations, behavioral/mental health and the importance of well child visits and medical homes. They continue to support families by addressing the social determinants of health with their Bridge 2 Resources program.

The Back to School Task Force surveyed providers across the Commonwealth in February 2021 and the findings are below:







	GREATLY DECREASED	DECREASED	NO CHANGE	INCREASED	GREATLY INCREASED	TOTAL	WEIGHTED AVERAGE
	0.50%	0.50%	12.44%	51.24%	35.32%		
0	1	1	25	103	71	201	4.20

Based on the results of the survey, the Task Force plans to continue to support their community by addressing the social determinants of health, provide mental health resources, educational opportunities, outreach, and tele town halls. A Back to School Website was developed to assist schools and families during the pandemic. This website's targeted audience is school staff and leadership, school nurses and families. Beginning in 2020, the Task Force has hosted several town halls, provided a school tool kit, and continues to promote COVID vaccination efforts (sample of posters below):

Cross collaboration with VDOE, VDH, VA AAP and VASN to provide professional development opportunities to promote and strengthen mental health and well-being through partnerships and programs during the Summer Institute for School Nursing 2021: School nurses participated in a professional development session by Dr. Connie Honsinger: "Collective Trauma and Creating Safety as We Return to School" during the Summer Institute for School Nursing (SISN) 2021. Student recovery depends on the return to in-person learning with robust social emotional support. School nurses will have the opportunity to become certified in Mental Health First Aid during the Summer Institute for School Nursing (SISN) 2022.

Strategy 2: Maintain data capacity for school health immunization data

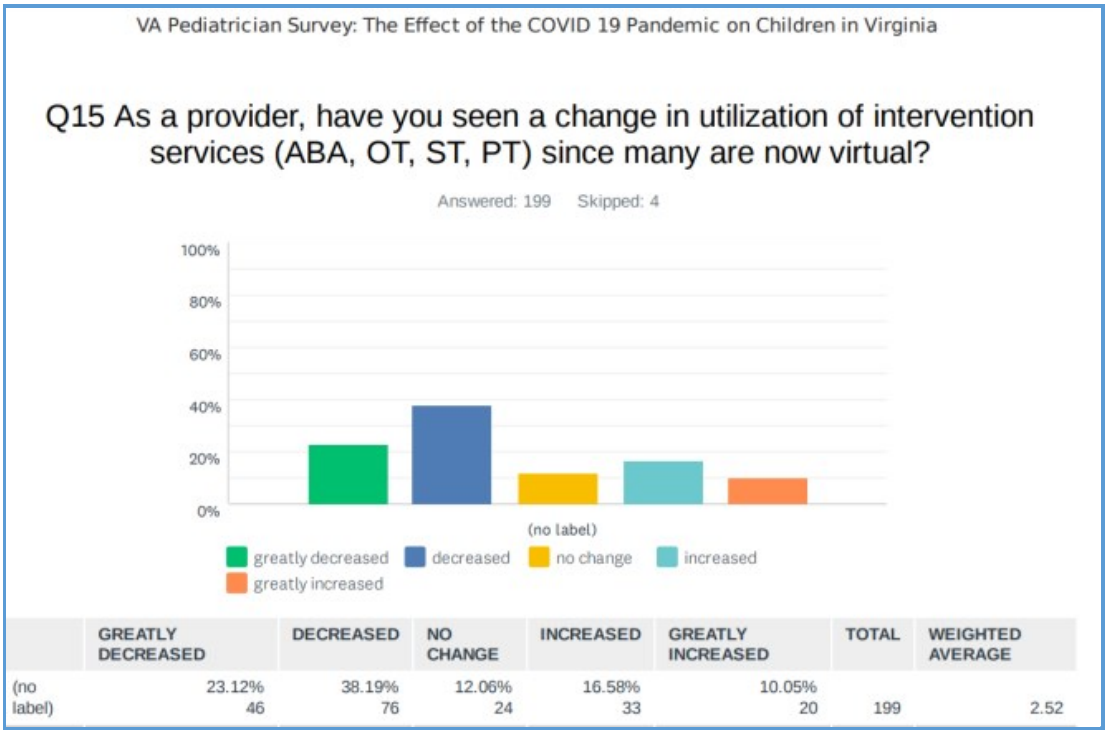
ESM NARRATIVE: ESM 12.2: Mandatory data collection would prove to be beneficial when evaluating and making adjustments in school health programs and policies. School nurses who have access to accurate and reliable data are able to leverage community support for the implementation of school health programs.

Currently, there are no existing mandates to provide data collection of school health services information in Virginia schools.

Data regarding general school health services, including the potential financial impact and student outcomes, is limited due to the lack of a requirement that school divisions report such data to DOE. During the 2022 Virginia General Assembly, Senator Kiggans introduced SB704 to allow for the collection of health services provided by each school, number of students with chronic health conditions, the percentage of students with health services written in their record, the number of visits to the school health office and dispositions, staffing levels of school health personnel and other information deemed necessary but the House Subcommittee recommended continuing to 2023 by a voice vote.

The Virginia Department of Education has requested for school divisions to voluntarily report their school health data, by June 30th of this current 2021-2022 school year. Virginia has 132 school divisions but only 90 (68%) reported data to VDOE for the 2020-2021 school year. In 2021, Virginia schools reported 207,850 students having a primary health care provider (A primary care provider is a main doctor or provider who manages most of the student's medical issues. Students go to their primary care provider for their yearly physical exam and preventive health care. A primary care provider can be a physician, physician assistant (PA), or nurse practitioner (NP).) and 118,226 students reported having a primary dental provider (A primary dental care provider manages most of the student's dental needs / issues. A student's primary dental care provider is responsible for delivering services to meet the student's dental care needs.) School nurses help link students to medical and dental homes and empower them to manage their conditions. School nurses are often the only regular healthcare provider some students see and not all Virginia school divisions employ a school nurse.

As school buildings remained closed during 2020-2021, many students missed their school based therapy interventions and were unable to obtain needed health care. School based therapy interventions support a child's ability to participate and be successful in school.

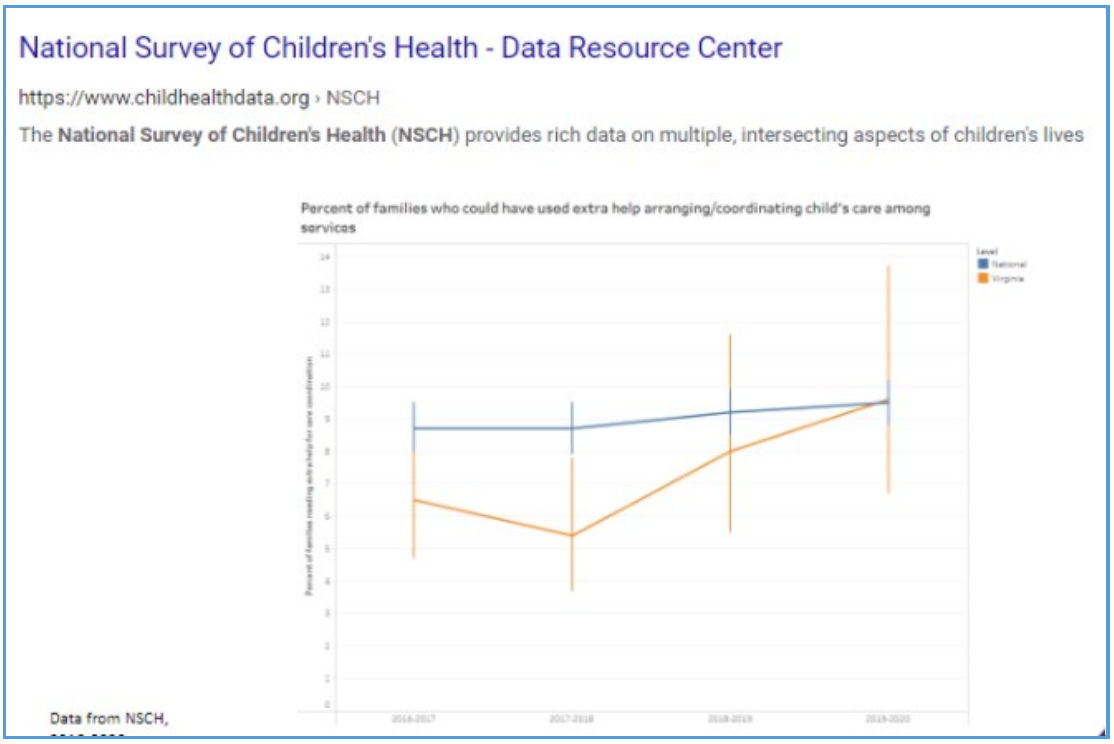


	GREATLY DECREASED	DECREASED	NO CHANGE	INCREASED	GREATLY INCREASED	TOTAL	WEIGHTED AVERAGE
(no label)	23.12% 46	38.19% 76	12.06% 24	16.58% 33	10.05% 20	199	2.52

Data collected by the NSCH suggest Virginia families need extra help arranging or coordinating their child's care among services. This is slightly higher than the national average. The impact of the decrease in the utilization of intervention services in the school setting due to virtual learning will continue to affect student health for years to come, VDH and VDOE continue to encourage school nurses to coordinate with community resources to address social determinants of health and promote physical health, academic achievement, social-emotional health, and advocate for students safely returning to schools. School nurses have been instrumental in students safely returning to in person learning during the pandemic.

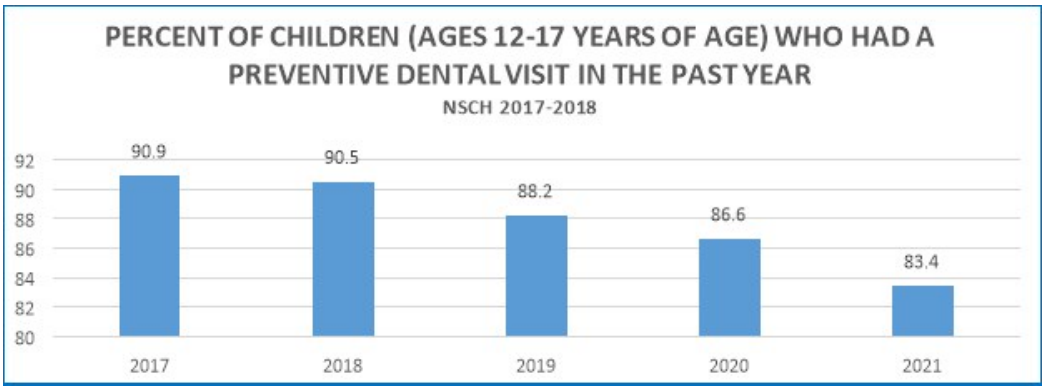
The Commonwealth of Virginia School Entrance Health Form (MCH213G) was revised in October 2020. The revision of the 2014 School Entrance Health Form was a cross collaboration between VDOE, AAP and VDH Division of Immunization, Community Health Services, and School Health. The School Entrance Health Form (MCH213G) is a tool for health care providers, school nurses, schools, and families to assess a child's readiness for school (NOM 13) and to support and

improve a student's academic achievement and school success. Updates to the form included health information, screenings, developmental readiness and the ACIP recommendations for school required immunizations. The school entrance physical requirement for a student enrolling in elementary school for the first time provides information to school divisions that, without the physical requirement, may have failed to be noticed by parents/guardians or school staff. The MCH213G form was made available to Virginia families, schools and healthcare providers in English and Spanish in October 2020. The VDH School Health Website provides an online fillable form option for healthcare providers and families.



PRIORITY 4: Oral Health

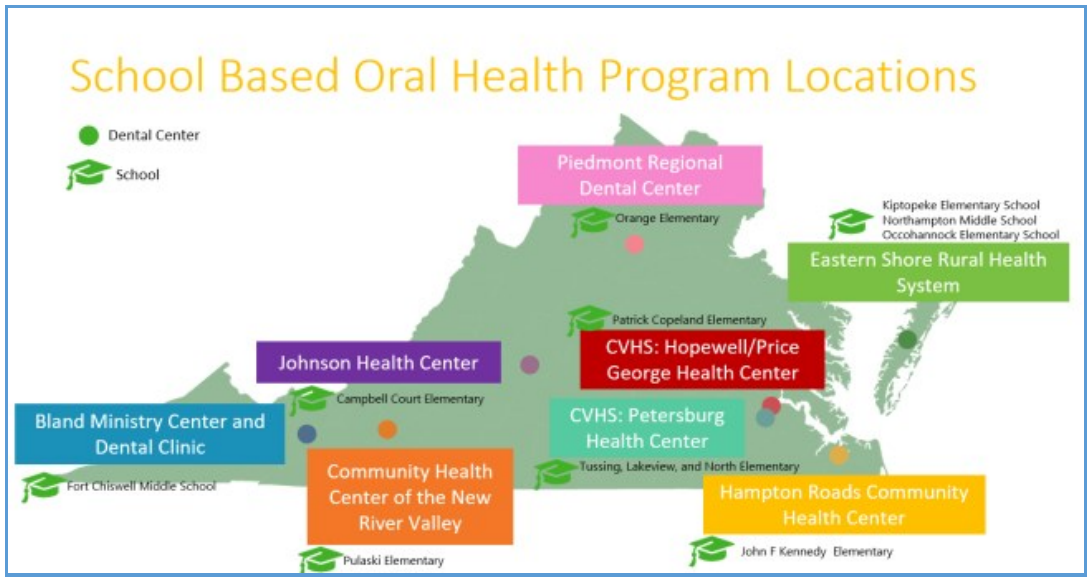
OBJECTIVE	By June 30, 2025, increase the percentage of children, ages 12-17, who had a preventive dental visit in the past year from 88.2% (NSCH 201) to 93.5%
PERFORMANCE MEASURE	NPM 13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.
Evidence-based or –informed strategy measures	ESM 13.2.1: Oral Health Collaborative Project links dental safety net clinics to school nurses for oral health integration.



Strategy 1: Continue cross collaboration with school-based oral health programs.

This program is a cross collaboration between school divisions, school nurses, Virginia Health Catalyst, Virginia Department of Health and Virginia Department of Education. Schools in underserved communities were selected to participate in this school based oral health program. A cohort of school nurses was established and received specialty technical training during the Summer Institute for School Nursing 2021 conference. In 2021, 17 school nurses agreed to participate in the program and coordinated eight dental-safety net clinics. The Oral Health Collaborative Project linking dental safety net clinics to schools, a school-based oral health safety net clinics program, was established in Hopewell, Petersburg, Colonial Heights, Orange, Culpepper, Bland, Giles, Lynchburg, and Pulaski counties.

Due to COVID-19, most of the clinics, except for 1, started caring for students in January 2022. Unfortunately, no students were seen from Oct 1, 2020, to Sept 20, 2021, through the school based oral health program. New River Valley began to see students in the late fall of 2021. This program continues to provide ongoing technical assistance to school nurses for school based oral health programs. Future plans are to expand the number of students that receive oral health care in the school setting by adding additional cohorts and continuing to support existing cohorts Please see the image below.



ADOLESCENT HEALTH DOMAIN
FY23 APPLICATION YEAR
The following programmatic strategies and activities will continue as methods to advance and improve outcomes in each of the identified priority areas.

PRIORITY 1	Reproductive justice and support: Promote equitable access to choice-centered reproduction-related services
OBJECTIVE	Reduce the rate of mistimed pregnancies from 25.3% (PRAMS 2018) to 21.8%
OUTCOME MEASURE	SPM4: Pregnancy Intention: Mistimed or unwanted pregnancy (wanted to become pregnant late or never)

Strategy 1: Implement evidence-based comprehensive sexual education in areas of the state with disproportionately high rates of teen pregnancy and low access to sexual health information; Advocate for policy change that requires sex education in Virginia to be medically accurate, comprehensive, inclusive, and required

Title V funds will continue to be used to support comprehensive sex education program at its three community partner agencies, ultimately serving 960 youth.

Strategy 2: Assure Resource Mothers staff are trained in the Growing Great Kids curriculum, a skills-driven program designed to promote healthy child development and strengthen protective factors for families in a home visiting setting, and increase capacity of youth-serving agencies to implement AIM4TM, an evidence-based pregnancy prevention program designed for parenting teens

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 GGK training and one AIM4TM training in either the online or in-person format.

Strategy 3: Local Health District (LHD) Strategy: Conduct community/environmental scan and gap analysis regarding adolescent reproductive health –assessing community, public and private partners that provide outreach, education, and appropriate reproductive health services to adolescents

LHDs that working on efforts within this strategy will receive ongoing TA from Title V and MCH Epidemiology Teams to develop, expand, and strengthen the district capacity to serve the reproductive health needs of the adolescent population.

PRIORITY 2	**Mental Health**
OBJECTIVE	By June 30, 2025, decrease the rate of hospitalization for nonfatal injury per 100,000 children ages 10 to 19 from 182. 6 (HCUP – State Inpatient Databases (SID) 2015) to 124.79
PERFORMANCE MEASURE	NPM 7.2: Rate of hospitalization for non-fatal injury per 100,000 children, ages 10-19
Evidence-based or –informed strategy measures	ESM 7.2.1 – Number of gatekeepers trained in the prevention of suicide among youth.

Strategy 1: Provide suicide prevention trainings to processionals interacting with youth and adolescents

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 will continue its work in expanding the reach of the SPIAG to assist in identify additional partners in suicide prevention efforts.

Activity	Completion Dates	Responsible Staff
Coordinate Suicide Intervention Skills Trainings at campuses, schools, and disparate population gatekeeper organizations statewide	10/2022 – 9/2023	James Madison University; Suicide and Violence Prevention Coordinator
Contract with American Association of Suicidology to coordinate 3 "Recognizing and Responding to Suicide Risk" trainings	10/2022 – 9/2023	James Madison University
Expand the roster of SPIAG enrollment to include MCH Title V partners	10/2022 – 9/2023	VDH Suicide and Violence Prevention Coordinator

PRIORITY 3	**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)**
OBJECTIVE	By June 30, 2025, increase the proportion of adolescents, ages 12-17, in Virginia who are engaged in transition services to adult health care from 11.6% (NSCH 2017-2018) to 14.2%
PERFORMANCE MEASURE	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
Evidence-based or –informed strategy measures	ESM 12.2: Percentage of Virginia school divisions reporting into the VDOE school health data system

Strategy 1: Provide resource and professional development opportunities to school nurses
Strategy 2: Maintain data capacity for school health immunization data

Expand and empower the school nurse workforce by continuing to advocate for a school nurse in every public school in Virginia and mandatory school health data collection. Continue to provide training and professional development opportunities to school nurses by offering monthly zoom meetings for all school nurses and quarterly meetings with school nurse coordinators. These meetings will continue to provide school health updates, resources, guidance, mental health resources and programs, opportunities for school based oral health programs, immunization data collection analysis and education, and professional development opportunities for all school nurses. Establish and Implement school health programs designed to increase vaccination rates, provide oral health services and address social determinants of health. Maintain partnerships and continue cross collaboration with VDH Division of Immunization, Community Health Services, and Division of Epidemiology, Medical Reserve Corp (MRC), Local health Departments, Virginia Department of Education (VDOE), Virginia Chapter of the American Academy of Pediatrics (VA AAP), Virginia Health Catalyst and Delta Dental, Virginia HPV Immunization Taskforce (VHIT), Virginia Department of Health Office of Family Health Services Division of

Reproductive Health, Virginia Department of Health Injury and Prevention, Immunize VA, Project Hope, Children's Hospital of Richmond, and the Virginia Association of School Nurses.

PRIORITY 4	Oral Health
OBJECTIVE	By June 30, 2025, increase the percentage of children, ages 12-17, who had a preventive dental visit in the past year from 88.2% (NSCH 201) to 93.5%
PERFORMANCE MEASURE	NPM 13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.

Strategy 1: Continue cross collaboration with school-based oral health programs

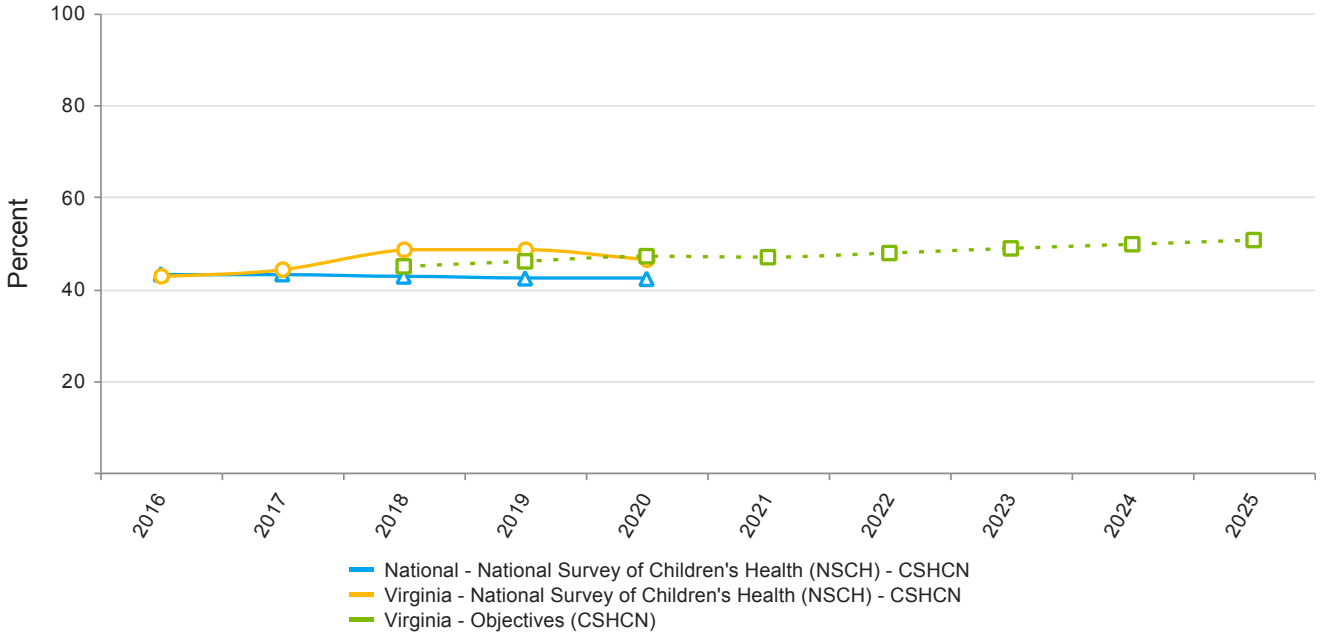
(See above)

Children with Special Health Care Needs

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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		44.9	46	47.1	46.9
Annual Indicator	42.7	44.2	48.4	48.6	46.4
Numerator	167,058	172,978	188,625	174,804	155,562
Denominator	391,428	391,467	389,683	360,019	335,140
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	47.8	48.8	49.7	50.6

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					
	2017	2018	2019	2020	2021
Annual Objective	25	100	250	400	40
Annual Indicator	0	0	0	37	49
Numerator					
Denominator					
Data Source	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	45.0	50.0	55.0	60.0

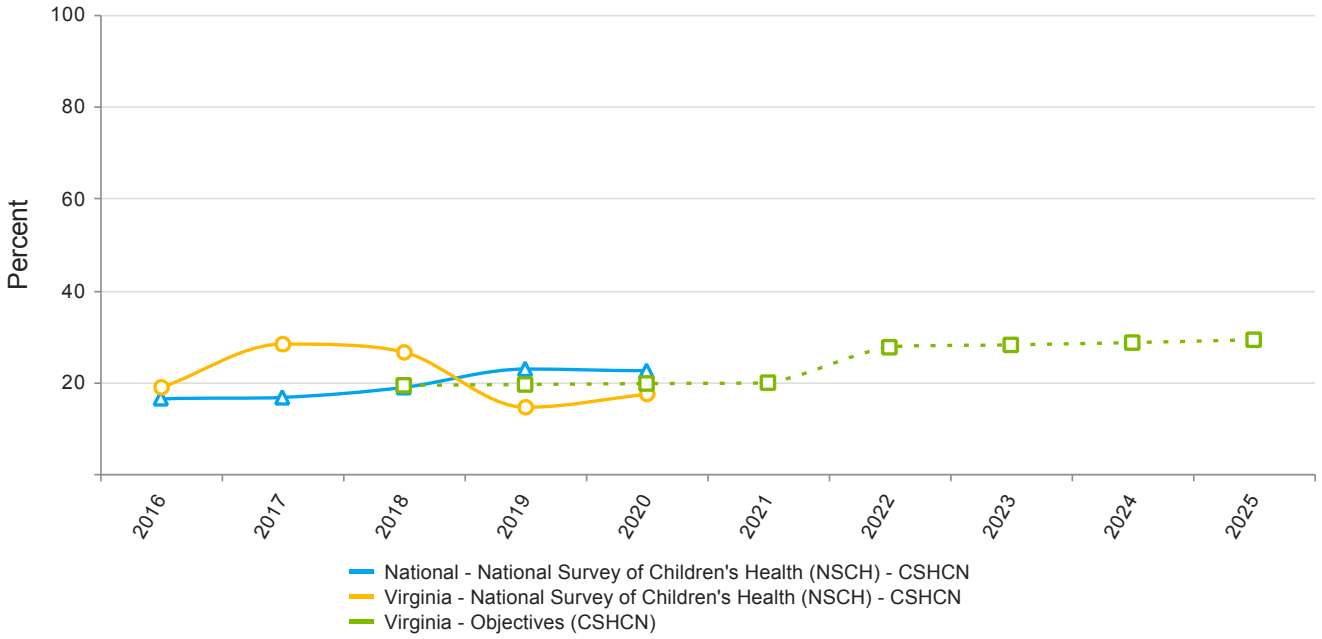
ESM 11.2 - Percentage of children served by the VA CYSHCN Program who report having a medical home

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	90	91.5	93	94.5	96
Annual Indicator	98.9	96.8	99	96	95.4
Numerator	4,391	4,239	4,788	5,490	3,348
Denominator	4,439	4,377	4,835	5,719	3,508
Data Source	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	97.5	98.0	99.5	99.5

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services 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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		19.3	19.5	19.7	19.9
Annual Indicator	18.8	28.1	26.5	14.5	17.4
Numerator	31,194	48,657	47,355	22,590	23,724
Denominator	166,277	172,958	179,018	155,964	136,302
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	27.6	28.1	28.6	29.2

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	25	100	250	400	40
Annual Indicator	0	0	0	45	49
Numerator					
Denominator					
Data Source	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Provisional	Final	Final	Final

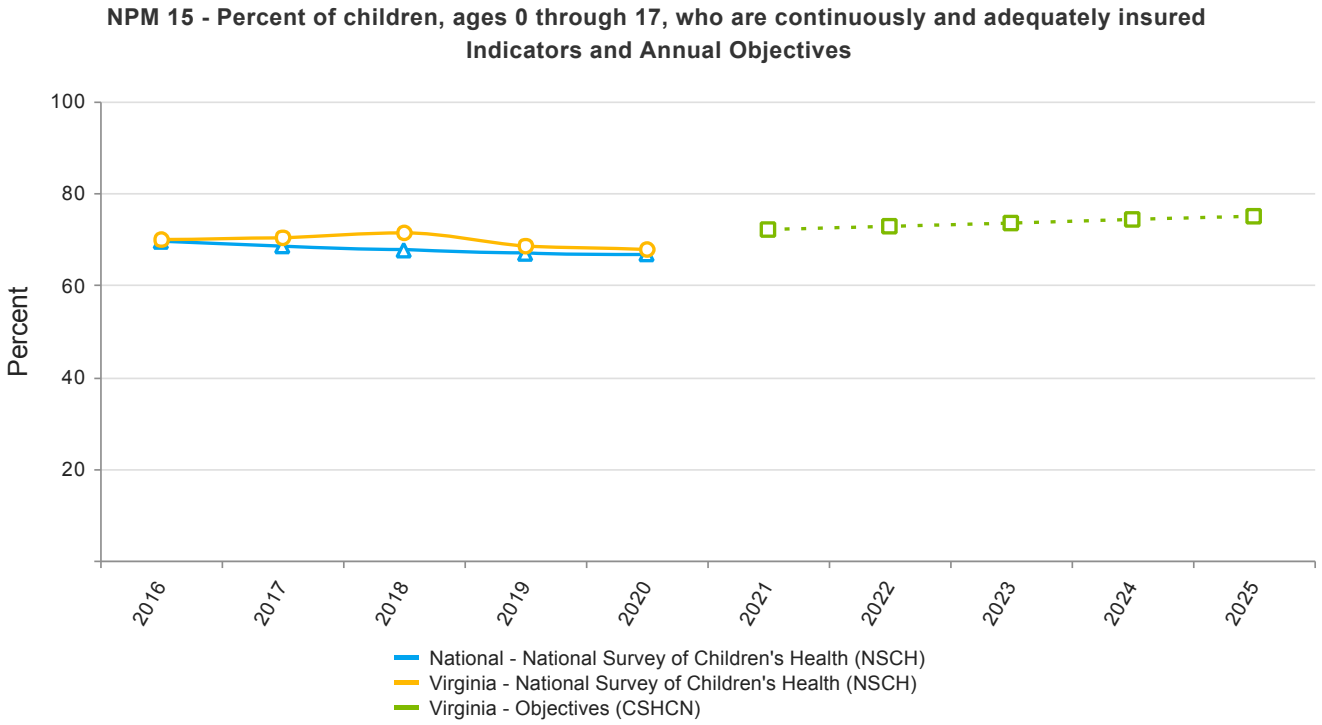
Annual Objectives				
	2022	2023	2024	2025
Annual Objective	45.0	50.0	55.0	60.0

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			75
Annual Indicator		68.2	68.2
Numerator		90	90
Denominator		132	132
Data Source		VDH and VDOE School Health Nurse Documentation	VDH and VDOE School Health Nurse Documentation
Data Source Year		2020	2020
Provisional or Final ?		Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	77.0	79.0	81.0	83.0



NPM 15 - Children with Special Health Care Needs

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2019	**2020**	**2021**
Annual Objective			72
Annual Indicator	71.2	68.5	67.7
Numerator	1,323,014	1,274,181	1,257,254
Denominator	1,857,510	1,859,679	1,856,744
Data Source	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020

State Provided Data			
	2019	2020	2021
Annual Objective			72
Annual Indicator	71.3	66.9	62.9
Numerator			
Denominator			
Data Source	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	72.7	73.4	74.2	74.9

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Inactive - Completed		
State Provided Data			
	2019	**2020**	**2021**
Annual Objective			40
Annual Indicator			550
Numerator			
Denominator			
Data Source			VDH CYSHCN Program, VA DMAS
Data Source Year			2021
Provisional or Final ?			Final

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:	Inactive - Completed		
State Provided Data			
	2019	**2020**	**2021**
Annual Objective			3
Annual Indicator			6
Numerator			
Denominator			
Data Source			VDH CYSHCN Program
Data Source Year			2021
Provisional or Final ?			Final

ESM 15.3 - Increase percentage of uninsured children served by Child Development Clinics (CDCs) who are referred to Medicaid (if eligible) and/or other financial resources

Measure Status:	Active		
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	94.0	96.0	98.0

State Performance Measures

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			100
Annual Indicator		100	100
Numerator		4	5
Denominator		4	5
Data Source		CYSHCN Program Documentation	CYSHCN Program Documentation
Data Source Year		2020	2021
Provisional or Final ?		Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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 50.6%	
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

Seek new partners and continue to promote the online training modules for healthcare providers and families to educate them on the importance of healthcare transition (including those with special health care needs)

Assure youth with special health care needs receive the services necessary to make transitions to all aspects of adult life (including adult health care, work, and independence) through referrals to adult providers, utilizing transition tools when appropriate (CYSHCN National Standard: Transition to Adulthood)

Utilize Division of Population Health Data epidemiologists and state family delegate to administer transition survey statewide (Standard: Got Transition's Six Core Elements of Health Care Transition - Transition Completion & Youth and Family Engagement)

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

Assure families of children with special health care needs will have adequate private or public insurance, or both, to pay for the services they need (CYSHCN National Standard: Insurance & Financing)

Assure families of children with special health care needs partner in decision making at all levels, and are satisfied with the services they receive (CYSHCN National Standard: Family Professional Partnerships/Cultural Competence)

ESMs	Status
ESM 15.1 - Number of Managed Care Organizations (MCO) and Care Connection for Children (CCC) Care Coordinators that attend statewide meeting	Inactive
ESM 15.2 - Number of Managed Care Organization (MCO) and Care Connection for Children (CCC) regions that commit to partnering with each other to reduce barriers	Inactive
ESM 15.3 - Increase percentage of uninsured children served by Child Development Clinics (CDCs) who are referred to Medicaid (if eligible) and/or other financial resources	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 that annually demonstrate active incorporation of family engagement (i.e., Care Connection for Children, Child Development Centers, Bleeding Disorders Program, Sickle Cell Program)

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 HEALTH CARE NEEDS DOMAIN
SUMMARY/OVERVIEW
FY21 ANNUAL REPORT

CYSHCN PROGRAM DESIGN AND OVERVIEW

The VDH, Children with Special Health Care Needs (CSHCN) 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 CSHCN (as described in the national standards). The Virginia State Plan for CSHCN 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 issued Request for Proposals (RFPs) and the agency is in final negotiations with contractors. The goal is to have agreements in place by the beginning of FY23. This service was one of the former Governor of Virginia's budget priorities and is supported by 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 CSHCN 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 CSHCN programs include the Care Connection for Children, Sickle Cell, and Bleeding Disorders programs. The Child Development Center program is included but it provides assessments of any child suspected of having a developmental and/or behavioral condition. Due to the size and complexity of the Virginia Newborn Screening System, it has its own manager and functions in partnership with the CSHCN program (both programs fall under the Division of Child and Family Health along with Title V). To maximize federal funding and facilitate linkages to care, most CSHCN efforts are provided in partnership with major health care systems and universities. **In FY21, the CSHCN program served approximately 6,412 families.** This represents a decrease in service level from FY20 (6613) that is mostly due to COVID restrictions. Our goal is to eventually return to pre-COVID levels of service (7498).

Care Connection for Children (CCC)

The CCC program is a statewide network of six regional centers of excellence that provide care coordination services to reduce barriers that families face when trying to access care. Such services include, but are not limited to:

- Medical insurance benefit evaluation and referral (including Medicaid);
- Linkage to a primary care provider/medical home;
- Referrals to necessary resources and specialty services;
- Family-to-family support via parent coordinators;
- Support from the Virginia Department of Education's (DOE's) state educational consultants and;
- A pool of funds for uninsured or underinsured families with no other means for obtaining life-preserving medications and/or durable medical equipment.

In FY21, the CCC program served 2,740 families.

Child Development Clinics (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 FY21, the CDC program served 2,321 families, resulting in 5,340 diagnoses and 5,484 referrals for additional services.

Virginia Bleeding Disorders Program (VBDP)

The Virginia Bleeding Disorders Program is a legislatively enacted program established by the Commonwealth of Virginia through the Virginia Department of Health, Office of Family Health Services for the care and treatment of persons with hemophilia and other inherited bleeding disorders. Virginia recognizes that the ongoing medical costs of treating such

bleeding disorders often exceed the financial capacity of families, despite the existence of various types of medical and hospital insurance. In order to address the need, the Virginia Bleeding Disorders Program provides a "safety net" for persons with inherited bleeding disorders. The safety net includes:

- Coordinated, family oriented, multidisciplinary services for persons with congenital bleeding disorders;
- A Pool of funds to assist with the purchase of factor and/or supplies and;
- Insurance case management and premium assistance to help keep eligible clients insured.

In FY21, the VBDP served 414 people.

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 23.

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 FY21, the clinics served 937 families.

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 previous Governor), and the drafting/implementation of state regulations (https://law.lis.virginia.gov/admincode/title12/agency5/chapter191/section340/[1]). By the end of FY 21, the documents were drafted to solicit proposals for applications.

STATE ACTION PLAN UPDATES

PRIORITY 1: Strong systems of care for all children: Strengthen the continuum supporting physical/socioemotional development (i.e., screening, assessment, referral, follow-up, coordinated community-based care) – *Medical Home*

OBJECTIVE	By June 30, 2025, increase the percentage of typical and children with special health care needs served by the VDH CYSCHN Program who can identify a primary care provider as a medical home from 48.4% (NSCH 2017-2018) to 50.6%
OUTCOME MEASURE	NPM 12 - Percent of children with and without special health care needs having a medical home12

Strategy 1: Work closely with community partners and Virginia's CYSHCN centers (i.e. Care Coordination for Children Centers, Child Development Centers, Virginia Bleeding Disorders Program sites, Sickle Cell Program sites) to promote the online training module for health care providers and families to educate them on a comprehensive care approach to provide a medical home for children (including those with special health care needs)

Activity	Expected Completion Date	Responsible Staff
Renew contract with UVA	7/1/21	Marcus Allen (CSHCN Director)
Hold quarterly meetings with UVA to encourage promotion of the resource and discuss any updates that need to happen	Quarterly	Marcus Allen with Jennifer MacDonald
Continue to communicate with partners to promote the modules	Ongoing	Marcus and UVA
Follow up with Florida Title V regarding their desire to partner with VDH on the modules and make a final decision on partnership	6/30/21	Marcus, UVA, Florida Title V/CYSHCN
Gather any evaluation data or feedback from UVA about the modules	by 6/30/21	VDH & UVA
Tracking of people who complete the modules	by 6/30/21	VDH & UVA

The transition and medical home modules were launched in the fall of 2019 after more than two years of development. Staff renewed the contract with the University of Virginia (UVA) to continue this work. During FY 21, we held meetings with UVA throughout the year to receive updates. It is important to note that this specific module is part of a suite of training programs that includes transition, breastfeeding, newborn screening blood spot, critical congenital heart disease and Early Hearing Detection and Intervention. During state fiscal year 21, UVA reported an enrollment of 20 people for the *Medical Home for Youth and Family* module and 43 people for the *Medical Home for Healthcare Providers* module.

CYSHCN and UVA staff had several meetings with Florida to discuss the possibility of partnering. After much discussion, Florida decided to pursue a different strategy. UVA shared that they promote our modules through various mechanisms that include emails to providers who have completed their trainings (not just transition and medical home). UVA also stated that they have plans to update the modules.

Strategy 2: Assure children with special health care needs receive coordinated, ongoing, comprehensive care within a medical home (*CYSHCN National Standard: Medical Home*).

Activity	Expected Completion Date	Responsible Staff
Partner with family-identified medical home to coordinate care for CYSHCN served through CCCs, CDCs, SCPs, and Bleeding disorders programs	Ongoing	Marcus, Shamaree
Partner with family-identified medical home to coordinate entry into specialty care for newborns with a positive hemoglobinopathy screening.	Ongoing	Shamaree
All CYSHCN programs will continue to promote medical home and help families find one if needed	Ongoing	Marcus, Shamaree
All programs will help to promote the medical home module to families once they have been created and they will be asked to promote the modules within their health systems as a whole.	Ongoing	Marcus, Shamaree, center partners
Partner with state and National AAP to promote fact sheet for pediatricians on the National Survey of Children's Health. Virginia will be the first state to pilot this. The document focuses on medical home	by 6/30/21	Marcus & State/National AAP
CDC program will continue to work with the Virginia Department of Medical Assistance Services (DMAS) and MCOs on any reimbursement issues related to services it provides on behalf of VDH	Ongoing	Marcus, DMAS, MCOs, CDCs

As a unit, the CYSHCN team continued to require that all of its programs include work plan language regarding promoting the importance of a medical home to all families served. Centers are expected to connect families to a medical home, if they don't have one. The CCC Program continued to work directly with primary care and specialty care providers to provide care coordination services to families and help link them to services as needed. The program helped to obtain prior authorizations; explained health insurance/benefits to families; linked families to sometimes hard to find durable medical equipment providers; helped families to obtain medications that are often life preserving and helped families to overcome any barriers that made it difficult for the child with special needs to get services.

The CDC program continued to serve as a resource for providers and families and provided assessments of children suspected of having developmental and/or behavioral conditions. Diagnoses and final reports were shared with medical homes (with permission from each family) and short term care coordination was provided to link families to services. Due to insurance requirements and waiting periods for service, most clinics encourage families to seek support from their medical home first unless the referral is generated by the medical home. Children who do not have a medical home are connected to one. During FY 21, COVID caused significant setbacks to the program but all were up and running by the end of the fiscal year, with certain precautions. This program is critical. Title V funding helps to support services statewide and partners are expected to use the revenue that they earn to help sustain the program. It serves as an invaluable resource to medical home providers who need assistance regarding evaluating patients for developmental/behavioral conditions.

The VBDP and Pediatric Comprehensive Sickle Cell Centers continued to partner with medical homes to coordinate care in partnership with families[2]. For the sickle cell centers, they have discussions regarding the need for a medical home at initial visit and thereafter. Families are educated on the importance of having well visits, including staying up to date on vaccines.

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 CYSCHN and their families *(CYSHCN National Standard: Easy to Use Services and Supports / Care Coordination)*

Activity	Expected Completion Date	Responsible Staff
Conduct subrecipient monitoring to ensure partners meet required service levels for providing care coordination and other similar services.	Ongoing	Marcus and Shamaree
Maintain infrastructure for centralized data system (CCC-SUN) for use by statewide CCC staff to track and document case management and care coordination services, insurance type, pool of funds, and I&Rs.	Ongoing	Marcus
Collaborate with CCC Directors to encourage staff to become and maintain certifications as case managers	Ongoing	Marcus
Convene center director/consultant meetings to provide technical assistance and troubleshoot issues. Staff will make annual site visits (when possible and after COVID) and/or offer technical assistance via phone or email.	Ongoing	Marcus and Shamaree
CDC program will continue to provide assessments of children throughout the state of Virginia suspected of having developmental and/or behavioral conditions. Once diagnosed, the results will be shared with the medical home (with permission from the family) and children will be referred for services.	Ongoing	Marcus, CDC centers
CYSHCN program will continue to promote telehealth and support the CDC centers as they provide services remotely. Regular calls will be held statewide with centers to encourage teamwork in working to overcome barriers to telehealth and to deal with any other program struggles.	Ongoing	CDC Centers
Sickle cell centers will continue to offer satellite clinics as capacity allows, as well as telehealth services. These off site clinics in two regions of Virginia and telehealth services during the pandemic improve access to care for families.	Ongoing	Shamaree, Sickle cell centers
Southwest Virginia CCC will continue to support onsite telehealth services for families in partnership with UVA.	Ongoing	SWVA CCC staff and UVA

The CYSHCN program in Virginia partners very closely with major medical centers across the state. Contractual partners include: Children's Hospital of the King's Daughters in the tidewater region, the University of Virginia Health System in the blue ridge region, Carilion Health System in the Roanoke/southwest region, INOVA Health System and Children's National Medical Center in the northern region, Virginia Commonwealth University Health System in the central region and a partnership with James Madison University in the Shenandoah region. 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 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.

During the past fiscal year, the CYSHCN program maintained all of its critical relationships despite struggles regarding COVID and increasing center personnel costs. The CCC program database was upgraded to function in Chrome and Microsoft Edge. This was not a simple process and involved extensive testing and communication to work out any bugs. The change protects the security of the database and helps to keep it functioning optimally.

Telehealth and other methods of communication were heavily used. The CDC program did some developmental/behavioral assessments via telemedicine because COVID limited personal interaction. In fact, several clinical partners mentioned that they can sometimes observe children better in their home environment. There is less anxiety and the children don't often realize they are being observed. Telemedicine also saves parents time and money as they can avoid paying bus fare or the cost of gas to travel to appointments.

Specifically, our CCC center in SWVA continued to offer several clinics via telemedicine. They even accommodated families in person at their physical location when they had issues with reliable internet access. Staff connected with the University of Virginia virtually from a private clinic room in the local health department with specialists more than 3 hours away.

The CYSHCN program director continued to have regular director's meetings with CCC partners and offered technical assistance on budget issues and staffing issues. This has led to two centers taking more of an active role in paying for services. The director also maintained communication with CDC leadership and this helped centers to share lessons learned regarding telemedicine and using evidenced based assessment tools.

During FY 21, the sickle cell centers and hemophilia treatment centers conducted in-person and telehealth appointments. Despite telehealth appointments, centers saw an increase in their no-show rate due to COVID-19. Many patients canceled their appointments and did not reschedule. Some of the sickle cell centers provided a "Day Hospital" to ensure continuity of care in hopes of avoiding hospital admissions. The "Day Hospital" treated patients with pain or fever in the clinic during normal business hours. If patients presented to the emergency room during normal business hours, they were transferred to the "Day Hospital" if appropriate.

One of the sickle cell centers moved, which now allows for more continuity of services. They are located in the same building as the adult hematologist and have the ability to conduct transcranial doppler (TCDs) during comprehensive visits. This is more convenient for families and improves the overall compliance rate. During the comprehensive clinics, patients meet with the provider and nurse educator. If needed and available, patients meet with the social worker, psychologist, and education consultant.

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.
In FY 21, there were discussions about having a satellite clinic for the Southwest Virginia population. Resources are limited in that area and the nearest hemophilia treatment center could be more than two hours away, one way.

PRIORITY 2: Strong systems of care for all children: Strengthen the continuum supporting physical/socioemotional development (i.e., screening, assessment, referral, follow-up, coordinated community-based care) – *TRANSITION*

OBJECTIVE	By June 30, 2025, increase the percentage 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
OUTCOME MEASURE	NPM13: 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

Strategy 1: Work closely with community partners and Virginia's CYSHCN centers (i.e. Care Coordination for Children Centers, Child Development Centers, Virginia Bleeding Disorders Program sites, Sickle Cell Program sites) to launch two sets of training modules for health care providers and families on a comprehensive care approach to healthcare transition

Please see narrative provided under the Medical Home narrative as the project encompasses both priorities.

Strategy 2: 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)*

Activity	Expected Completion Date	Responsible Staff
Through CCCs, facilitate transition from child to adult-oriented health care systems (e.g. transition planning tools, educational plans).	Ongoing	Marcus
Partner with the Comprehensive Sickle Cell Centers to ensure that all transition-age patients complete the American Society of Hematology transition readiness assessment tool or a similar tool/process.	Ongoing	Shamaree
Partner with funded hemophilia treatment centers to ensure the transition process from pediatric to adult treatment centers (e.g. biannual transition calls between regional hemophilia treatment centers and the state's only comprehensive adult treatment center; development of transition plan of care).	Ongoing	Shamaree
Encourage all CYSHCN programs to promote the transition and medical home community/family modules and provider modules	Ongoing	Marcus, Shamaree, UVA development team

The CCC program continued to use its program specific transition tool. This tool helps families prepare their child with special needs to transition clinically, socially, educationally, and vocationally. All CYSHCN programs are expected to support VDH in promoting the online transition modules 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. The[3][VP4][VP5] sickle centers continued to work on finding adult providers willing to receive transitioning sickle cell clients. The funding for the adult centers will help alleviate some of the struggle with transition for this population. The social worker continued to work with transition-age patients and their families to help them

identify and understand areas of their life that are affected by their disease as they approach adulthood. For FY 21, one of the bleeding disorders' centers reopened an adult comprehensive program. Prior, there was only one adult comprehensive HTC part of the VBDP. The reopening of the adult comprehensive program will address an underrepresented, underserved population.

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*)

Activity	Expected Completion Date	Responsible Staff
Address youth/family engagement component of HCT assessment by ensuring onboarded youth advisors receive training about the 6 Core Elements.	After staff hired	Maddie (support from Marcus and Carla)
Engage youth advisors and parents (including engaging Family Delegate, VDH youth advisors, KASA, Family-to-Family, Virginia Board for People with Disabilities, etc.) in program development.	End of FY 2021	Maddie, Marcus, Carla, Shamaree
Task youth advisors with engaging state and community partners (e.g. go out and build partnerships with KASA, etc.)	Ongoing	Maddie (support from Marcus and Carla)
Address transition completion component of HCT assessment by developing and implementing HCT feedback survey for all CYSHCN programs.	Ongoing	Marcus, Carla, Meagan, Maddie, Shamaree
Following module launch event, brainstorm with Medical Neighborhood team on promoting medical neighborhood concept (including medical home and transition policy, tracking and monitoring, readiness, planning, and transfer of care).	Ongoing	Marcus, UVA, Carla, Shamaree
Engage partners (e.g. Family Delegate, KASA), youth advisors, and families in encouraging others to complete modules.	Ongoing	Marcus, Maddie, Carla

During FY21, the CYSHCN staff consulted with the Virginia MCH hired youth advisors regarding our healthcare transition survey. The advisors provided constructive feedback on the survey draft and were involved in team decision making. VDH was fortunate enough to hire an exceptional MCH Epidemiology Lead and he took over planning for the implementation of the survey with support from the team (including the CYSHCN Director). Much of this work spanned FY21 and FY22 reporting years. The survey has been loaded into RedCap and is ready to be implemented. VDH's MCH Family Delegate stated that many people are experiencing survey fatigue and she has found that incentives are often helpful. VDH accepted this recommendation and obtained leadership approval to offer a small financial incentive to people who complete the survey. The MCH Lead Epidemiologist is taking the lead on this to assure that survey participants receive their incentive. Our goal is to survey 200 people. Those who complete the survey will get a $5 electronic gift card[6].

Strategy 4: 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)*

Activity	Expected Completion Date	Responsible Staff
Maintain paid parent coordinators and/or promote family involvement at CCC centers to provide support and resources to families served.	Ongoing	Marcus
Assure CYSHCN centers identify and address family barriers, priorities, and concerns (e.g. sickle cell psychosocial assessments) while promoting family engagement in decision-making at all levels of care planning and management (e.g. IEPs, 504 plans, home management of bleeding disorders).	Ongoing	Marcus, Shamaree
Solicit, document, and respond to family feedback on satisfaction with services (e.g. bleeding disorders family satisfaction survey every other year, CCC parent survey every 5 years).	Ongoing	Shamaree, Marcus
Empower and equip populations impacted by sickle cell and bleeding disorders to manage complexities of the disease through various community support and education activities/programs (e.g. youth transition camp, faith-based outreach).	Ongoing	Shamaree
CYSHCN programs will continue to partner with the VA Department of Education (DOE) to support families utilizing the expertise of educational consultants.	Ongoing	All Programs

The CYSHCN Program Director continued to encourage Care Connection for Children (CCC) centers to employ parent coordinators as staff. Maintaining such staff has been difficult because personnel costs have increased drastically statewide. Most of the parent coordinators who are employed have a child with a special health care need so they understand the unique challenges families face. In addition to providing general support to families, parent coordinators in various regions across the Commonwealth work to: maintain center resource lists; create newsletters; lead educational activities and trainings; and work closely with families on overcoming barriers to care.

Another one of our core programs, the Child Development Clinics (CDCs) also actively engaged families. The CDCs continued to provide assessments of children suspected of having developmental and/or behavior conditions. Families are an active part of the assessments that are done and they receive documentation regarding diagnoses. In addition, center staff members refer them to clinical and non-clinical resources for assistance and share the results of their assessments with other providers serving the family (with permission).

The Virginia Bleeding Disorders Program (VBDP) and the Sickle Cell Program (SCP) continued to have a number of programs/events to support families in decision[7] making at all levels. The VBDP educated families on home therapy management for those who infuse at home. One hemophilia treatment center worked with local rural pediatricians to gain access to care for patients. VBDP also sent out the national patient needs assessment to all patients and family members who had been seen in the past year. The SCP centers offered genetic counseling to aid in future reproductive decision making. Many of the events were either postponed or held virtually. Social workers continued to send out pertinent information for families as topics arose 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*.

PRIORITY 3: Finances as a root cause: Increase the financial agency and well-being of MCH populations

OBJECTIVE	By June 30, 2025, increase the proportion of children with special healthcare needs in Virginia who are continuously and adequately insured from 71.3% (NSCH 2017-2018) to 74.9%
OUTCOME MEASURE	NPM 15 - Percent of children, ages 0 through 17, who are continuously and adequately insured.

Strategy 1: Assure families of children with special health care needs will have adequate private or public insurance or both to pay for the services they need *(CYSHCN National Standard: Insurance & Financing)*

Activity	Expected Completion Date	Responsible Staff
Through CYSHCN programs, conduct medical insurance benefits evaluation and coordination, to include identifying potential Medicaid-eligible families, providing assistance with applying, and providing ongoing education and support to access covered services.	Ongoing	Marcus, Shamaree
Work towards strengthening relationship with DMAS/MCOs and health systems by exploring opportunities for shared financing to sustain and expand services.	Ongoing	Marcus
Administer a Care Connection for Children pool of funds for payment of direct medical care services for the uninsured and underinsured clients.	Ongoing	Marcus
Administer a bleeding disorders pool of funds for payment of direct medical care services for the uninsured and underinsured clients.	Ongoing	Shamaree
Manage an insurance case management contract (PSI) to help assure people with bleeding disorders have ongoing access to insurance.	Ongoing	Shamaree
Continue to encourage social work support at the VBDP and SCP centers across the state	Ongoing	Shamaree
Plan and hold a meeting between VDH CCC care care coordinators and MCO care coordinators regarding working together to eliminate barriers families face to care and with Medicaid insurance. At the meeting, the VDH Title V Director will share the results of the agency needs assessment. She will also help facilitate a discussion with the CYSHCN director regarding efforts that can be made to address concerns about transportation, health equity, recreational opportunities, and transportation needs.	By September 2021	Marcus, Carla, DMAS staff (Virginia Medicaid agency)
The Virginia Bleeding Disorders program will conduct a needs assessment in partnership with Virginia Commonwealth University (VCU) to evaluate the extent to which the program serves its target population and is maximizing the funding based on changes in healthcare and treatment options.	By June 2021	Shamaree and VCU
The CYSHCN director will work with CCC and CDC partners to update each work plan template. A specific focus will be on outreach to underserved and minority populations with a health equity lens.	By June 2021	Marcus, CCC/CDC
VDH will explore a regional meeting in the SWVA area to discuss issues related to developmental/behavioral follow-up services. The proposed meeting would focus on potential solutions to the problem	By September 2021	Marcus, SWVA CDC

The CYSHCN programs will continue to help families struggling with insurance issues by connecting them to public and private options as needed. The CCC program reports that about 93.5% of CYSCHN served are insured and the CDC program reports that 97% are insured. As for the VBDP, 98% 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 Accessia Health (formerly Patient Services Incorporated). Accessia Health will continue to provide insurance case management and premium assistance to help eligible families maintain insurance coverage. Based on the data reported from the centers, 98% of sickle cell patients have private or public insurance. Each center has social work support to help families address insurance needs and as with all VDH CYSHCN programs, families are encouraged to apply for Medicaid if it appears they are eligible.

The expansion of Medicaid continues to be popular in Virginia and has been received well. Program partners continue to support families as they seek to access insurance options. This is critical for all programs but it makes the most difference for young adults transitioning and for people of all ages who have hemophilia. Since implementation of Medicaid expansion, the CYSHCN program has already had a number of clients with hemophilia transition to Medicaid.
VDH will continue to manage a Pool of Funds (POF) for the CCC and VBDP. The POF is the payer of last resort, and helps families purchase needed medications when no other viable options are present, including insurance. The Hearing Aid Loan Bank is located at one of the regional CCC centers and continues to provide gap-filling services to families of children with hearing loss. In addition, the Care Coordination Notebook -- Financing and Managing Your Child's Health Care -- continues to be available, providing an overview of how health insurance works, how to understand and use deductibles and co-insurance- but needs to be updated.

The qualitative portion of the VDH Title V/MCH needs assessment identified that health insurance for health care services for CYSHCN is both an asset and a frustration for families. As documented in the needs assessment report, one of the most significant accomplishments has been the expansion of Medicaid coverage. This has led to more parents being insured, as indicated by a subject matter expert interviewed for the qualitative part of our needs assessment. In other words, healthy insured parents can lead to healthy insured children. However, Virginia still has significant work to do. The qualitative part of our needs assessment also demonstrated that parents struggle to understand their insurance and what it provides. Examples of barriers mentioned included: filling out required paperwork; understanding information about insurance/confusion; being able to access certain medications; language issues; not having insurance at all; and MCO/benefit changes mid-year that at times may disrupt services provided. This is further supported by data from the National Survey of Children's Health that shows that more than 25% of parents state that their insurance is not adequate or they had gaps in insurance. Our CCC program continues to be a very significant support to families when it comes to understanding insurance. Care coordinators actually contact insurers on behalf of clients and even go as far as partnering with Medicaid to provide needed support. At times, this has included finding alternative funding when Medicaid funding is not enough. For example, staff have received grant money to help make a vehicle accessible and to remodel a bathroom to make it usable for children.

In order to promote and further capitalize on the Medicaid relationship, VDH CYSHCN leadership had several meetings with the Virginia Department of Medical Assistance Services (DMAS, Virginia's Medicaid agency). After several discussions, DMAS invited care coordinators from our CCC program to one of their managed care care coordinator's meetings. At the meeting, DMAS and VDH leaders explained each organization's care coordination program to include an example of a family that benefited from the partnership. Call participants were encouraged to continue to work together, even if only informally. According to DMAS, more than 550 people attended the call. VDH held a follow-up meeting with DMAS to explore ways that we can continue to strengthen the relationship. Due to the Public Health Emergency, DMAS did ask to discuss this in more detail at a later time. Staff were overwhelmed with the need to support clients and this was well understood. VDH plans to re-engage with DMAS after the Public Health Emergency expires.

KEY PARTNERSHIPS AND COLLABORATIONS

CYSHCN Public-Private Partnership Network

The CYSHCN program partners closely with major public and private medical centers and universities across the state. Contractual partners include:

Child Development Clinics

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 Clinic, Norfolk, VA: https://csgdocs.com/specialties/developmental-pediatrics/

Virginia Commonwealth University Child Development Clinic, Richmond, VA: https://www.chrichmond.org/Services/Developmental-Pediatrics.htm

Carilion Pediatric Neurodevelopmental Clinic, Roanoke, VA: https://www.carilionclinic.org/specialties/pediatric-child-development

Care Connection for Children

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 Daughters, 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

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 we collaborate with readily refer children to these specialties within their own health system and services are generally offered at the same campus. This similar benefit exists for CYSHCN served through our CCC, CDC, and bleeding disorder programs, at health systems.

In addition, 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. The 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 development of 504 plans and IEPs.

CONSUMER/FAMILY ENGAGEMENT/PARTNERSHIP

The CYSHCN Program works very closely with the MCH Family Delegate for Virginia and will continue to do so. Staff attend and participate in quarterly Department of Education Family Engagement Network meetings (led by the state family delegate and DOE staff) and heavily rely on her for advice. She has been a key senior advisor in the design of a transition survey that the agency plans to implement and will be a key advisor at the table when decisions are made regarding future initiatives (based on the survey results). The CYSHCN Director has accepted an invitation to serve on the Partnership for People with Disabilities Advisory Council, housed at Virginia Commonwealth University. He or one of his senior staff members will attend all meetings (the state family delegate works for this organization). The CCC program will continue to encourage its centers to employ parent coordinators and all programs will continue to enthusiastically engage families to care for children with special needs.

MCH WORKFORCE CAPACITY

The CYSHCN program in Virginia is very large. Ten staff members report to the CYSHCN Program Director but 8 of them work as part of the Care Connection for Children program providing care coordination to clients outside of the VDH central office. This leaves 3 people (including the director) to manage the program statewide (program director, office support specialist, blood disorders coordinator). The limited capacity makes it hard to provide technical assistance, manage budgets, review and approve the many invoices that are received, renew contracts, serve on national committees, and manage CYSHCN population health initiatives. VDH MCH management is aware of the need for at least one additional central office staff member and they have made the position a priority. However, there must first be funding available to support it. The CYSHCN director has a very strong relationship with MCH management and they have agreed to continue to work together to look for ways to provide support.

Workforce issues continue to exist at the CCC centers. Over the past year, at least two centers have had at least three vacancies at one time. In order to address this, the CYSHCN director made himself available for technical assistance. At one of the centers, he facilitated regular meetings with the center director and two senior staff. He made budget decisions with them and advised them on the type of staff that would be acceptable to hire as care coordinators. This guidance was needed because the center's longtime director retired and the center operated with an acting director for a number of months. The acting director accepted the position fulltime and all positions have finally been filled.

CHALLENGES/BARRIERS

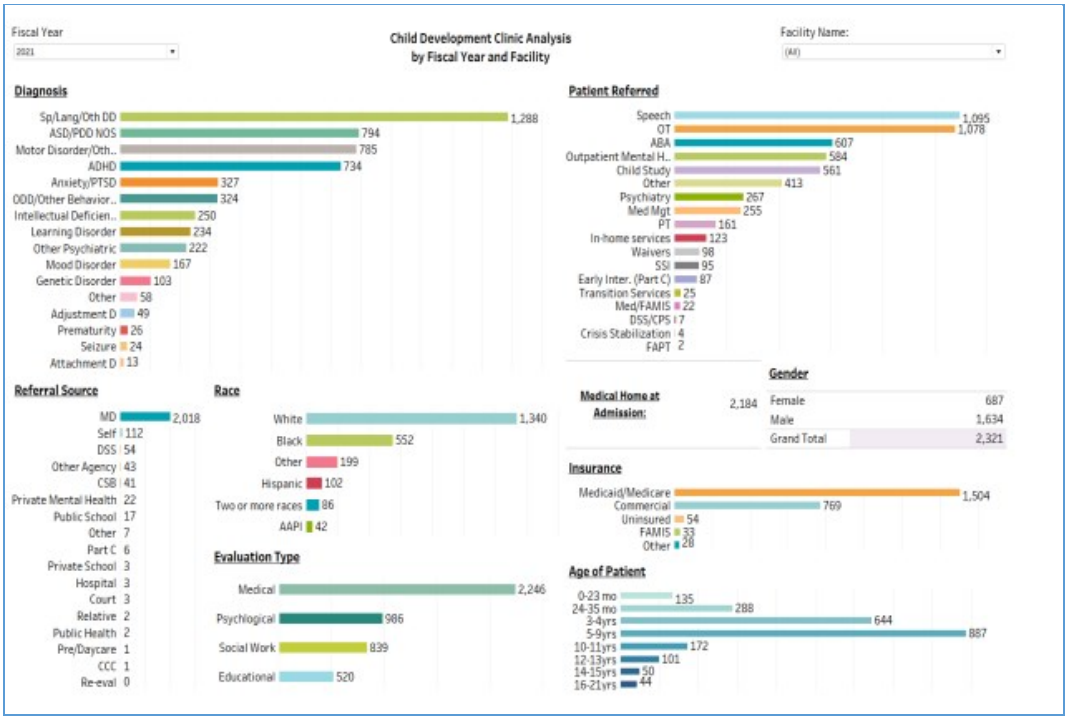
Salary expansion is an issue that many of our partners face but this issue is most significant when it comes to the CCC program. Care coordination staff tend to be emotionally invested in serving children with special health care needs and they tend to stay in their positions long term. Two centers reclassified their staff (for retention) and this created a budget crisis, since VDH provides almost all of their funding. VDH MCH leadership (including the CYSHCN director) has been clear for

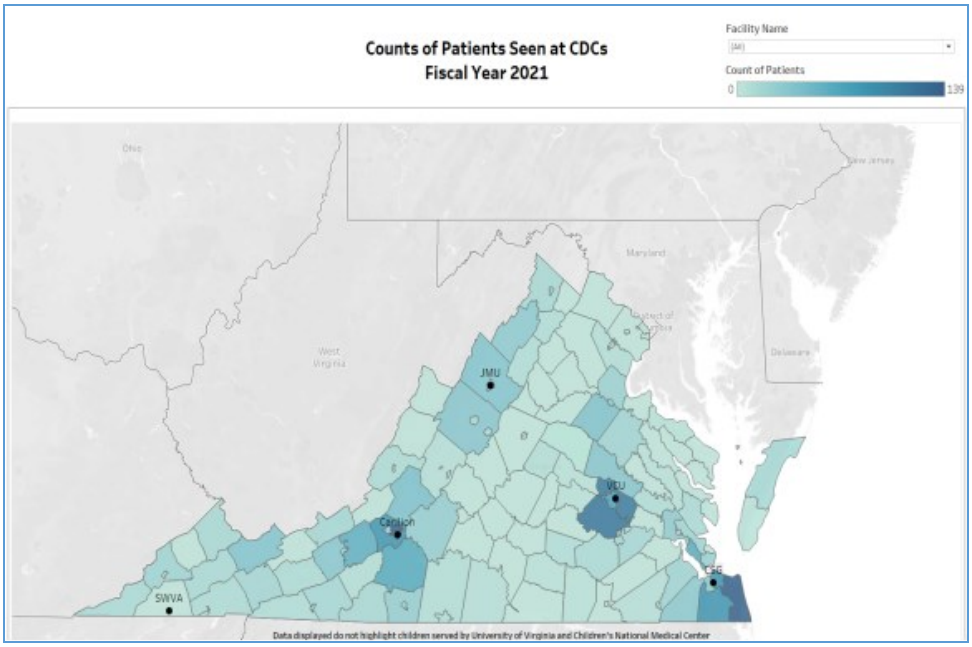
many years that the agency is not able to continuously increase center budgets. This year, the CYSHCN director had to stand firm and hold to this commitment. In one situation, he negotiated by providing temporary (unspent vacancy savings) funding to support the center until they could secure grant funds to supplement their budget. This prevented a layoff and a reduction in staff. In the second situation, temporary funding was not feasible as the deficit was too large. The CYSHCN director had several conversations with the center director and encouraged her to approach her health system to request more support. After several discussions, she finally agreed and ended up receiving support to close the budget deficit, preventing staffing losses and reductions in service.

EMERGING ISSUES

Public health equity has been a theme across our country for several years now and Virginia is no different. In order to address this, the CYSHCN Program Director added equity related language to the CCC and CDC work plans during FY21. The biggest equity project that the CYSHCN program endeavored upon was in partnership with one of our sister divisions, Population Health Data. The CYSHCN Program Director collects data about the CDC program yearly and logs it into a large spreadsheet. Examples of data collected include: diagnoses made; referrals received; referrals made; evaluation type; race of clients; gender of clients; geographic location of clients; etc. However, until recently, the program has not had the capacity to really maximize use of the data. The recent hire of epidemiologists by Population Health Data has really changed this significantly. The CYSHCN Director had regular meetings with two epidemiologists in the division and the decision was made to use the software tool Tableau to look for trends. To date, the epidemiologists have used the data provided to them to map out the number of children served by county/city. This has exposed some concerns regarding the program's reach in rural areas. There is also concern regarding the number of clients served by race. The trends (by race) seem to be the most significant when it comes to the Asian American, Pacific Islander population and the Latinx population. Our plan moving forward in FY23, is to request that our CDC centers across the state increase their reach by geography/race and to seek to form relationships with these communities. Center partners are interested in this work. The biggest barrier is capacity. Centers have waiting lists that exceed six months with some being closer to a year.

Please note the two images below. They represent examples of the work. The software tool Tableau is needed in order to be able to fully take advantage of the data. This was explained to partners when the data was shared with them[8].





PROGRAM LOGOS AND 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. She collaborated with our office's communication team and received feedback/input from medical center and community based partners. During the first year of the new logo, there was an unprecedented demand for educational materials from the community. So much so, that the program was unable to keep up initially with literature requests. There was a drop in publication requests during COVID but requests are starting to come back as the country emerges from the pandemic. The Sickle Cell Data Collection (SCDC) logo is the official program logo developed by the Centers for Disease Control and Prevention team. VDH received funding to collect data about people living with sickle cell disease in Virginia. We use this logo on materials related to the project.

Care Connection for Children™

[1]Shamaree, please update this section
[2]Shamaree, you can add your language here. It can be brief and does not need to be long unless you have a lot to add.
[3]Please update your part her too Shamaree, doesn't appear to need much. I think the UVA adult center is the biggest update! That is big accomplishment in my book!
[VP4]

[VP5]

[6]Remember to include survey as attachment
[7]Shamaree, please update your part
[8]Shamaree, please feel free to add anything here you would like about your programs...not mandatory but please feel free.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS DOMAIN
FY23 APPLICATION YEAR

PRIORITY	Strong systems of care for all children: Strengthen the continuum supporting physical/socioemotional development (i.e., screening, assessment, referral, follow-up, coordinated community-based care) – ***Medical Home.***
PERFORMANCE MEASURE	NPM 11 - Percent of children with and without special health care needs having a medical home
OBJECTIVE	By June 30, 2025, increase the percentage of typical and children with special health care needs served by the VDH CYSCHN Program who can identify a primary care provider as a medical home to 96%

Strategy 1: Seek new partners and continue to promote the online training module for health care providers and families to educate them on a comprehensive care approach to provide a medical home for children (including those with special health care needs).

Activity	Expected Completion Date	Responsible Staff
Renew contract with UVA	7/1/22	Marcus Allen (CSHCN Director)
Hold quarterly meetings with UVA to encourage promotion of the resource. Discussions will include partnerships with other organizations and broader sharing of the resource.	Quarterly	Marcus Allen with Cynthia deSa
Continue to communicate with partners to promote the modules	Ongoing	Marcus and UVA
Gather any evaluation data or feedback from UVA about the modules	by 6/30/23	VDH & UVA
Tracking of people who complete the modules	by 6/30/23	VDH & UVA

The transition and medical home modules were launched in the fall of 2019 after more than two years of development work. VDH plans to continue to meet with UVA 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. We will also work closely with UVA to require them to update the modules as needed.

Strategy 2: Assure children with special health care needs receive coordinated, ongoing, comprehensive care within a medical home (*CYSHCN National Standard: Medical Home*).

Activity	Expected Completion Date	Responsible Staff
Partner with family-identified medical home to coordinate care for CYSHCN served through CCCs, CDCs, SCPs, and Bleeding disorders programs. S	Ongoing	Marcus, Shamaree
Partner with family-identified medical home to coordinate entry into specialty care for newborns with a positive hemoglobinopathy screening. Care coordination services will also be offered to all other children confirmed via newborn screening.	Ongoing	Shamaree, Marcus, other staff making referrals
All CYSHCN programs will continue to promote medical home and help families find one if needed	Ongoing	Marcus, Shamaree
CYSHCN leadership will continue to work with state Medicaid on any issues that may be a barrier to care for the children we serve	Ongoing	Marcus, DMAS, MCOs, CDCs, CCCs

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 well as help to resolve problems families face accessing durable medical equipment and medications. The VBDP and Pediatric Comprehensive Sickle Cell Centers will continue to partner with medical homes to coordinate care in partnership with families.

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 CYSCHN and their families *(CYSHCN National Standard: Easy to Use Services and Supports / Care Coordination)*.

Activity	Expected Completion Date	Responsible Staff
Conduct subrecipient monitoring to ensure partners meet required service levels for providing care coordination and other similar services.	Ongoing	Marcus and Shamaree
Maintain infrastructure for centralized data system (CCC-SUN) for use by statewide CCC staff to track and document case management and care coordination services, insurance type, pool of funds, and I&Rs.	Ongoing	Marcus
Collaborate with CCC Directors to encourage staff to become and maintain certifications as case managers	Ongoing	Marcus
Convene center director/consultant meetings to provide technical assistance and troubleshoot issues. Staff will make annual site visits (when possible and after COVID) and/or offer technical assistance via phone or email.	Ongoing	Marcus and Shamaree
CDC program will continue to provide assessments of children throughout the state of Virginia suspected of having developmental and/or behavioral conditions. Once diagnosed, the results will be shared with the medical home (with permission from the family) and children will be referred for services.	Ongoing	Marcus, CDC centers
CYSHCN program will continue to promote telehealth and support the CDC centers as they provide services remotely. Regular calls will be held statewide with centers to encourage teamwork in working to overcome barriers and to deal with any other program struggles. Specific efforts will be made to continue to work to provide more services in rural Southwest Virginia.	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	Shamaree, Sickle cell centers
Southwest Virginia CCC will continue to support onsite telehealth services for families in partnership with UVA.	Ongoing	SWVA CCC staff and UVA

The CYSHCN program in Virginia partners very closely with major medical centers across the state. Contractual partners include: Children's Hospital of the King's Daughters in the Tidewater Region, the University of Virginia Health System in the

Blue Ridge region, Carilion Health System in the Roanoke/southwest region, INOVA Health System and Children's National Medical Center in the northern region, and Virginia Commonwealth University Health System in the central region. This partnership benefits families tremendously because they are able to receive the services they need through one "open door". For example, children with sickle cell disease often need care from several specialty providers such as nephrologists, neurologists, and radiologists. The health systems VDH partners with readily refer children to specialties within their own health system and services are generally offered on the same campus. This same benefit exists for CYSHCN served through the CCC, CDC, and bleeding disorder programs.

Two of the SCP sites implement satellite clinics in areas with geographic need for services in order to improve family access to 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 the CCC program and CDC program work very challenging, at times. Many of the CCC program care coordinators work from home and this may continue at least through the beginning of FY23. 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. Service levels are down statewide. The program hopes to be able to begin to recover during the next fiscal year but it will take some time to figure out new norms.

In the CDC program, telemedicine has emerged as a complement to traditional in person services (expanded because of COVID). 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 some feel when in a strange environment, such as a clinic. In order to continue to improve, the CYSHCN Director will hold virtual meetings and start in person site visits again (depending on the status of the pandemic). The CYSHCN Program Director's goal is to work hard over the next year to more effectively utilize center data and to push to restore service levels back to pre-pandemic norms. However, COVID caused major disruptions in this program and it may take years to fully recover.

PRIORITY	Strong systems of care for all children: Strengthen the continuum supporting physical/socioemotional development (i.e., screening, assessment, referral, follow-up, coordinated community-based care) – ***Transition*.**
PERFORMANCE MEASURE	NPM 11 - 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
OBJECTIVE	By June 30, 2025, increase the percentage 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

Strategy 1: Seek new partners and continue to promote the online training modules for health care providers and families to educate them on the importance of healthcare transition (including those with special health care needs).

Activity	Expected Completion Date	Responsible Staff
Renew contract with UVA	7/1/23	Marcus Allen/Cyndi deSa
Hold quarterly meetings with UVA to encourage promotion of the resource. Discussions will include a stronger partnership with the *Got Transition* and other organizations and broader sharing of the resource at forums such as the AMCHP National Conference	Quarterly	Cindy deSA with support from Marcus
Continue to communicate with partners to promote the modules	Ongoing	Marcus and UVA
Gather any evaluation data or feedback from UVA about the modules	by 6/30/23	VDH & UVA
Tracking of people who complete the modules	by 6/30/23	VDH & UVA

The transition and medical home modules were launched in the fall of 2019 after more than two years of development work. VDH plans to continue to meet with UVA and our goal will be to seek broader utilization of the modules among providers to promote transition and its key components.

Strategy 2: 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).*

Activity	Expected Completion Date	Responsible Staff
Through CCCs, facilitate transition from child to adult-oriented health care systems (e.g. transition planning tools, educational plans).	Ongoing	Marcus
Partner with the Comprehensive Sickle Cell Centers to ensure that all transition-age patients complete the American Society of Hematology transition readiness assessment tool or a similar tool/process.	Ongoing	Shamaree
Partner with funded hemophilia treatment centers to ensure the transition process from pediatric to adult treatment centers (e.g. biannual transition calls between regional hemophilia treatment centers and the state's only comprehensive adult treatment center; development of transition plan of care).	Ongoing	Shamaree
Encourage all CYSHCN programs to promote the transition and medical home community/family modules and provider modules	Ongoing	Marcus, Shamaree, UVA development team
Complete the process of establishing an Adult Comprehensive Sickle Cell Network by executing contracts with regional providers	July 2022	Shamaree Cromartie

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 Virginia Commonwealth University, the University of Virginia 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 3 years. Several requests for proposals were issued and VDH is in final negotiations with health system partners to fully execute contracts.

Strategy 3: Utilize Division of Population Health Data epidemiologists and state family delegate to administer transition survey statewide. (*Standard: Got Transition's Six Core Elements of Health Care Transition – Transition Completion & Youth and Family Engagement*).

Activity	Expected Completion Date	Responsible Staff
Implement Survey	August 2023	Dane/epi team, Marcus, Family Delegate (Dana)
Analyze data from survey and begin discussions regarding strategies to improve youth transition	December 2023	Dane/epi team, Cyndi DeSa, family delegate (Dana), Marcus

During FY21-22, VDH collaborated with our family delegate, youth advisors, epi team and block grant director to draft a transition survey for youth/parents. The draft has been finalized and staff received permission to provide gift cards to survey participants. It is anticipated that the survey will be launched by August of 2022 with a goal of analyzing the data and making recommendations to improve transition services by the end of FY23.

PRIORITY	Finances as a root cause: Increase the financial agency and well-being of MCH populations.
PERFORMANCE MEASURE	NPM 15 - Percent of children, ages 0 through 17, who are continuously and adequately insured.
OBJECTIVE	By June 30, 2025, increase the proportion of children with special health care needs in Virginia who are continuously and adequately insured from 71.3% (NSCH 2017-2018) to 74.9%

Strategy 1: Assure families of children with special health care needs will have adequate private or public insurance or both to pay for the services they need *(CYSHCN National Standard: Insurance & Financing).*

Activity	Expected Completion Date	Responsible Staff
Through CYSHCN programs, conduct medical insurance benefits evaluation and coordination, to include identifying potential Medicaid-eligible families, providing assistance with applying, and providing ongoing education and support to access covered services.	Ongoing	Marcus, Shamaree
Work towards increased support from health systems to pay for care coordination services through the CCC program	Ongoing	Marcus
Administer a Care Connection for Children pool of funds for payment of direct medical care services for the uninsured and underinsured clients.	Ongoing	Marcus
Administer a bleeding disorders pool of funds for payment of direct medical care services for the uninsured and underinsured clients.	Ongoing	Shamaree
Manage an insurance case management contract to help assure people with bleeding disorders have ongoing access to insurance.	Ongoing	Shamaree

Continue to encourage social work support at the VBDP and SCP centers across the state	Ongoing	Shamaree
Continue to engage DMAS with a focus on strengthening MCO care coordinator contacts by region for the CCCs	By September 2023	Marcus, DMAS staff (Virginia Medicaid agency)
The Virginia Bleeding Disorders program will use the needs assessment completed by VCU to inform program changes as capacity and funding allow	By June 2023	Shamaree and VCU
The CYSHCN director will continue to promote health equity as required in the CCC and CDC work plans. VDH epidemiologists will partner with the CYSHCN program to publish data for the CDC program	By June 23	Marcus, CCC/CDC, epi partners
VDH CYSHCN program held meetings with Carilion regarding follow-up CDC services for the SWVA region. The CYSHCN director will continue to discuss the implementation plan that Carilion and the SWVA CDC agreed to for telehealth.	Ongoing	Marcus, SWVA CDC, Carilion leadership

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 Accessia Health (formerly Patient Services Incorporated). Accessia Health 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 the 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. The loan bank is a partnership between the Virginia Department of Education, the VDH CYSHCN program, the University of Virginia CCC and the VDH Early Hearing Detection and Intervention program. Staff have been in discussions regarding the future of the loan bank and will continue those discussions during FY23.

Strategy 2: 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).*

Activity	Expected Completion Date	Responsible Staff
Maintain paid parent coordinators and/or promote family involvement at CCC centers to provide support and resources to families served.	Ongoing	Marcus
Assure CYSHCN centers identify and address family barriers, priorities, and concerns (e.g. sickle cell psychosocial assessments) while promoting family engagement in decision-making at all levels of care planning and management (e.g. IEPs, 504 plans, home management of bleeding disorders).	Ongoing	Marcus, Shamaree
Solicit, document, and respond to family feedback on satisfaction with services (e.g. bleeding disorders family satisfaction survey every other year, CCC parent survey every 5 years).	Ongoing	Shamaree, Marcus
Empower and equip populations impacted by sickle cell and bleeding disorders to manage complexities of the disease through various community support and education activities/programs (e.g. youth transition camp, faith-based outreach).	Ongoing	Shamaree
CYSHCN programs will continue to partner with the VA Department of Education (DOE) to support families utilizing the expertise of educational consultants.	Ongoing	All Programs

The regional Care Connection for Children centers (CCC) will continue to be encouraged to employ parent coordinators as staff. Maintaining such staff has been difficult but care coordinators will continue to actively engage families in order to offer resources and support. Most of the parent coordinators who are employed have a child with a special health care need so they understand the unique challenges families face. In addition to providing general support to families, parent coordinators in various regions across the Commonwealth work to: maintain center resource lists; create newsletters; lead educational activities and trainings; and work closely with families on overcoming barriers to care.

Another one of our core programs, the Child Development Centers (CDCs) also actively engage families. The CDCs provide assessments of children suspected of having developmental and/or behavior conditions. Families are an active part of the assessments that are done and they receive documentation regarding diagnoses. In addition, center staff members refer them to clinical and non-clinical resources for assistance and share the results of their assessments with other providers serving the family.

The Virginia Bleeding Disorders Program (VBDP) and the Sickle Cell Program (SCP) will continue to have a number of programs/events to support families in decision making at all levels (as COVID allows). The VBDP educates families on

home therapy management for those who infuse at home. The SCP centers offer genetic counseling to aid in future reproductive decision making. The regional centers provide events for families, including social gatherings and overnight camps (has been suspended due to COVID) with educational and group activities focusing on transition and self-advocacy. The program will continue to provide basic information about SCD and a forum for families to discuss the challenges for caring for an infant with SCD. Social workers will continue to send out pertinent information for families as topics arise pertaining to medical advances in SCD. Families with newborns diagnosed with SCD will be given a copy of *Hope and Destiny: A Patient's and Parent's Guide to Sickle Cell Anemia* and patients entering the transition phase will be given a copy of *Hope and Destiny Jr* (as funding allows).

Cross-Cutting/Systems Building

State Performance Measures

SPM 1 - Cross-Cutting (Early and Continuous Screening): Percent of infants diagnosed with a newborn screening disorder who are referred to care coordination services in the CYSHCN program

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			100
Annual Indicator	100	100	100
Numerator		436	301
Denominator		436	301
Data Source	VDH Newborn Screening Program, VDH EHDI	VDH Newborn Screening Program, VDH EHDI	VDH Newborn Screening Program, VDH EHDI
Data Source Year	2018	2019	2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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	2021
Annual Objective			Yes	Yes
Annual Indicator		Yes	Yes	Yes
Numerator				
Denominator				
Data Source		VDH Adolescent Health Program	VDH Adolescent Health Program	VDH Adolescent Health Program
Data Source Year		2019	2020	2021
Provisional or Final ?		Final	Final	Final

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

SPM 3 - MCH Workforce Development (Racial Equity): Provide dedicated space, technical assistance, and learning opportunities that advance racial equity among MCH workforce.

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			Yes
Annual Indicator		No	Yes
Numerator			
Denominator			
Data Source		OFHS MCH Program Documentation	OFHS MCH Program Documentation
Data Source Year		2020	2021
Provisional or Final ?		Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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 2025, increase equity in VDH’s public health initiatives by incorporating youth voice into the development, planning, and management of public health initiatives that impact young people
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 with representation cross the Commonwealth
Finalize an equitable family engagement definition and framework, and create a state performance measure that directly measures the percent of family engagement in decision-making across VA's Title V programs

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): Provide dedicated space, technical assistance, and learning opportunities that advance racial equity among MCH workforce.

Objectives

By 2025, provide dedicated space, technical assistance, and learning opportunities that advance racial equity across MCH workforce

Strategies

Engage with Urban Baby Beginnings in AMCHPS' Healthy Beginnings with Title V: Advancing Anti-Racism in Preterm Birth Prevention Learning and Practice Cohort

Partner with Blue Ridge Health District and Birth Sisters of Charlottesville in CityMatCH Alignment for Action Learning Collaborative

Increase opportunities for workforce development for local health districts to align with MCH leadership competencies

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 diagnosed with a newborn screening disorder who are referred to care coordination services in the CYSHCN program

Objectives

Maintain 100% referral rate, and improve/streamline processes by which all infants with confirmed newborn screening disorders are referred to CYSHCN care coordination services

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 diagnosed with a newborn screening disorder who are referred to care coordination services in the CYSHCN program

Objectives

Maintain 100% Referral rate and improve/streamline processes by which all infants with confirmed newborn screening disorders are referred to CYSHCN care coordination services

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

CROSS-CUTTING/SYSTEMS BUILDING DOMAIN
SUMMARY/OVERVIEW
FY21 ANNUAL REPORT

DOMAIN CONTRIBUTORS

DOMAIN CONTRIBUTORS:
Youth Advisors - Adolescent Health Program – Division of Child and Family Health
Newborn Screening Program - Division of Child and Family Health

DOMAIN OVERVIEW

YOUTH ADVISORS: Adolescent Health Program's Youth Advisors provide expertise, guidance and feedback on current and future public health initiatives.

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.

STATE ACTION PLAN UPDATES

PRIORITY 1: 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.

OBJECTIVE	By 2025, increase equity in VDH's public health initiatives by incorporating youth voice in the development, planning, and management of public health initiatives that impact young people
PERFORMANCE MEASURE	SPM 2: Cross-Cutting (Youth Leadership): Develop and sustain the Virginia Department of Health Youth Advisor Program

Strategy 1: Hire two part-time Youth Advisors to provide expertise, guidance and feedback on current and future public health initiatives; Fund regional system that incorporates numerous and diverse youth voices into public health in Virginia.

During the FY21 reporting period, VDH's Adolescent Health team laid the foundation for its Youth Advisor Program. VDH hired two part-time Youth Advisors, and VDH's Adolescent Health Coordinator and Youth Advisors spoke with other states, community stakeholders, and partner programs to gain insight about possible program models. The team decided on a two-pronged approach: 1) The General Body Meetings would be open to any high school aged youth in Virginia and would focus on various public health topics, and 2) The Executive Board (E-Board) Meetings would include a small group teens who demonstrated the interest and capacity to engage in public health program planning and implementation. Initially, the Adolescent Health Team believed that regional councils would be the best approach to ensuring representation across the Commonwealth, but has decided that regular virtual meetings open to all youth would be a more efficient and effective approach. The Youth Advisory Councils convened during FY22.

PRIORITY 2: Racism as a root cause: Explore and eliminate drivers of structural and institutional racism within OFHS programs, policies, and practices to improve maternal and child health.

OBJECTIVE	By 2025, provide dedicated space, technical assistance, and learning opportunities that advance racial equity across MCH workforce
PERFORMANCE MEASURE	SPM 3: MCH Workforce Development: Develop and strengthen MCH partnerships that address racial equity.

Strategy 1: Engage with Urban Baby Beginnings in AMCHP's Healthy Beginnings with Title V: Advancing Anti-Racism in Preterm Birth Prevention – Learning and Practice Cohort.

In July 2021, AMCHP launched an 18-month capacity building project that brings teams from six states together as a cohort to learn about and practice dismantling racism in state health department policies and practices. The goal of this project is to build transformational partnerships between state MCH/Title programs and CBO's. Virginia is one of six state teams selected to participate in this learning and practice cohort, alongside Urban Baby Beginnings, Virginia's leading non-profit that provides outstanding community support services specifically for pregnant and parenting families in Virginia. Through monthly team meetings and monthly learning and practice cohort meetings, the team identified that workforce development for Virginia's doula community was critical, especially in light of the recent Medicaid doula benefit. A shared work plan including action steps was developed, and the group will advance the work beyond the January 2023 end date for AMCHP support. There are currently seven MCH Team members who participate in the cohort alongside Urban Baby Beginnings.

Strategy 2: Partner with Blue Ridge Health District and Birth Sisters of Charlottesville in CityMatCH Alignment for Action Learning Collaborative.

The Blue Ridge Health District and Birth Sisters of Charlottesville, a doula collective supporting BIPOC mothers, is one of eight team selected national for the CityMatCH Alignment for Action Learning Collaborative (AAC), a two-year initiative, which began in March 2021. Title V leadership team provides consultation and partnering to assist in their strategic planning of community-led efforts to address racism and implicit bias in the Charlottesville maternal and child health care community, including OB/GYN, Family Medicine, Pediatric providers and healthcare organizations. This Team meets weekly, and receives support from CityMatCH monthly. The Team's initial goals are to hold a community-wide education event, Listening to the Living, which will provide critical context to the black maternal mortality rates in Virginia, including personal stories from black women from the Charlottesville community. This virtual event is planned for March 2023. The Team plans to work across three domains; 1. Create a method by which the black woman's birthing experience is shared back to the medical community to evoke process/systems change;2 . Explore methods by which Black medical providers, including

nurses, midwives, pediatricians and OB/GYN providers, who train at University of Virginia will remain and serve the Black birthing community or methods by which new Black providers can be recruited and retained; 3. Serve as a clearinghouse for information and awareness regarding black maternal mortality. This dynamic team is composed of three Title V/MCH Team members, two Blue Ridge health district team members, two Birth Sisters of Charlottesville members, a UVA Sociology PhD candidate and a UVA student intern.

PRIORITY 3: MCH data capacity: Maintain and expand state MCH data capacity, to include ongoing needs assessment activities, program evaluation, and modernized data visualization and integration.

OBJECTIVE	Maintain 100% referral rate and improve/streamline processes by which all infants with confirmed newborn screening disorders are referred to CYSHCN care coordination services.
PERFORMANCE MEASURE	SPM 1: Cross-Cutting (early and continuous screening): Percent of infants diagnosed with a newborn screening disorder who are referred to care coordination services in the CYSHCN program.

Strategy 1: Maintain the VaCARES Registry and expand capacity to document and track referrals of infants from the Newborn Screening Program to CYSHCN programs

The Virginia Newborn Screening Programs (VNSP) include the Newborn Bloodspot Screening Program (NBSP), the Early Hearing Detection and Intervention Program (EHDI), and the Critical Congenital Heart Disease Screening Program (CCHD). The overarching goal for the VNSP is to strive for optimal outcomes of Virginia's affected infants through early diagnosis, referral, and intervention by identification with newborn screening. All newborns born in the Commonwealth of Virginia are required to receive a newborn screening within 24-48 hours after birth (NBSP and CCHD) or prior to discharge from the hospital (EHDI). The NBSP and EHDI programs monitor the newborn screening results of all babies born within the Commonwealth of Virginia, as well as request follow-up and diagnostic testing for up to 6 months (NBSP) and 36 months (EHDI). In September 2020, Virginia implemented a targeted congenital Cytomegalovirus (cCMV) screening program for any infant who fails the hearing screen at birth to be screened for cCMV before hospital discharge. The CCHD program focus is on quality assurance and passive surveillance by confirming positive CCHD newborn screens to refer for care coordination. The programs provide information to the Virginia Birth Defects Surveillance Program through the Virginia Congenital Anomalies Reporting and Education System (VaCARES). The Birth Defects Surveillance Program (BDS) is a passive surveillance tool and serves as a data repository for birth defects to be reported for the first 2 years of life. The birth defects data informs stakeholders regarding the prevalence of birth defects in Virginia and potential impact of those affected with rare diseases. All infants identified with a disorder on Virginia's newborn screening panel are referred for care coordination services in the CYSHCN program.

The maintenance and ongoing support of the VaCARES Registry is provided by the VDH Office of Information Management to allow stakeholders to document birth defects. It also provides programmatic staff the ability to query the prevalence of a certain birth defect affecting those in Virginia up to age 2 years. The CCHD NBS program has a manual process for documentation that enables the program to track the number of infants referred and who accepted services to CYSHCN programs. A future process improvement would be to automate documentation to track number of infants referred and who accepted services to CYSHCN programs. DCFH partnered with internal agency teams to identify needs, gaps and future direction of the current birth defects surveillance system. A comprehensive evaluation of VDH's birth defects surveillance program and VaCARES was completed in October 2020 with the assistance of a Program Evaluator. A logic model for the program was generated that will assist in the transition to a more active surveillance system and provide more opportunities for quality assurance initiatives. A work plan was developed in the process of applying for a grant with the CDC; however, it was not selected for funding. The BDS program worked with VDH OFHS Division of Population Health Data staff from June

through August 2021 to consolidate and submit data for two reports for the National Birth Defects Prevention Network. These were complex requests that took a lot of time and effort to complete, and the data was accepted and contributed to publications. An additional target in FY21 was to coordinate and partner with external stakeholders to increase the percentage of birthing facilities that report CCHD information into from 65% (2020 baseline) to 75% by September 2021. CCHD program activities focused on follow-up and referrals during this reporting period due to the CCHD NBS Coordinator vacancy and limitations of current reports directly accessible to BDS program staff.

Strategy 2: Partner with NYMAC (New York-Mid-Atlantic Regional Genetics Network) to assess and respond to state needs related to genetic services.

Programmatic leadership, Christen Crews, MSN, RN, and Virginia's Family Delegate, Dana Yarborough, served as a co-leaders on a project to collaborate with NYMAC (New York - Mid-Atlantic Regional Genetics Network) to assess and respond to state needs related to genetic services. This project is ongoing and includes a diverse team of stakeholders from across the Commonwealth. A current product of this collaboration is the development of a "Genetic Navigator" training toolkit to assist community health workers, case managers, social workers, etc. help bridge the gap and ensure those who need genetic services have a better understanding for the need to be seen by the specialist.

PRIORITY 4: Upstream/Cross-sector strategic planning: Eliminate health inequities arising from social, political, economic, and environmental conditions through strategic, nontraditional partnerships.

OBJECTIVE	Maintain 100% referral rate and improve/streamline processes by which all infants with confirmed newborn screening disorders are referred to CYSHCN care coordination services.
PERFORMANCE MEASURE	SPM 1: Cross-Cutting (early and continuous screening): Percent of infants diagnosed with a newborn screening disorder who are referred to care coordination services in the CYSHCN program.

Strategy 1: Maintain and expand family engagement on state NBS Advisory Committee. The Newborn Bloodspot and the EHDI Programs both have advisory committees with family representatives serving on the board. The programs have public comment periods during their advisory committees and invite parent speakers to share their stories. The VA EHDI team continues to provide support to families with newly diagnosed children, a follow-up specialist provides referrals to families interested in receiving family to family support. Additionally, they refer children to Care Connection for Children (CCC) for case management services and to the Infant and Toddler Connection in Virginia for early intervention services. Parents are provided a brief description of these services and referral is made when requested. VA EHDI also mails resources and materials to families of newly diagnosed children to include information on hearing loss, language and communication modalities, and amplification options. Resources from family support organizations and upcoming events are also shared with families.

Strategy 2: Sustain Early Hearing Detection & Intervention Program, to include support for paid 1-3-6 Family Educators.

Staff will continue their work with VCU's Center for Family Involvement to provide family to family support and will continue recruiting children and families who are deaf and or hard of hearing for advisory committee participation. VA EHDI will continue to strengthen follow up activities to newly diagnosed children and children who are older. Overall, VA EHDI will continue to implement technological advancements to achieve program goals and objectives The Virginia EHDI program partners with the Center for Family Involvement at Virginia Commonwealth University, and Family Educators continue to provide family-to-family support. In Nov 2021, VA EHDI had the first Statewide Learning Community with stakeholders from each region of the state. The results from the Virginia 2020 EHDI needs assessment on the impact of COVID in EHDI systems of care was presented during this meeting. In April 2022, the Virginia EHDI program and Center for Family

Involvement collaborated with Virginia Center for Inclusive Communities to host the first series of "Your Role in Workplace Diversity, Equity and Inclusion Trainings. Workshop topics included: Foundations of Diversity and Inclusion, Unconscious Bias 201, The Cycle of Prejudice, Understanding and Addressing Microaggressions, Exploring Racial Equity, and Exploring Socioeconomic Status.

In order to increase collaboration between families and professionals, VA EHDI and Virginia Hands and Voices hosted a series of three lunch and learn webinars in September 2021. The goal of this series was to introduce parents of newly diagnosed deaf and hard of hearing children to the professionals who will serve their families. In this video series, parents of children with hearing loss interviewed a geneticist, an audiologist, and an otolaryngologist. These lunch and learn series were well received and had approximately 20-30 people in attendance at each screening.

The EHDI program collaborated with Gallaudet University to provide American Sign Language (ASL) Connect Classes for families at no cost. These classes included 8 week sessions with 30 minutes per class sessions for Virginia families interested in learning ASL. There were spring, summer, and fall sessions in 2021 and around 40 families participated.

A training was developed on risk indicators for hearing loss in collaboration with an audiologist, Dr. Cynthia Clark, at the University of Virginia. This training was designed to support providers to have a better understanding of risk factors that impact late onset hearing loss and provide guidance to hospital staff on how to capture risk indicators and recommendations for outpatient screening in this population of children. Due to the implementation of cCMV, primary care provider training for cCMV screening was hosted in collaboration with the Virginia American Academy of Pediatrics and INOVA Health systems. The speakers included VA EHDI staff, an Infectious Disease Specialist, a Pediatrician, an Audiologist and an Ear Nose Throat Specialist. Each provider shared their perspectives on cCMV screening and how Primary Care Providers can manage the care for children who are screened for cCMV in Virginia. The training included an overview of the CMV screening process, discussing the process for relaying results to PCP's, presenting CMV testing and treatment options and discussion of the care process model for children who screen positive for cCMV. This training is available on INOVA Health Systems website for Continuing Medical Education. The VA EHDI team has developed a comprehensive compliance training for all EHDI stakeholders to include policies for newborn hearing and audiological assessment. This training will also focus on legislation in place for newborn hearing screening and guidance on reporting to the VA EHDI program as well as recommendations for outpatient testing. This training will be hosted in Early 2022.

CROSS-CUTTING/SYSTEMS BUILDING DOMAIN
FY23 APPLICATION YEAR

The following programmatic strategies and activities will continue as methods to advance and improve outcomes in each of the identified priority areas.

PRIORITY 1	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.
OBJECTIVE	By 2025, increase equity in VDH's public health initiatives by incorporating youth voice in the development, planning, and management of public health initiatives that impact young people
PERFORMANCE MEASURE	SPM 2: Cross-Cutting (Youth Leadership): Develop and sustain the Virginia Department of Health Youth Advisor Program

Strategy 1: Expand Youth Advisor role, providing expertise, guidance, and feedback on current and future public health initiatives across all MCH populations.

Strategy 2: Fund, develop, and establish Youth Advisory Councils with representation across the Commonwealth.

Youth Advisor Program and its work to engage with young people across the Commonwealth in a meaningful way. The Youth Advisor Program will host at least 12 meetings annually with young people and will facilitate the creation of at least one public health project/product that was planned, implemented, and disseminated by youth. The Youth Advisor Program will also facilitate opportunities for young people to provide feedback on various VDH programs, including but not limited to suicide prevention and dating violence prevention.

Strategy 3: Finalize an equitable family engagement definition and framework, and create a state performance measure that directly measures the percent of family engagement in decision-making across VA's Title V programs.

In Summer 2022, VDH's Title V program sponsored two interns through the National MCH Workforce Development Center Summer Internship Program. The Interns, Pooja Deshpande (MPH 2023, UNC Chapel Hill Gillings School of Global Public Health) and Ashley Zuniga (BSW 2023, East Carolina University), engaged in a project entitled, "Moving towards Equitable Family Engagement in Virginia Title V. The interns explored definitions of equitable family engagement, collaboration and leadership through conducting family focus groups, and key informant interviews of Title V staff as well as national organization staff members. Themes of equitable family engagement were identified. Recommendations were then developed regarding collaborative definitions of equitable engagement with families, as well as ways in which current practices can be improved or modified to increase equitable engagement with families through Title V at the state level.

PRIORITY 2	Racism as a root cause: Explore and eliminate drivers of structural and institutional racism within OFHS programs, policies, and practices to improve maternal and child health.
OBJECTIVE	By 2025, provide dedicated space, technical assistance, and learning opportunities that advance racial equity across MCH workforce
PERFORMANCE MEASURE	SPM 3: MCH Workforce Development: Develop and strengthen MCH partnerships that address racial equity

Strategy 1: Engage with Urban Baby Beginnings in AMCHP's Health Beginnings with Title V: Advancing Anti-Racism in Preterm Birth Prevention – Learning and Practice Cohort

Strategy 2: Partner with Blue Ridge Health District and Birth Sisters of Charlottesville in CityMatCH Alignment for Action Learning Collaborative

Strategy 3: Increase opportunities for workforce development for local health districts to align with MCH leadership competencies.

PRIORITY 3	MCH data capacity: Maintain and expand state MCH data capacity, to include ongoing needs assessment activities, program evaluation, and modernized data visualization and integration.
OBJECTIVE	Maintain 100% referral rate and improve/streamline processes by which all infants with confirmed newborn screening disorders are referred to CYSHCN care coordination services.
PERFORMANCE MEASURE	SPM 1: Cross-Cutting (early and continuous screening): Percent of infants diagnosed with a newborn screening disorder who are referred to care coordination services in the CYSHCN program.

Strategy 1: Maintain the VaCARES Registry and expand capacity to document and track referrals of infants from the Newborn Screening Program to CYSHCN programs

Strategy 2: Partner with NYMAC (New York-Mid-Atlantic Regional Genetics Network) to assess and respond to state needs related to genetic services.

PRIORITY 4	Upstream/Cross-sector strategic planning: Eliminate health inequities arising from social, political, economic, and environmental conditions through strategic, nontraditional partnerships.
OBJECTIVE	Maintain 100% referral rate and improve/streamline processes by which all infants with confirmed newborn screening disorders are referred to CYSHCN care coordination services.
PERFORMANCE MEASURE	SPM 1: Cross-Cutting (early and continuous screening): Percent of infants diagnosed with a newborn screening disorder who are referred to care coordination services in the CYSHCN program.

Strategy 1: Maintain and expand family engagement on state NBS Advisory Committee.

Strategy 2: Sustain Early Hearing Detection & Intervention Program, to include support for paid 1-3-6 Family Educators.

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

TECHNICAL ASSISTANCE

The Virginia Department of Health (VDH) MCH/Title V Program does not have any TA requests for Application Year 2023.

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 - MCH Key Partners List.pdf

Supporting Document #02 - medicaid-community-doula-recruitment-flyer-english.pdf

Supporting Document #03 - LDH Bundled Activitites FY22-23.pdf

Supporting Document #04 - Title V Virginia MCH Summer Interns 2022 presentations.pdf

Supporting Document #05 - 2022 Transition survey (1).pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - Org Chart 2022.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Virginia

	FY 23 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	$ 3,986,367	(31.9%)
B. Children with Special Health Care Needs	$ 3,861,793	(30.9%)
C. Title V Administrative Costs	$ 996,592	(8.1%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 8,844,752	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 5,933,268	
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)	$ 1,707,091	
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)	$ 13,734,376	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 35,534,823	

OTHER FEDERAL FUNDS	FY 23 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 7,351,165
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	$ 828,426
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 4,009,531
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education Program	$ 748,784
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 94,910
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 219,054
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Care Access Program - VMAP	$ 482,506

	FY 21 Annual Report Budgeted		FY 21 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 12,287,553 (FY 21 Federal Award: $ 12,457,398)		$ 12,375,275	
A. Preventive and Primary Care for Children	$ 3,795,675	(30.9%)	$ 3,960,088	(32%)
B. Children with Special Health Care Needs	$ 5,130,124	(41.8%)	$ 3,836,335	(30.9%)
C. Title V Administrative Costs	$ 1,227,859	(10%)	$ 990,022	(8%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 10,153,658		$ 8,786,445	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 9,215,665		$ 9,282,539	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 1,618,704		$ 1,702,690	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 2,086,819		$ 1,707,091	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 12,921,188		$ 12,692,320	
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		$ 25,067,595	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 0		$ 14,300,655	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 25,208,741		$ 39,368,250	

OTHER FEDERAL FUNDS	FY 21 Annual Report Budgeted	FY 21 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		$ 13,776
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education Program		$ 923,687
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants		$ 7,166,489
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start		$ 843,529
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning		$ 4,489,167
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention		$ 381,500
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > PEDIATRIC MENTAL HEALTH CARE ACCESS PROGRAM (VMAP)		$ 482,507

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: An increased focus was needed in this domain.	
2.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: This area had been given more focus than preventive care for children, requiring an adjustment.	
3.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Staff vacancies still need to be fille.	
4.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Income received from care connection center insurance billings, put back into their programs.	

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 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	$ 1,619,462	$ 1,608,786
2. Infants < 1 year	$ 1,494,888	$ 1,485,033
3. Children 1 through 21 Years	$ 3,986,367	$ 3,960,088
4. CSHCN	$ 3,861,793	$ 3,836,335
5. All Others	$ 498,296	$ 495,011
Federal Total of Individuals Served	$ 11,460,806	$ 11,385,253

IB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	$ 1,214,596	$ 1,113,905
2. Infants < 1 year	$ 1,401,457	$ 1,299,556
3. Children 1 through 21 Years	$ 2,989,776	$ 2,970,412
4. CSHCN	$ 2,896,345	$ 2,877,587
5. All Others	$ 840,874	$ 835,429
Non-Federal Total of Individuals Served	$ 9,343,048	$ 9,096,889
Federal State MCH Block Grant Partnership Total	$ 20,803,854	$ 20,482,142

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 23 Application Budgeted	FY 21 Annual Report Expended
1. Direct Services	$ 249,148	$ 247,505
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 59,796	$ 59,401
B. Preventive and Primary Care Services for Children	$ 99,659	$ 99,002
C. Services for CSHCN	$ 89,693	$ 89,102
2. Enabling Services	$ 6,228,699	$ 6,187,638
3. Public Health Services and Systems	$ 5,979,551	$ 5,940,132
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		$ 138,603
Physician/Office Services		$ 223
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 73,806
Laboratory Services		$ 34,873
Direct Services Line 4 Expended Total		$ 247,505
Federal Total	$ 12,457,398	$ 12,375,275

IIB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Direct Services	$ 99,971	$ 99,323
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 23,993	$ 23,838
B. Preventive and Primary Care Services for Children	$ 39,988	$ 39,729
C. Services for CSHCN	$ 35,990	$ 35,756
2. Enabling Services	$ 4,841,568	$ 4,810,212
3. Public Health Services and Systems	$ 4,404,510	$ 4,373,004
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		$ 55,621
Physician/Office Services		$ 89
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 29,618
Laboratory Services		$ 13,995
Direct Services Line 4 Expended Total		$ 99,323
Non-Federal Total	$ 9,346,049	$ 9,282,539

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Virginia

Total Births by Occurrence: 94,794 **Data Source Year: 2020**

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	93,359 (98.5%)	3,320	301	301 (100.0%)

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	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1
ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy

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. The program is currently establishing a long-term follow-up program for dried blood-spot disorder outcomes.

Form Notes for Form 4:

Note for 2021 reporting year: Data reported from most recent validated data year 2020; 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:	**2021**
	Column Name:	**Core RUSP Conditions**
	Field Note: *For Glycogen Storage Disease Type II (Pompe) data: 6 cases of possible/probable late onset - not included in count because not confirmed. No presumptive positive or confirmed diagnoses are listed for Spinal Muscular Atrophy (SMA) or X-linked Adrenoleukodystrophy as screening for these disorders was not implemented until March 16, 2022. *For Critical Congenital Heart Disease data: Defined as total number of infants born in 2020 with 1) Positive (Fail) Pulse Oximetry Screening result reported into VISITS, AND 2) CCHD diagnosis reported into VaCARES, AND 3) CCHD diagnosis confirmed by a provider or hospital. This reflects a change in case definition from last year's report.	
2.	**Field Name:**	**Core RUSP Conditions - Total Number Referred For Treatment**
	Fiscal Year:	**2021**
	Column Name:	**Core RUSP Conditions**
	Field Note: *For Critical Congenital Heart Disease data: Defined as the total number of confirmed CCHD cases (as defined by (C) above) who were referred to CCC as a result of CCHD follow-up. This reflects a change in case definition from last year's report.	

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 2021

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	5,180	31.8	0.0	62.5	5.4	0.3
2. Infants < 1 Year of Age	3,147	31.8	0.0	62.5	5.4	0.3
3. Children 1 through 21 Years of Age	22,827	25.0	0.0	69.0	6.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	6,350	34.0	0.0	65.0	1.0	0.0
4. Others	20,103	10.0	0.0	82.0	8.0	0.0
Total	51,257					

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	94,749	Yes	94,749	100.0	94,749	5,180
2. Infants < 1 Year of Age	94,794	Yes	94,794	100.0	94,794	3,147
3. Children 1 through 21 Years of Age	2,226,361	Yes	2,226,361	100.0	2,226,361	22,827
3a. Children with Special Health Care Needs 0 through 21 years of age^	418,340	Yes	418,340	100.0	418,340	6,350
4. Others	6,266,450	Yes	6,266,450	30.5	1,911,267	20,103

^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:	**2021**
	Field Note: Data note for reporting year 2021: Resource Mothers Program Data (REDCap entries from community health workers); WebVision – Report #081 from the Data Warehouse using the date range Oct 1, 2020 to Sep 30, 2021; Number reported Title V funded BabyCare (Prenatals) services from LHDs (WebVision – Report #009 using the date range Oct 1, 2020 to Sep 30, 2021); Number reported includes pregnant and postpartum women receiving safe sleep kits/counseling/education/maternity/referral services from LHDs - obtained from LHD reports (numbers refer to SFY2022, with the intent of moving LHDs to proper reporting schedule).	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2021**
	Field Note: Data note for reporting year 2021: 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 (CY2020, VA EHDI); Resource Mothers Program Data (REDCap entries from community health workers); Number reported Title V funded BabyCare (Infant) services from LHDs (WebVision – Report #009 using the date range Oct 1, 2020 to Sep 30, 2021); Number reported includes infants receiving safety seats/immunizations/case management services from LHDs - obtained from LHD reports (numbers refer to SFY2022, with the intent of moving LHDs to proper reporting schedule).	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2021**
	Field Note: Data note for reporting year 2021: WebVision – Report #081 from the Data Warehouse using the date range Oct 1, 2020 to Sep 30, 2021; 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; Number reported includes children receiving BabyCare/education services/immunizations from LHDs - obtained from LHD reports (numbers refer to SFY2022, with the intent of moving LHDs to proper reporting schedule).	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2021**
	Field Note: Data note for reporting year 2021: CCC-SUN, Individual Program Reports from partners (CCC, CDC, Sickle cell, and Bleeding Disorders programs under 21); Number reported includes CYSHCN receiving counseling/education services from LHDs - obtained from LHD reports (numbers refer to SFY2022, with the intent of moving LHDs to proper reporting schedule).	

5.	**Field Name:**	**Others**
	Fiscal Year:	**2021**

Field Note:
Data note for reporting year 2021: WebVision – Report #081 from the Data Warehouse using the date range Oct 1, 2020 to Sep 30, 2021; 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); Number reported includes others receiving counseling/education services from LHDs - obtained from LHD reports (numbers refer to SFY2022, with the intent of moving LHDs to proper reporting schedule).

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2021**

Field Note:
Data note for reporting year 2021: 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 CFRT, partial salaries and curricula for Adolescent Health, partial funding for Resource Mothers curricula (pregnant and parenting teens); MCH epi team partial salaries; Needs Assessment support; IVP epi partial salaries; support to maternal collaboratives and state task forces; dental health services and educational activities.

2.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2021**

Field Note:
Data note for reporting year 2021: Title V provides 100% salary support for Mat/Inf, EHDI program manager staff and Birth Defects surveillance coordinator; provides support for VACARES; support to perinatal collaboratives.

3.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2021**

Field Note:
Data note for reporting year 2021: Includes partial salary for Child Health, 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), Early Childhood Advisory Committee (ECAC), and the Rare Disease Council (RDC); development of school health guidelines for all public schools and in consultation for private/parochial schools; includes dental health services and educational activities.

4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2021**

	Field Note: Data note for reporting year 2021: 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); salaries for a wage position for dental health among CYSHCN, and work of Care Connection for Children centers.	
5.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2021**
	Field Note: Data note for reporting year 2021: Title V provides funding to 35 local health districts to carry out essential public health services in every community in Virginia (includes maternal and child health programming and some 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 2021

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	98,334	52,654	21,583	15,258	170	7,579	124	0	966
Title V Served	3,336	1,517	288	988	14	61	0	0	468
Eligible for Title XIX	30,149	11,697	11,010	6,087	47	1,047	29	0	232
2. Total Infants in State	94,794	50,784	20,827	14,857	167	7,215	119	0	825
Title V Served	2,154	1,096	616	0	0	20	0	0	422
Eligible for Title XIX	30,069	11,669	10,977	6,070	47	1,045	29	0	232

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2021**
	Column Name:	**Total**
	Field Note: Note for reporting year 2021: Data reported are most recent validated year (2020) of Virginia Vital Events Statistics	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2021**
	Column Name:	**Total**
	Field Note: Data note for reporting year 2021: WebVision – Report #082 and #083 from the Data Warehouse using the date range Oct 1, 2020 to Sep 30, 2021	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2021**
	Column Name:	**Total**
	Field Note: Note for reporting year 2021: Data reported are most recent validated year (2020) of Virginia Vital Events Statistics	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2021**
	Column Name:	**Total**
	Field Note: Note for reporting year 2021: Data reported are most recent validated year (2020) of Virginia Vital Events Statistics	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2021**
	Column Name:	**Total**
	Field Note: Data note for reporting year 2021: Number reported Title V funded BabyCare (Infant) services from LHDs (WebVision – Report #006 using the date range Oct 1, 2020 to Sep 30, 2021)	

6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2021**
	Column Name:	**Total**

Field Note:
Note for reporting year 2021: Data reported are most recent validated year (2020) 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	2023 Application Year	2021 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 230-6977 x211	(804) 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	Cindy deSa
4. Contact Person's Telephone Number	(804) 864-7674	(804) 864-7674
5. Number of Calls Received on the State MCH "Hotline"		18,578

B. Other Appropriate Methods	2023 Application Year	2021 Annual Report Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
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		407
5. State Title V Social Media Websites	VDH Facebook, Instagram, Twitter, TikTok, Livestories, mySidewalk	Facebook, Twitter, Instagram, Livestories
6. Number of Hits to the State Title V Program Social Media Websites		1,968

Form Notes for Form 7:

Application Year 2023, Section B5: 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 2021, Section B6: Breakdown of social media website posts Facebook = 849 posts (other notes: 44,760,117 impressions)
Instagram = 60 posts (other notes: 8,769 impressions)
Twitter = 1,059 posts (other notes: 840,428 impressions)
MCH LiveStories (not social media, but relevant website https://insight.livestories.com/s/v2/maternal-and-child-healthvirginia-overview/9c64848e-1a0c-4d5b-9f0f-2a571c37e076) = 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	Children with Special Health Care Needs 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 St
City/State/Zip	Richmond / VA / 23219
Telephone	(804) 828-0352
Extension	
Email	dvyarbrough@vcu.edu

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Virginia

Application Year 2023

No.	Priority Need
1.	Upstream / Cross-Sector Strategic Planning: Eliminate health inequities arising from social, political, economic, and environmental conditions through strategic, nontraditional partnerships.
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.
3.	Mental Health: Promote mental health across MCH populations, to include reducing suicide and substance use.
4.	Finances as a Root Cause: Increase the financial agency and well-being of MCH populations.
5.	Racism: Explore and eliminate drivers of structural and institutional racism within OFHS programs, policies, and practices to improve maternal and child health.
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.
7.	Reproductive Justice & Support: Promote equitable access to choice-centered reproduction-related services, including sex education, family planning, fertility/grief support, and parenting support.
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).
9.	Maternal and Infant Mortality Disparity: Eliminate the racial disparity in maternal and infant mortality rates by 2025.
10.	Oral Health: Maintain and expand access to oral health services across MCH populations.

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 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
2020	79.8 %	0.1 %	74,285	93,115
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
2019	66.9	2.7	603	90,160
2018	69.2	2.8	634	91,628
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
2016_2020	21.6	2.1	107	494,872
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**
2020	8.3 %	0.1 %	7,824	94,688
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
2020	9.6 %	0.1 %	9,086	94,717
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**
2020	27.2 %	0.1 %	25,744	94,717
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
2020/Q3-2021/Q2	0 %			
2019/Q4-2020/Q3	0 %			
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
2019	5.5	0.2	537	97,663
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
2019	5.8	0.2	566	97,429
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
2019	3.9	0.2	377	97,429
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
2019	1.9	0.1	189	97,429
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
2019	220.7	15.1	215	97,429
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
2019	96.5	10.0	94	97,429
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
2020	6.7 %	1.2 %	5,925	88,320
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
2019	7.2	0.3	643	89,804
2018	7.2	0.3	653	90,696
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
2019_2020	9.6 %	1.2 %	169,750	1,771,153
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**
2020	15.0	1.3	139	923,852
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
2020	34.0	1.8	364	1,069,640
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
2018_2020	9.6	0.8	156	1,626,668
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
2018_2020	12.4	0.9	201	1,626,668
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
2019_2020	18.0 %	1.4 %	335,140	1,857,445
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
2019_2020	17.3 %	3.2 %	58,084	335,140
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
2019_2020	3.0 %	0.6 %	47,121	1,556,124
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
2019_2020	8.9 %	1.0 %	138,140	1,545,565
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
2019_2020	46.7 %	5.0 %	95,754	205,072
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
2019_2020	91.5 %	1.1 %	1,698,937	1,855,965
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
2019_2020	14.9 %	2.1 %	121,217	812,135
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
2017	68.8 %	4.1 %	69,000	100,000
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
2020_2021	67.2 %	1.3 %	1,176,366	1,750,544
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
2020	73.7 %	2.9 %	389,928	528,766
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
2020	90.9 %	1.9 %	480,730	528,766
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
2020	84.0 %	2.4 %	443,928	528,766
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**
2020	13.1	0.2	3,488	267,017
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
2020	11.8 %	1.7 %	10,418	88,269
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
2019_2020	2.7 %	0.6 %	49,632	1,857,445
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**	**2021**
Annual Objective			84.6
Annual Indicator	82.9	91.7	87.5
Numerator	73,338	84,128	78,142
Denominator	88,459	91,769	89,302
Data Source	NIS	NIS	NIS
Data Source Year	2016	2017	2018

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

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**	**2021**
Annual Objective			27.5
Annual Indicator	26.4	30.4	27.5
Numerator	22,710	27,265	23,681
Denominator	85,942	89,656	85,967
Data Source	NIS	NIS	NIS
Data Source Year	2016	2017	2018

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

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		27.1	27.9	28.3	29.5
Annual Indicator	26.8	29.1	31.4	29.9	31.3
Numerator	67,562	59,469	54,036	67,406	73,254
Denominator	252,334	204,083	171,987	225,762	234,340
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
2022	**2023**	**2024**	**2025**
Annual Objective	29.9	30.3	30.7	31.1

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	85.5	94.9	92.8	90.7	88.7
Annual Indicator	101.5	95.4	98.6	88.4	95.1
Numerator	785	982	1,013	906	970
Denominator	773,528	1,029,557	1,026,897	1,025,381	1,020,363
Data Source	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	86.7	84.8	82.9	81.0

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	172	162.9	156.8	151	145.3
Annual Indicator	182.6	196.3	184.5	168.1	173.7
Numerator	1,451	2,087	1,964	1,800	1,854
Denominator	794,656	1,062,972	1,064,407	1,070,646	1,067,063
Data Source	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives				
2022	**2023**	**2024**	**2025**
Annual Objective	139.9	134.7	129.6	124.8

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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		44.9	46	47.1	46.9
Annual Indicator	42.7	44.2	48.4	48.6	46.4
Numerator	167,058	172,978	188,625	174,804	155,562
Denominator	391,428	391,467	389,683	360,019	335,140
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	47.8	48.8	49.7	50.6

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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		19.3	19.5	19.7	19.9
Annual Indicator	18.8	28.1	26.5	14.5	17.4
Numerator	31,194	48,657	47,355	22,590	23,724
Denominator	166,277	172,958	179,018	155,964	136,302
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	27.6	28.1	28.6	29.2

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**	**2021**
Annual Objective			16.7
Annual Indicator	11.6	16.5	16.6
Numerator	56,684	71,210	75,517
Denominator	489,697	431,868	455,838
Data Source	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-NONCSHCN
Data Source Year	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	16.8	17.0	17.1	17.3

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**	**2021**
Annual Objective	45	49.7	50.8	50.4	50.9
Annual Indicator	46.5	44.7	49.9	48.4	46.7
Numerator	44,225	42,882	46,558	43,840	41,629
Denominator	95,088	95,839	93,304	90,596	89,193
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2016	2018	2019	2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	51.4	51.9	52.4	52.9

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		93.2	94.3	89.1	80.5
Annual Indicator	81.4	83.1	82.4	80.5	77.1
Numerator	1,407,907	1,448,110	1,463,318	1,432,504	1,360,700
Denominator	1,729,004	1,741,839	1,775,616	1,778,464	1,763,868
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		79.7	80.7	79.7	80.5
Annual Indicator	75.7	78.4	78.9	77.6	74
Numerator					
Denominator					
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	81.3	82.1	82.9	83.7

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2017: the data source is the latest available data year (2016) from the National Survey of Children's Health. Data are 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 are 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 are 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 are reported from age break-out for children age 1-5 years and children age 6-11 years.	
5.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2021: the data source is the latest available data year (2019_2020) from the National Survey of Children's Health. Data are reported from age break-out for children age 1-5 years and children age 6-11 years.	
6.	**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					
	2017	2018	2019	2020	2021
Annual Objective		93.2	94.3	89.1	90
Annual Indicator	90.9	90.5	88.2	86.6	83.4
Numerator					
Denominator					
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	90.8	91.7	92.6	93.5

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2017: the data source is the latest available data year (2016) from the National Survey of Children's Health. Data is reported from age break-out for children age 12-17 years.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2018: the data source is the latest available data year (2016_2017) from the National Survey of Children's Health. Data is reported from age break-out for children age 12-17 years.	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2019: the data source is the latest available data year (2017_2018) from the National Survey of Children's Health. Data is reported from age break-out for children age 12-17 years.	
4.	**Field Name:**	**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:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2021: the data source is the latest available data year (2019_2020) from the National Survey of Children's Health. Data is reported from age break-out for children age 12-17 years.	
6.	**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**	**2021**
Annual Objective			72
Annual Indicator	71.2	68.5	67.7
Numerator	1,323,014	1,274,181	1,257,254
Denominator	1,857,510	1,859,679	1,856,744
Data Source	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020

State Provided Data			
	2019	**2020**	**2021**
Annual Objective			72
Annual Indicator	71.3	66.9	62.9
Numerator			
Denominator			
Data Source	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	72.7	73.4	74.2	74.9

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2019: the data source is the latest available data year (2017_2018) from the National Survey of Children's Health. Data are 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 are reported from SHCN status break-out for CYSHCN.	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2020: the data source is the latest available data year (2019_2020) from the National Survey of Children's Health. Data are reported from SHCN status break-out for CYSHCN.	
4.	**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
State Performance Measures (SPMs)

State: Virginia

SPM 1 - Cross-Cutting (Early and Continuous Screening): Percent of infants diagnosed with a newborn screening disorder who are referred to care coordination services in the CYSHCN program

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			100
Annual Indicator	100	100	100
Numerator		436	301
Denominator		436	301
Data Source	VDH Newborn Screening Program, VDH EHDI	VDH Newborn Screening Program, VDH EHDI	VDH Newborn Screening Program, VDH EHDI
Data Source Year	2018	2019	2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Note for Reporting Year 2021: 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	2021
Annual Objective			Yes	Yes
Annual Indicator		Yes	Yes	Yes
Numerator				
Denominator				
Data Source		VDH Adolescent Health Program	VDH Adolescent Health Program	VDH Adolescent Health Program
Data Source Year		2019	2020	2021
Provisional or Final ?		Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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.	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Note for 2021 reporting year: VDH hired two part-time Youth Advisors, and VDH's Adolescent Health Coordinator and Youth Advisors spoke with other states, community stakeholders, and partner programs to gain insight about possible program models. The team decided on a two-pronged approach: 1) The General Body Meetings would be open to any high school aged youth in Virginia and would focus on various public health topics, and 2) The Executive Board (E-Board) would consist of teens who have demonstrated the interest and capacity to engage in program planning and implementation about a topic of their choice. Initially, the Adolescent Health Team believed that regional councils would be the best approach to ensuring representation across the Commonwealth, but has decided that regular virtual meetings open to all youth would be a more efficient and effective approach. The Youth Advisory Councils convened during FY22.	

SPM 3 - MCH Workforce Development (Racial Equity): Provide dedicated space, technical assistance, and learning opportunities that advance racial equity among MCH workforce.

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			Yes
Annual Indicator		No	Yes
Numerator			
Denominator			
Data Source		OFHS MCH Program Documentation	OFHS MCH Program Documentation
Data Source Year		2020	2021
Provisional or Final ?		Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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.

2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Note for 2021 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 continues to partner 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.

CityMatCH Alignment for Action Learning Collaborative (AAC): The Blue Ridge Health District and Birth Sisters of Charlottesville, a doula collective supporting BIPOC mothers, is one of eight teams selected nationally for the AAC two-year initiative, which began in March 2021. Title V leadership team provides consultation and partnering to assist in their strategic planning of community-led efforts to address racism and implicit bias in the Charlottesville maternal and child health care community, including OB/GYN, Family Medicine, Pediatric providers and healthcare organizations.

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			23.8
Annual Indicator	25.3	27.1	25.1
Numerator			
Denominator			
Data Source	VA PRAMS	VA PRAMS	VA PRAMS
Data Source Year	2018	2019	2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	23.3	22.8	22.3	21.8

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 reporting year: 2018 VA PRAMS data; Survey Question: Thinking back to just before you got pregnant with your new baby, how did you feel about becoming pregnant?; Answer options included in analysis: "I wanted to be pregnant later" and "I didn't want to be pregnant then or at any time in the future"; Division of Population Health Data, Office of Family Health Services.	
2.	**Field Name:**	**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.	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Note for 2021 reporting year: 2020 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.	
4.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: % decrease of 10% (HP2020 method) based on 2018 VA PRAMS baseline data.	

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			100
Annual Indicator		100	100
Numerator		4	5
Denominator		4	5
Data Source		CYSHCN Program Documentation	CYSHCN Program Documentation
Data Source Year		2020	2021
Provisional or Final ?		Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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.

2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Note for 2021 reporting year: The CCCs have family engagement written into their workplans. The goal is to have a parent staff member on board or to 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 has family representatives on 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.

SPM 6 - Promotion and strengthening of optimal mental/behavioral health and well-being through partnerships and programs

Measure Status:			Active
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	48.6	51.4	54.3

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Note for 2021 reporting year: New for FFY21.

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	2021
Annual Objective			1.8	2.1
Annual Indicator	2.2	2	2.3	2.2
Numerator	9.6	9.7	10.6	10.7
Denominator	4.4	4.9	4.7	4.8
Data Source	VDH Division of Health Statistics	VDH Division of Health Statistics	VDH Division of Health Statistics	VDH Division of Health Statistics
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	1.9	1.7	1.5	1.2

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 are 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 are 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 are the black/white infant mortality rates	
4.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2021: the data source is the latest available data year (2020) from the VDH Division of Health Statistics. Data reported are the black/white infant mortality ratio per 1,000 VA residents	
5.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: % decrease needed to 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	2021
Annual Objective			2.8	2.4
Annual Indicator	1.9	2.2	2.7	2.1
Numerator	52.6	32.4	38.2	49.1
Denominator	27.7	14.5	14.1	23.7
Data Source	National Vital Statistics System	National Vital Statistics System	National Vital Statistics System	National Vital Statistics System
Data Source Year	2013-2017	2014-2018	2015-2019	2016-2020
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	2.1	1.8	1.5	1.2

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:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2021: 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, 2016-2020.	
5.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: % decrease needed to reduce disparity to 1.23 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

State Provided Data			
	2019	2020	2021
Annual Objective			Yes
Annual Indicator			No
Numerator			
Denominator			
Data Source			OFHS MCH Program Documentation
Data Source Year			2021
Provisional or Final ?			Final

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

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Note for reporting year 2021: Due to a vacancy for the Maternal-Infant Health Consultant, this objective was unable to be accomplished this year.

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	2021
Annual Objective	7	15	20	25	35
Annual Indicator	15	30	30	30	50
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	VDH Division of Child and Family Health
Data Source Year	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	50.0	100.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Data note for reporting year 2017: Developmental screening resources, training, and TA were provided to local health district staffs and non-MIECHV home visiting staff. The training included two face-to-face events and one poly com linked to eight sites. In addition, training requests were referred to community ASQ trainers to assure timely response in addressing needs. TA and resources were provided upon request via email, nursing newsletter to the health districts, or phone call.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Data note for reporting year 2018: Trainings were done with the local health department staff administering Resource Mothers, Healthy Start, MIECHV and other non-evidence based home visiting programs.	

3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Data note for reporting year 2019: Work with the Virginia Early Childhood Foundation and selection of the 6 hub sites began late summer 2019. Hubs started surveying the screening landscape and establishing relationships and partnerships to support on-going systems collaboration and infrastructure building. Within the hubs, over 50 potential or informal partners were identified across hubs. Partners included several local coalitions which are themselves comprised of multiple stakeholders with capacity for resource sharing and cross-sector collaboration. Systems coordination activities included hosting informational meetings, identifying potential partners, learning which entities are already conducting screens and assessing how screens are being conducted (paper, online, ASQ or other, referral capacity, etc.).

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.

5.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Data note for reporting year 2021: A total of 2,089 screens were conducted in FY21 quarter 4, nearly doubling the 1,148 screens documented in the previous quarter. Of the total 2,089 screens, 585 (28%) were in the monitoring zone, and 209 (10%) either resulted in referral or were flagged for referral. In addition, overall, partnerships increased slightly this quarter; only one Hub lost a partner, due to conflicting VKRP (Virginia Kindergarten Readiness Program) requirements requiring the use of a different assessment/screening tool. 154 partners were identified in FY21 Quarter 4 across the six Hubs, a gain of nine partners over the previous quarter. DSI Hubs report 57 MOUs (Memorandum of Understandings) in place with regional partners, with 22 pending. One hundred partners are administering screens, with an additional 32 planned in the future. Data sharing agreements are in place with 42 partners, with 19 pending.

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

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	14	16
Numerator		
Denominator		
Data Source	VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program
Data Source Year	2020	2021
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	16.0	17.0	18.0	19.0

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	2021
Annual Objective			2,549	2,549	2,549
Annual Indicator		2,596	1,560	1,738	426
Numerator					
Denominator					
Data Source		VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program
Data Source Year		2018	2019	2020	2021
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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.	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Note for 2021 reporting year: FY21 efforts were impacted by COVID throughout the entire four quarters of the year. LISSDEP distribution sites are mainly comprised of local health departments. The vast majority of these volunteer distribution sites suspended program services or greatly reduced issuing safety seats due to the necessity to redirect health department staff for administering vaccinations, essential tasks, and adherence to social distancing recommendations. Additionally local health departments faced staffing shortages, which further limited their ability to provide services. A few sites adopted suggestions provided for educating and issuing seats; such as utilizing simulator seats on a one-on-one basis, issuing seats during other required contact appointments, and educating solely outside in parking lots with touchless training whenever possible. During this period of time, LISSDEP sites were unable to coordinate large-scale community level events to help meet demand and promote the program.	

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	2021
Annual Objective			10	20	250
Annual Indicator		102	195	237	501
Numerator					
Denominator					
Data Source		VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program
Data Source Year		2018	2019	2020	2021
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	300.0	350.0	400.0	600.0

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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	25	100	250	400	40
Annual Indicator	0	0	0	37	49
Numerator					
Denominator					
Data Source	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	45.0	50.0	55.0	60.0

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. These data are 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	
5.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Note for 2021 reporting year: The total number of people who enrolled for the medical home modules is 69. The breakdown by module type can be viewed below. These data are from state fiscal year 2021 (7/1/2020-6/30/2021). VDH's contract with UVA is on the state fiscal year. Medical Home for Healthcare Family=20 Medical Home for Healthcare Providers=49	

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

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	90	91.5	93	94.5	96
Annual Indicator	98.9	96.8	99	96	95.4
Numerator	4,391	4,239	4,788	5,490	3,348
Denominator	4,439	4,377	4,835	5,719	3,508
Data Source	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	97.5	98.0	99.5	99.5

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Note for 2017 reporting year: This figure represents data taken from 3 of our programs (CDC, VBDP, and SCP).	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for 2018 reporting year: Data provided for this ESM includes 3 of the 4 Children and Youth with Special Health Care Needs Programs (Child Development Centers, Sickle Cell, and Bleeding Disorders). The Care Connection for Children Program collects data regarding primary care provider but it is via survey. The 2018 survey result showed that 97.5% of parents surveyed report that their child has a primary care provider. It should also be noted that the Bleeding Disorders Program serves people of all ages, however the data represents clients under the age of 21.	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 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).	
5.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Note for 2021 reporting year: The programs we have data for are the Child Development Clinics (CDC), Sickle Cell Program (SCP), and the Virginia Bleeding Disorders Program (VBDP). The VBDP provides the data as a percentage. Staff used that to calculate the count for the numerator.	

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

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	25	100	250	400	40
Annual Indicator	0	0	0	45	49
Numerator					
Denominator					
Data Source	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Provisional	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	45.0	50.0	55.0	60.0

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. These data are 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	
5.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Note for 2021 reporting year: The total number of people who enrolled for the modules is 92. The breakdown by module type can be viewed below. These data are from state fiscal year 2021 (7/1/2020-6/30/2022). VDH's contract with UVA is on the state fiscal year. Healthcare Transition for Healthcare Family= 43 Healthcare Transition for Healthcare Providers= 49	

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			75
Annual Indicator		68.2	68.2
Numerator		90	90
Denominator		132	132
Data Source		VDH and VDOE School Health Nurse Documentation	VDH and VDOE School Health Nurse Documentation
Data Source Year		2020	2020
Provisional or Final ?		Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	77.0	79.0	81.0	83.0

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.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Note for 2021 reporting year: During the 2022 Virginia General Assembly, SB 704 was introduced to allow for the data collection of health services provided by each school, number of students with chronic health conditions, the percentage of students with health services written in their record, the number of visits to the school health office and dispositions, staffing levels of school health personnel and other information deemed necessary; however, the House Subcommittee recommended continuing to 2023 by a voice vote.	

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**	**2021**
Annual Objective			6	6	6
Annual Indicator		3	4	8	7
Numerator					
Denominator					
Data Source		VDH Oral Health Program documentation	VDH Oral Health Program documentation	VDH Oral Health Program documentation	VDH Oral Health Program documentation
Data Source Year		2018	2019	2020	2021
Provisional or Final ?		Final	Final	Final	Final

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

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for 2018 reporting year: There were 3 Regional Oral Health Collaborative Projects that implemented work plans to increase dental visits among pregnant women in FY18. South Hampton Roads, Northern Virginia, Richmond/Petersburg; Central Virginia, Newport News and Southside to come in 2019. SWVA to come in 2020.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 reporting year: There were 4 Regional Oral Health Collaborative Projects that implemented work plans to increase dental visits among 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.	
4.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Note for 2021 reporting year: There were 7 Regional Oral Health Collaborative Projects that implemented work plans and/or education to increase dental visits among pregnant women in FY21. Two projects in Richmond, three in Hampton Roads, and one each in Williamsburg/Newport News and Southwest VA.	

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**	**2021**
Annual Objective			6	6	6
Annual Indicator		3	4	8	9
Numerator					
Denominator					
Data Source		VDH Oral Health Program documentation	VDH Oral Health Program documentation	VDH Oral Health Program documentation	VDH Oral Health Program documentation
Data Source Year		2018	2019	2020	2021
Provisional or Final ?		Final	Final	Final	Final

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

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Note for 2018 reporting year: There were 3 Regional Oral Health Collaborative Projects that implemented work plans to increase dental visits among among children (ages 0-11 years) and adolescents (ages 12-17 years). South Hampton Roads, Northern Virginia, Richmond/Petersburg; Central Virginia, Newport News and Southside to come in 2019. SWVA to come in 2020.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Note for 2019 reporting year: There were 4 Regional Oral Health Collaborative Projects that implemented work plans to increase dental visits among pregnant women in FY19. Richmond/Petersburg, South Hampton Roads, Northern Virginia, and Newport News.	
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.	
4.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Note for 2021 reporting year: There were 9 Regional Oral Health Collaborative Projects that implemented work plans and/or education to increase dental visits among children and adolescents in FY21. Three projects in Richmond, three in Hampton Roads, one in Southwest VA, and two state-wide projects with Smart Beginnings and Head Start.	

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

Measure Status:	Inactive - Completed		
State Provided Data			
	2019	**2020**	**2021**
Annual Objective			40
Annual Indicator			550
Numerator			
Denominator			
Data Source			VDH CYSHCN Program, VA DMAS
Data Source Year			2021
Provisional or Final ?			Final

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.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Note for 2021 reporting year: The number reported by Department of Medical Assistance Services (DMAS) was 550. This number included MCO care coordinators, VDH CCC care coordinators and other interested parties. DMAS invited VDH to one of its regularly held MCO care coordinator's meetings. Due to being met, this ESM is being retired.	

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:	Inactive - Completed		
State Provided Data			
	2019	**2020**	**2021**
Annual Objective			3
Annual Indicator			6
Numerator			
Denominator			
Data Source			VDH CYSHCN Program
Data Source Year			2021
Provisional or Final ?			Final

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.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Note for 2021 reporting year: At the call, all centers and care coordinators agreed to work together. Due to being met, this ESM is being retired.	

ESM 15.3 - Increase percentage of uninsured children served by Child Development Clinics (CDCs) who are referred to Medicaid (if eligible) and/or other financial resources

Measure Status:	Active		
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	94.0	96.0	98.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Note for 2021 reporting year: Baseline data will be obtained

Form 10
State Performance Measure (SPM) Detail Sheets

State: Virginia

SPM 1 - Cross-Cutting (Early and Continuous Screening): Percent of infants diagnosed with a newborn screening disorder who are referred to care coordination services in the CYSHCN program
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): Provide dedicated space, technical assistance, and learning opportunities that advance racial equity among MCH workforce.
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:**
Healthy People 2030 Objective:	Develop and strengthen MCH workforce that advances racial equity.
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. Specifically as it relates to MCH workforce, because public health staff assumed new and expanded responsibilities while attempting to deliver their core responsibilities and services under strained and unusual conditions during the pandemic, this shift severely impacted the local health district MCH workforce, stressing an essential and necessary part of the MCH infrastructure. As this workforce is returning to their “new normal” operations, it is imperative that Title V ensure that the local health districts have resources available that will encourage, assist, and support the realignment of staff to MCH leadership skills, competencies, and evidence-based strategies that will move the needle on the important outcomes.

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 that annually demonstrate active incorporation of family engagement (i.e., Care Connection for Children, Child Development Centers, Bleeding Disorders Program, Sickle Cell Program)
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	Assure families of children with special health care needs partner in decision making at all levels and are satisfied with the services they receive (CYSHCN National Standard: Family Professional Partnerships / Cultural Competence).
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of CYSHCN programs documenting family engagement in work plans and annual reports **Denominator:** Number of CYSHCN programs
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.

SPM 6 - Promotion and strengthening of optimal mental/behavioral health and well-being through partnerships and programs
Population Domain(s) – Women/Maternal Health, Adolescent Health

Measure Status:	Active
Goal:	To increase the percentage of mental health screenings through strengthened partnerships and programs to bolster and close gaps in mental and behavioral health services.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Local Health Districts that screen/refer MCH populations for mental and behavioral health services **Denominator:** Total number of Local Health Districts
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Child and Family Health (Local Health District reports).
Significance:	The VDH Title V MCH needs assessment identified a cross-cutting priority in mental health across MCH populations, including reducing suicide and substance use. Support systems, referral networks, and access to mental health care are necessary to help close gaps, and ensuring partnerships and programs are in place will help achieve this goal.

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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Maintain and expand MCH data capacity regarding school health</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 Virginia school divisions reporting into the VDOE school health data system</td></tr>
<tr><td>Denominator:</td><td>Number of Virginia school divisions</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>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)</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

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:	Inactive - Completed
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:	Inactive - Completed
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.

ESM 15.3 - Increase percentage of uninsured children served by Child Development Clinics (CDCs) who are referred to Medicaid (if eligible) and/or other financial resources
NPM 15 – Percent of children, ages 0 through 17, who are continuously and adequately insured

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>ESM Subgroup(s):</td><td>CSHCN</td></tr>
<tr><td>Goal:</td><td>To ensure that uninsured children served by the Child Development Clinics are able to better access Medicaid and/or other financial resources to pay for services they need.</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 uninsured children served by the CDCs who are referred to Medicaid and/or other financial resources</td></tr>
<tr><td>Denominator:</td><td>Number of uninsured children served by the CDCs</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>VDH CYSHCN Program Documents</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>Assure families of children with special health care needs will have adequate private or public insurance or both to pay for the services they need (CYSHCN National Standard: Insurance & Financing). This strategy is further supported by data from the National Survey of Children’s Health that shows that more than 25% of parents state that their insurance is not adequate or they had gaps in insurance. By working on improving the financial agency of uninsured children, we can better connect them to services and improve NPM 15.</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

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 2021

	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	Annually	12	Yes	

Other Data Source(s) (Optional)

	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
9) ESSENCE	Yes	Yes	Monthly	1	No	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

Data Source Name:	**1) Vital Records Birth**
	Field Note: VDH Data Warehouse/Oracle Server
Data Source Name:	**2) Vital Records Death**
	Field Note: VDH Data Warehouse/Oracle Server
Data Source Name:	**3) Medicaid**
	Field Note: Virginia All-Payer Claims Database (APCD) is a program under authority of the Virginia Department of Health (VDH) that collects paid medical and pharmacy claims for roughly 4 - 4.5 million Virginia residents with commercial, Medicaid and Medicare coverage across all types of healthcare services.
Data Source Name:	**4) WIC**
	Field Note: VDH Intranet - WIC → Data and Statistics; Monthly PDF reports
Data Source Name:	**5) Newborn Bloodspot Screening**
	Field Note: Virginia Congenital Anomalies Reporting and Education System (VaCARES)
Data Source Name:	**6) Newborn Hearing Screening**
	Field Note: VDH Data Warehouse/Oracle Server
Data Source Name:	**7) Hospital Discharge**
	Field Note: VDH Data Warehouse/Oracle Server - Virginia Health Information (VHI) inpatient hospital discharges
Data Source Name:	**8) PRAMS or PRAMS-like**
	Field Note: Annual VA PRAMS dataset

Other Data Source(s) (Optional) Field Notes:

Data Source Name:	**9) ESSENCE**
	Field Note: Syndromic surveillance