Maternal and Child Health Services Title V Block Grant

Virginia

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FY 2024 Application/ FY 2022 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

COMMONWEALTH *of* VIRGINIA

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July 18, 2023

Michael D. Warren, MD, MPH, FAAP
Associate Administrator
Maternal Child Health Bureau (MCHB)
Health Resources and Services Administration (HRSA)
US Department of Health and Human Services (DHHS)
5600 Fishers Lane
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Dear Dr. Warren,

It is with pleasure that I submit Virginia's 2024 Title V Block Grant Application and 2022 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, adolescents, and children and youth with special healthcare needs, and their families.

We look forward to this continued partnership.

Most sincerely,

Cynthia C. deSa, MPH, MSW, LCSW
Maternal Child Health/Title V Director
Office of Family Health Services
Division of Child and Family Health

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.

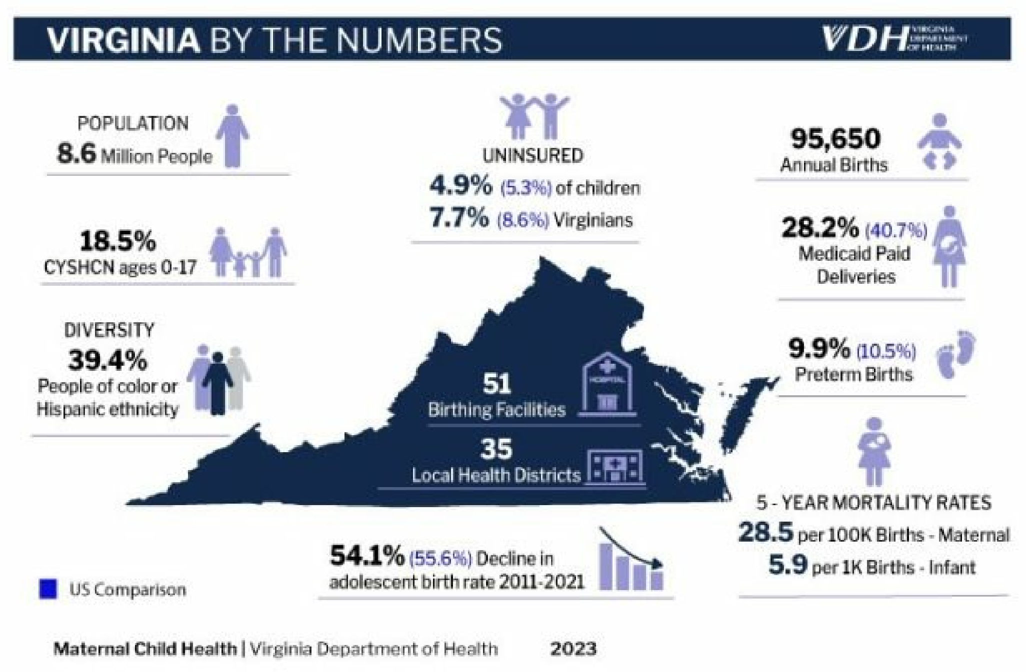
II. Logic Model

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: January 31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview



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.

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 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

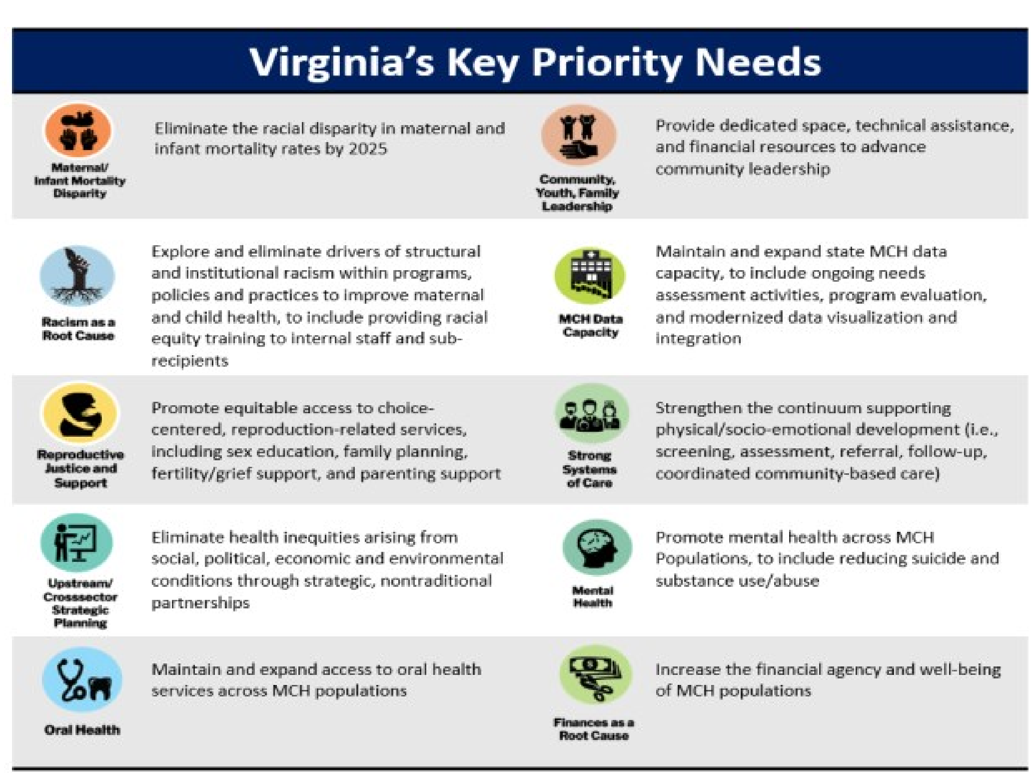
(LHDs).

NEEDS ASSESSMENT

Virginia conducted a comprehensive statewide needs assessment in 2019. The key priorities identified during this assessment shape and drive the objectives and strategies for the 5-year period from 2020-2025. Virginia'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 program 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.



PERFORMANCE MEASURES AND OUTCOMES

Virginia ranks 14th for the overall health of women and children (2022) IMPROVING

Women's/Maternal Health

The maternal health priorities reflect: (i) ongoing need to address maternal morbidity and mortality, mental health for women of reproductive age, and risk factors associated with preterm births; (ii) promote equitable access to choice-centered, reproduction-related services, including sex education, family planning, fertility/grief support, and parenting support; (iii) maintain and expand state MCH data

capacity, to include ongoing needs assessment activities, program evaluation, and modernized data visualization and integration; and (iv) maintain and expand access to oral health services. Title V strategies work with a diverse set of partners to improve the outcomes for women before, during, and after pregnancy.

• 11th overall for the health of women (2022)	WORSENING
• 46.3% of women had a preventive dental visit during pregnancy (NPM 13.1)	STABLE
• Percentage of women reporting that they wanted to become pregnant later or never was 19.9% (2021)	IMPROVING
• 38.7% of pregnancies were described by women as unintended (2021)	IMPROVING
• Maternal morbidity rate was 73.8 per 10,000 delivery hospitalizations (NOM 2)	WORSENING
• non-Hispanic White – 55.5;	WORSENING
• non-Hispanic Black – 124.6;	WORSENING
• ≥35 years – 98.6	IMPROVING
• Maternal mortality rate was 26.8 per 100,000 live births (NOM 3)	WORSENING
• non-Hispanic White – 24.6;	WORSENING
• non-Hispanic Black – 55.0	WORSENING
• Leading causes of pregnancy-associated deaths were COVID-19, accidental overdose, cardiac conditions, cancer, hemorrhage, and chronic disease exacerbations	
• Percentage of women who experienced postpartum depressive symptoms following a recent live birth was 11.2% (2021)	IMPROVING
• Percentage of women who did not attend postpartum care due to COVID-19 pandemic was 7.1% (2021)	IMPROVING

Perinatal/Infant Health

Strategies focus on improving birth and infant outcomes and expanding state MCH data capacity to include ongoing needs assessment activities, program evaluation, and modernized data visualization and integration, as well as statewide breastfeeding supportive efforts.

• 23rd overall for the health of infants (2022)	IMPROVING
• 87.4% of moms ever breastfed and 19.0% breastfed for 1-10 weeks; 57.7% were still breastfeeding at the time of the VA PRAMS survey	IMPROVING
• Non-Hispanic White – 60.7%;	IMPROVING
• Non-Hispanic Black – 43.2%;	IMPROVING
• Non-Hispanic Other – 63.8%;	WORSENING
• Hispanic – 58%	IMPROVING
• Infant mortality rate was 5.9 per 1,000 live births (2020)	WORSENING
• White – 4.6;	STABLE
• Black – 10.1;	IMPROVING
• Hispanic – 6.5	WORSENING
• Leading causes of infant mortality: Respiratory distress disorders, accidental suffocation/strangulation, disorders related to short gestation & low birth weight, and sudden infant death syndrome	

Child Health

Title V's work in child health focuses on strong systems of care for all children, finances as a root cause, oral health, and mental health.

• 14th overall for the health of children (2022)	IMPROVING
• Percent of children, ages 9-35 months, who received a developmental screening using a parent-completed screening tool in the past year is 34.4% (NPM 6)	IMPROVING
• Rate of hospitalization for non-fatal injury among children was 79.1 per 100,000 (NPM 7.1)	IMPROVING
• <1 year – 204.6;	IMPROVING
• 1-4 years – 86.3;	IMPROVING
• 5-9 years – 49.8	IMPROVING
• 67% of children ages 1-5 years and 89.4% of children ages 6-11 years had a preventive dental visit (NPM 13.2)	IMPROVING

Adolescent Health

Adolescent Health focuses include mental health, oral health, finances as a root cause, and strong systems of care for all children.

• Rate of hospitalization for non-fatal injury among adolescents was 180.2 per 100,000 (NPM 7.2)	WORSENING

• 10-14 years – 92.0;	IMPROVING
• 15-19 years – 265.8	WORSENING
• 44.9% of middle school students experienced at least one form of bullying, bullying on school property or cyberbullying (2021) ◦ Those who experienced cyberbullying were more likely to report suicidality (48.9%), not feeling good about themselves (62.6%, n = 328), ever drank alcohol (32.0%), and ever-used electronic vapor products (14.1%).	IMPROVING
• 17.9% of high school students were victims of any form of bullying (2021) ◦ Those who experienced cyberbullying were more likely to report feeling sad for 2 weeks or more (74.0%), current alcohol use (40.6%), suicidality (56.4%), purposely hurting themselves without wanting to die (51.7%), electronic vapor products use (34.1%) and current marijuana use (24.6%).	IMPROVING
• 14.4 % of adolescents received services necessary to make transitions to adult health care (NPM 12)	WORSENING
• 88.6 % of adolescents (ages 12-17) had a preventive dental visit (NPM 13.2)	IMPROVING
• Teen pregnancy rate is 15.1 per 1,000 females ages 15 to 19 years	IMPROVING
Children with Special Health Care Needs CYSHCN focuses on strong systems of care for all children, finances as a root cause, and community, family, and youth partnerships.	
• Percent of children with special health care needs (CSHCN) is 18.5% (NOM 17.1)	IMPROVING
• 43.9% of CSHCN had a medical home (NPM 11)	WORSENING
• 19.5% of CSHCN age 12-17 years were engaged in transition services to adult health care (NPM 12)	IMPROVING
• 66.4% of CSHCN continuously and adequately insured (NPM 15)	WORSENING
Cross-Cutting / Systems Cross-cutting strategies include upstream/cross-sector planning, and racism as a root cause.	
• Expand capacity to document and track referrals of infants from the Newborn Screening Program to CSHCN programs	
• Develop and sustain the VDH Youth Advisor Program	
• Implement MCH workforce development policies addressing racial equity	
• Maintain and expand family engagement	

Worsening – Change in rate or percentage of 1% or greater in the wrong direction
Stable – Change in rate or percentage was 1% or less
Improving – Change in rate or percentage of 1% or greater in the right direction

IMPROVING THE HEALTH AND WELLBEING OF VIRGINIANS

Virginia's Title V Program is committed to the assurance of health and wellbeing for all people in the Commonwealth. Title V's programs and services focus on issues of equity, addressing the needs of underserved populations, and where there is demonstrated need. Funding supports strong programmatic efforts that synthesize the key state priorities into actionable strategies.

WOMEN/MATERNAL HEALTH The health and wellbeing of people of reproductive age is significantly impacted by the care they receive. Broad initiatives by Virginia's Title V Program to decrease the disparity in Black-White maternal mortality includes strengthening data-driven strategies in partnership with our MCH Epidemiology Team, utilizing community stakeholders to implement maternity mortality review team recommendations, increasing access to doula support for all Virginians, improving access to pregnancy prevention, and ensuring that pregnant women have their dental health needs met. Strong mental health initiatives address substance use in pregnant and parenting people, and pregnancy loss support in collaboration with our Reproductive Health Unit.

PERINATAL/INFANT HEALTH A critical priority remains supporting healthy pregnancies and improving birth and infant outcomes. Partnerships with birthing hospitals, the Virginia Neonatal Perinatal Quality Collaborative, Virginia's network of home visiting programs, all 35 local health districts, and local stakeholder groups strive to ensure healthy and supportive environments for Virginia's babies through perinatal programming that supports breastfeeding, assures infant safety, and scaffolds around substance-exposed infants.

CHILD HEALTH Early identification of developmental delays and social-emotional challenges is a critical priority. Core program components include training providers to support parents in completing Ages & Stages Questionnaires and identifying and promoting best practices that assure families receive appropriate referrals for further assessment, specialized intervention, or ongoing monitoring. Close partnership home visiting and various interagency initiatives prepare a workforce poised to seamlessly support health, development, learning, and school success. Strategies regarding injury prevention and oral health are prioritized for Virginia's children as well.

ADOLESCENT HEALTH A comprehensive structure exists to reduce adolescent and young adult suicide rate as well as to increase protective factors and improve systems to reduce risk factors associated with adolescence. Virginia's Title V program implements evidence-based comprehensive sexual education programs, provides suicide prevention trainings to professionals interacting with adolescents, supports pregnant and parenting teens through the Resource Mothers program, and ensures that school nurses have ongoing professional development and support.

CHILDREN AND YOUTH WITH SPECIAL HEALTHCARE NEEDS Through excellent stakeholder partnership to provide diagnostic and case management support in Care Connection for Children and Child Development Clinic across the state, Virginia's children with special healthcare needs receive coordinated and ongoing comprehensive, interdisciplinary support to ensure their access to medical homes and transition services.

CROSS-CUTTING/SYSTEMS-BUILDING Virginia's robust newborn screening program ensures early connections for families to supportive services. Virginia's two youth advisors provide expertise, guidance, and feedback on current and future public health initiatives, and additional collaborative work examines and addresses methods through which racial equity is advanced across all MCH populations.

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

MCH SUCCESS STORY

Adolescence is a time of significant development and changes in all aspects – physical, cognitive, and social. Creating a foundation of health literacy during this period is linked to downstream positive health outcomes. *GetReal: Comprehensive Sex Education That Works* is a comprehensive sexuality education curriculum that has been on the US Department of Health and Human Services (HHS) list of evidence-based programs since 2015. *Get Real* is a middle school curriculum that delivers accurate, age-appropriate information and emphasizes healthy relationship skills and family involvement through both classroom and take-home activities.

Virginia's Adolescent Health Program utilizes Title V funds to implement *Get Real* in partnership with community based organizations across the state.

Eastern Virginia Medical School has spent the last few years building the infrastructure for *Get Real* comprehensive sex education in Norfolk, Virginia. The Norfolk City Public School system is the 10th largest in Virginia, serving approximately 28,000 students K-12. EVMS draws from the Youth Participatory Action Research Framework (YPAR) and the Asset-Based Community Development Framework, and they engage youth every step of the way. Some strong examples of this include EVMS' "Open Calls," "Design-A-Thons," and Training Bootcamps, all of which invite teens to participate in a meaningful way. Interviews were held with NPS Physical Education (PE) and Family Life Education (FLE) teachers (6th - 10th grade), related school administrators, representatives of NPS parents/caregivers and/or student leaders. As parent engagement is a crucial tenant of the *Get Real* program, the EVMS/NPS program team hosted Parent Orientation and Q&A sessions to address questions/concerns from NPS students, parents/caregivers and other stakeholders. EVMS staff also made themselves available for multiple "Community Reviews" of the curriculum, followed by the review of NPS Executive Leadership. The *Get Real* program was then presented to the NPS School Board, after leaving additional time for feedback.

In May 2023, the Norfolk Public School Board voted to approve the *Get Real* curriculum in partnership with EVMS, largely thanks to their commitment to community and willingness to engage with all stakeholders - youth, parents, administrators, and community members.

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.

To execute this mission, Virginia's Plan for Well-Being (PfWB) 2023-2027 is a shared vision to improve the health of all Virginians. It outlines priority areas and includes strategies to improve the health of all people in Virginia. It is a tool for health care professionals, government agencies, community-based organizations, advocates, academicians, policymakers, and other stakeholders to use to catalyze action that will leverage resources and focus work towards measurable improvement. Grounded in data, the Plan for Well-Being identifies strategies to improve outcomes around five priority areas identified by the State Health Assessment Advisory Council in August 2022. A sixth priority area was identified in the spring of 2023, based on the increase of drug overdose deaths and the need to address this issue from a statewide perspective over the PfWB development time period. These priority issues include infant mortality, firearm deaths, obesity, substance use and drug overdose, mental health, and housing, transportation, and economic stability.

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 the Chief Operating Officer and Deputy Commissioners distributed across four main operating divisions: Population Health & Preparedness, Administration, Community Health Services, and Governmental and Regulatory Affairs.

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.

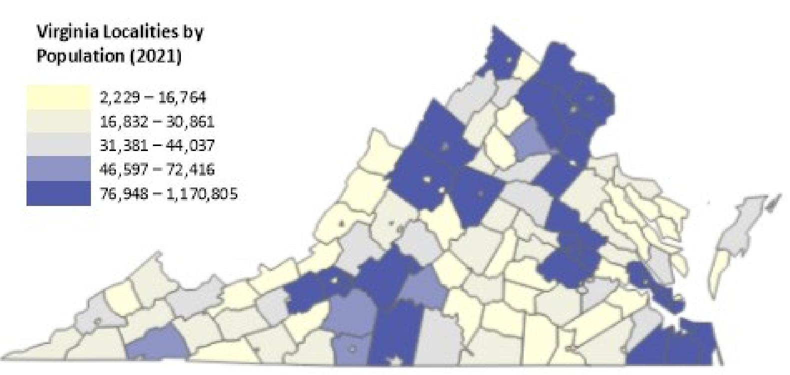
- **Reproductive Justice & Support:** Promote equitable access to choice-centered reproduction-related services, including sex education, family planning, fertility/grief support, and parenting support.
- **Upstream / Cross-Sector Strategic Planning:** Eliminate health inequities arising from social, 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.

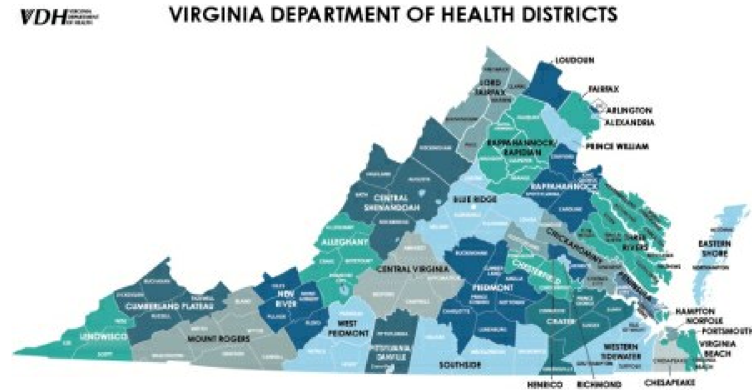
Population Density & Urbanization

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 200.6 per square mile. The largest independent cities are Virginia Beach (457,658), Chesapeake (247,172), Norfolk (238,556), the state's capital Richmond City (225,676) and Newport News City (185,069). 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, or 37% of the population, live in Northern Virginia. The most populous jurisdiction (and county) in the state is Fairfax County in Northern Virginia, with a climbing population of nearly 1.15 million. Fairfax County has a major urban business and shopping center in Tysons Corner, Virginia's largest office market. Neighboring Prince William County (477,224) 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 21.9% of the

state's population growth. Loudoun County in Northern Virginia with its 413,574 residents surpasses Chesterfield County in the Richmond MSA with its 359,798 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 nearly 8.7 million people (World Population Review).

Race/Ethnicity

Among people reporting one race alone, 67.2% identified as White, 20.3% identified as Black, 0.5% American Indian and Alaska Native, 7.5% Asian, and 0.1% Native Hawaiian and Pacific Islander (2021: ACS 5-Year Estimates Data Profiles, Demographic and Housing Estimates). There were 10.2% 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).

Virginia sits on ancestral lands of various Indigenous Tribes that were firmly established before the English settlement in Jamestown, and have made significant contributions to the survival of new settlers in Virginia. The Commonwealth of Virginia consists of 11 state recognized tribes (Virginia Indians), 7 which are federally recognized tribes (Federally Recognized Indian Entities). Of those identifying as American Indian and Alaska Native with one specified tribe alone, 14.4% identified as Central American Indian, 10.8% identified as Cherokee, 7.2% identified as Mexican American Indian, 3.2% identified as South American Indian, and 15.3% identified as an Other American Indian Tribe (2021: ACS 5-Year Estimates

Data Profiles, American Indian and Alaska Native Alone for Selected Tribal Groupings). Indigenous populations largely reside in the Three Rivers Health District in the eastern part of the Commonwealth.

There were over 1.7 million women of childbearing age (15-44 years) in 2021, with race and ethnicity composition consisting of 56.0% non-Hispanic White, 20.5% non-Hispanic black, 8.2% non-Hispanic Asian or Pacific Islander, 0.3% non-Hispanic Native American or Alaska Native, and 11.7% Hispanic (any race) (2021: CDC WONDER Population Estimates). The Virginia population, like that of the nation, is becoming more racially and ethnically diverse where 12.5% of the population are foreign-born (2021: ACS 5-Year Estimates Data Profiles, Selected Social Characteristics).

Age and Sex

In the Commonwealth of Virginia, gender identification was 49.5% as male and 50.5 as female, with an estimated 97.9 males per 100 females. The age breakdown of Virginians is 5.8% under 5 years, 22.0% under 18 years, and 15.5% of persons 65 years or older (2021: ACS 5-Year Estimates Data Profiles, Demographic and Housing Estimates). There were 186,643 grandparents, and 35.2% were responsible for their grandchildren under age 18 (2021: ACS 5-Year Estimates Data Profiles, Demographic and Housing Estimates).

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, 5.5% have a 9th to 12th grade education with no diploma, 23.8% are high school graduates or equivalent, 22.8% have a bachelor's degree, and 17.6% have a graduate or professional degree (2021: 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 over 4.4 million civilian workers, and 15.4% are in service occupations. The unemployment rate in Virginia was 4.6% as per ACS 2021, below the national rate of 5.5%. The median household income in Virginia is $80,615 compared to $69,021 in the U.S. (2021: ACS 5-Year Estimates Data Profiles, Selected Social Characteristics).

Compared to the U.S. population, a lower percentage of Virginia families lived in households with incomes below the federal poverty level (9.7% vs. 12.3% for the U.S.) and a lower percentage of children under age 18 lived in households with incomes below the federal poverty level (13.0% vs. 17.0% for the U.S.). However, wealth varies significantly across the state. The percentage of children living in poverty was 13.1% in 2021 (2021: ACS 5-Year Estimates Data Profiles, Poverty Status in the past 12 months). For the years 2020-2021, 17.7% of children with special health care needs lived in families with incomes less than 100% of the federal poverty level (2020-2021 National Survey of Children's Health (NSCH)). This is in comparison to children without special health care needs, of which 13.8% 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, 33.4% are rented. In renter-occupied units, nearly half (47.3%) pay 30 percent or more of their household income to rent (2021: ACS 5-Year Estimates Data Profiles, Selected Housing Characteristics). In 2019, 63% of Virginia children lived in low-income households with high housing cost burden (KIDSCOUNT Data Center) with the median rent in Virginia at $1,326. The median home value for owner-occupied units in Virginia is $295,500 (2021) compared to $248,400 in 2016, a 19.0% 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, 704,270 people are facing hunger, and 1 in 11 are children (Feeding America). According to 2021 America's Health Rankings, 7.8% 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 2021, 44.9% of households receiving Supplemental Nutrition Assistance Program (SNAP) benefits have children (Feeding America).

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 3.2% of children in the care of grandparents. The majority of Virginia parents (77.9%) report that they have someone to turn to for day-to-day emotional support with parenting or raising children (NCHS 2020-2021). There were 63.6% of high school students that have an adult to go to for help with a serious problem, a decrease from the previous survey year (Virginia YRBS).

Racism and Discrimination

Racism and discrimination are among other social determinants of health that negatively influence health. During their pregnancy, mothers expressed experiencing discrimination or harassment due to their race, ethnicity, or culture (6.5%); insurance or Medicaid status (4.1%); weight (6.5%); and marital status (2.1%). Approximately 19.7% of Non-Hispanic Black mothers, 1.9% of Hispanic mothers, and 15.4% of mothers identifying as another race reported discrimination or harassment due to their race, ethnicity, or culture (Virginia PRAMS 2021). Among high school students, 19.4% have been a victim of teasing or name-calling because of their actual or perceived race or ethnic background.

Health Care Access

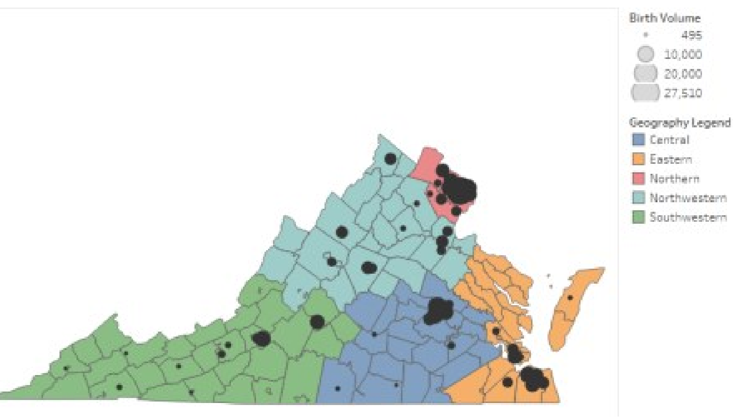
Primary Care Access and Health Insurance Coverage

Based on the 2021 ACS 5-Year Estimates, 92.1% of Virginians have health insurance of some kind, where 75.2% were private and 30.0% were public. 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. Among the uninsured population, 4.9% were under the age of 19, 13.8% were young adults (ages 24 to 34), 21.6% had less than a high school education, and racial identification was 6.4% as White, 8.7% as African American, 13.2% as American Indian and Alaska Native, and 22.9% Hispanic or Latine/x (2021 ACS 5-Year Estimates).

Health Care Professional Shortages and Birthing Hospitals

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). In addition, Virginia has 51 birthing hospitals that serve pregnant people in the Commonwealth as of 2023 (see Figure), and 55 counties (41.4%) are considered either maternity care deserts or having low access to maternity care (March of Dimes). Virginia has lower median allowed values for vaginal and C-section deliveries (including professional and facility costs) occurring at in-network hospitals than the national median, but higher median charged values to uninsured patients or delivering at out-of-network hospitals (Fair Health).



Performance Measures and Outcomes

DOMAIN: Women's/Maternal Health

According to America's Health Rankings (2022), Virginia ranks 11th 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 46.3% of moms had a preventive dental visit during pregnancy (2021 VA PRAMS). 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 19.9% (2021 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, 38.7% 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 28.5 per 100,000 live births, with a rate of 26.3 per 100,000 among White women and 43.9 per 100,000 among Black women (2017-2021). The Black/White Maternal Mortality Ratio was 1.7 (SOM 2).

NOM 2: Severe Maternal Morbidity – The rate of severe maternal morbidity in Virginia is 73.8 per 10,000 delivery hospitalizations, where hemorrhage accounts for 29.5 per 10,000 (2020). Increases were seen among other medical, obstetric, renal, and respiratory complications. Disparities exist among race/ethnicity (non-Hispanic Black – 124.6), health insurance (Medicaid – 92.8, Uninsured – 109.5), and maternal age (≥35 Years – 98.6).

SPM 6: Mental Health & Well-Being - The percentage of women who experience postpartum depressive symptoms following a recent live birth was 11.3% (2021 Virginia PRAMS). 23 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 (2021) showed 87.4% of respondents ever breastfed,19.0% breastfed for 1-10 weeks, and 57.7% were breastfeeding at the time of the survey. There were some differences observed in continuation by race, whereby at the time of the survey 60.2% of Non-Hispanic White moms were breastfeeding at the time of the survey, 63.8% of Hispanic moms, and 43.2% of Non-Hispanic Black moms.

NOM 9.1: Infant Mortality – Infant mortality is a sentinel measure of population health that reflects the underlying well-being of mothers and families, as well as the broader community and social environment that cultivate health and access to health-promoting resources. The infant mortality rate in Virginia is 5.9 per 1,000 live births (Virginia Vital Statistics System, 2021). A significant disparity exists in infant deaths between racial groups in Virginia, where non-Hispanic Black women had an infant mortality rate of 10.1, twice that for non-Hispanic White women (4.6 per 1,000 live births). Reduction in the disparity in infant mortality remains a priority of the upcoming 2023-2027 Virginia Plan for Well-Being. The Black/White Infant Mortality Ratio is 2.2 (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 102.4 per 100,000 live births (National Vital Statistics System, 2020); with disparities among race/ethnicity (non-Hispanic Black – 213.7), health insurance (Medicaid – 218.2, Uninsured – 100.9), and maternal age (<20 Years – 251.7).

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 (2022), Virginia ranks 14th overall for the health of children. The child mortality rate was 16.2 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 34.4% (2019-2020) in Virginia, compared to the U.S. at 34.8%. 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 79.1 per 100,000 in 2020. Among age groups, the annual indicator was 204.6 for children less than one year of age, 86.3 among children ages 1-4, and 49.8 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 180.2 per 100,000 in 2020. The annual indicator was 92 among age 10-14 years and 265.8 among age 15-19 years. 17.9% of high school students were victims of any form of bullying. Those who experienced cyberbullying had higher reports of feeling sad for 2 weeks or more (74.0%), current alcohol use (40.6%), and considered suicide (51.7%). In addition, LGBT students reported feeling sad more than heterosexual students (62.9% vs 30.4%) Virginia YRBS, 2021). The adolescent suicide rate was 11.7 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 (2020-2021) showed only 19.5% of adolescents received services necessary to make transitions to adult health care. Health care transition focuses on building independent health care skills – including self-advocacy, preparing for the adult model of care, and transferring to new providers.

NPM 13.2: Preventive Dental Visit (ages 12-17 years) – The NSCH (2020-2021) showed that 74.2% of adolescents had a preventive dental visit.

Pregnancy Intention – The teen pregnancy rate has been declining, with the rate in Virginia being 15.1 per 1,000 females aged 15 to 19 years (Virginia Vital Statistics System, 2021). 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 2021 at 30.8 and 25.1 per 1,000 females aged 15-19 respectfully. The Eastern (20.9), Southwestern (19.1), and Central (18.3) regions had rates higher than the state rate. The public savings in 2015 due to declines in the teen birth rate have totaled an estimated $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 18.5% (NSCH 2020-2021).

NPM 11: Medical Home (CSHCN ages 0-17 years) – The NSCH (2020-2021) showed that 43.9% 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 (2020-2021) showed that 19.5% of CSHCN age 12-17 years were engaged in transition services to adult health care. Transition to adult care is important to gain independent health care skills, prepare for an adult model of care, and transfer to new clinicians to continue services.

NPM 15: Continuous and Adequate Insurance (CSHCN ages 12-17 years) – The NSCH (2020-2021) showed that 66.4% of CSHCN were continuously and adequately insured. There were 34.1% of CSHCN that had public insurance only, 58.9% private insurance only, and 1.4% 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. In addition, the General Assembly passed legislation in 2020 for the Board of Health to adopt regulations to implement an adult comprehensive sickle cell network, as well as funding to support the adult clinics' infrastructure. The regulations have been incorporated in the VAC, and outlines the scope and services the adult comprehensive sickle cell network provides.

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.

Children's Cabinet: In June 2018, the former Virginia Governor Ralph Northam issued Executive Order No. 11 reestablishing the Children's Cabinet (Press Release). The former First Lady led 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 made the most of early childhood education resources. The Children's Cabinet prioritized 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 previous meetings of the Cabinet and workgroups can be found here https://www.governor.virginia.gov/childrens-cabinet/meeting-materials/. The Children's Cabinet did not continue into the new administration in 2022.

House Bill 1950 (2021 General Assembly) directed the VDH Office of the Chief Medical Examiner (OCME) to convene a workgroup to assess the feasibility of implementing the Fetal Infant Mortality Review Team (FIMRT), in which the Director of the Division of Child and Family Health served as a member. Although a report was published with the findings and recommendations from this workgroup in December 2021, a bill was not submitted in the 2022 legislative cycle to allow for its implementation at this time.

Virginia House Bill 2111 (2021 General Assembly) 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 2023 General Assembly directed the Task Force to also explore the role of implicit bias training for providers. A final report of recommendations due in December 2023.

New Legislation and Initiatives

The 2022 and 2023 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 of all efforts:

- House Bill 229 (2022) Social determinants of health; VDH shall collect & analyze information including demographic data.
- House Bill 1567 (2023) Perinatal Health; VDH to convene a work group to evaluate strategies to reduce maternal and infant mortality rates through expansion of the perinatal health hub model.
- Senate Bill 1254 (2023) Maternal Mortality Review Team; directs the MMRT to provide reports on an annual basis rather than a triennial basis.
- Senate Bill 1531 (2023) Virginia Neonatal Perinatal Collaborative; Directs the Secretary of Health and Human Resources to convene a work group to make recommendations to strengthen the Collaborative in doing quality improvement initiatives on a statewide basis.

III.C. Needs Assessment
FY 2024 Application/FY 2022 Annual Report Update

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 and Virginia Commonwealth University, 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. An updated survey has been developed for dissemination in Summer 2023.

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. New PRAMS dashboards were also launched for commonly requested indicators. The Injury and Violence Dashboard provides hospitalization data by mechanism and intent at the state, region, district, and locality levels. In conjunction with the Office of Epidemiology, the Firearm-Related Deaths Dashboard provides data by year, age group, race/ethnicity, sex, health district, and intent of injury on all types of firearm-related deaths to resident Virginians using Vital Records data. 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 epi reports, 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.

These tools have allowed the team to 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 recently conducted a state health assessment (SHA) and is in the process of releasing a new state health improvement planning (SHIP), known as the Virginia Plan for Well-Being (PfWB), for 2023-2027. 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 were involved to provide insights, data, and expertise regarding MCH populations, and infant mortality was selected as a state priority.

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:

- CityMatCH Alignment for Action Learning Collaborative: The purpose of this project is to better align state- and local-level MCH work. Blue Ridge Health District (BRHD) and Birth Sisters of Charlottesville, community-based doula collective supporting people of color, were selected to participate in this learning collaborative. Virginia's Title V leadership is providing consultation to assist BRHD 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. To meet one of the goals of the learning collaborative, Title V leadership and BRHD supported the Birth Sisters of Charlottesville to hold "Listening to the Living", an online learning event that centered black women's birth experiences to address racial disparities. This work was presented at CityMatCH in 2022.
- 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, Hispanic, Indigenous, Asian, Pacific Islander, and other racialized communities.
- National Maternal Child Health Workforce Development Center cohort: VDH's Title V staff is participating in the National MCH Workforce Development Center cohort to initiate a robust strategic process to strengthen maternal mental health in conjunction with the Reproductive Health and Injury/Violence Prevention teams. This cohort is an opportunity to breakdown silos to develop and implement better policies, programs, and practices across shared spaces. The outcome is that mental health and collaboration become a core value across all programs that serve MCH populations.

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.

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 continue to remain twice and nearly three times that of their White counterparts, respectively. To address these disparities, overall MCH efforts are focusing on contributing factors to mortality such as access to care (e.g., increasing home visiting, doula support, pregnancy loss support), family planning (e.g., increased access to highly and moderately effective contraceptives), maternal/caregiver 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. In partnership with sister agencies, this plan will be revised by MCH staff in 2024 to further align efforts to address racism that will help inform future year strategies and activities.

Maternal Health: Maternal mortality in Virginia due to direct and indirect obstetric causes has continued to have an upward trend. Data in 2021 indicate a maternal mortality rate of 47.0 per 100,000 live births, over three times higher than the rate in 2020 (15.8 per 100,000 live births). Increases continue to be driven by rates among non-Hispanic Black birthing people. Preliminary data from the Pregnancy-Associated Mortality Surveillance System indicate that approximately top two causes of deaths were attributed to COVID-19 and accidental overdoses. Late maternal deaths due to obstetric causes have also continued to increase, which provides insight into deaths occurring in the 4th Trimester and helps to inform efforts related to postpartum care. In preparation for the new five-year cycle and reporting of the new universal performance measure on postpartum visits, pre-planning is underway to determine how local health districts can be supported related to postpartum care activities.

Infant Health: In 2021, the top five most prevalent causes of infant mortality in Virginia included congenital malformations/chromosomal abnormalities, sudden unexpected infant death (SUID), disorders related to short gestation and low birthweight, newborn affected by maternal complications of pregnancy, and respiratory distress syndrome. Five hundred sixty-eight infants died before their first birthday in Virginia, making the overall infant mortality rate across all races 5.9 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 2.2. Emerging public health issues continue to be assessed. Current disease surveillance efforts within the Office of Epidemiology are indicating a rise in congenital syphilis in the Commonwealth, matching similar increases in national trends. Efforts are underway to improve education of providers and screening of the pregnant population.

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 2021, almost five Virginians died by drug overdose approximately every day. Virginia has seen a 56% increase in the number of drug overdose deaths from 2017-2021; approximately nine out of 10 drug overdose deaths each year (2017-2021) involved opioids. There was also an average of over 7,600 nonfatal drug overdose hospitalizations among Virginians each year from 2017-2021; in 2021 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 $250 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 2021, there were 6.2 maternal opioid related diagnoses (MOD) per 1,000 delivery hospitalizations and 5.6 NAS cases in Virginia per 1,000 birth hospitalizations. Although this is a decrease from 2020, higher MOD and NAS rates continue to be 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 is an initiative advancing statewide delivery of prenatal and postpartum education on child maltreatment and infant injury prevention to newborn and infant parents and caregivers prior to their maternity hospital discharge to home or setting after birth and/or as they access community level settings, inclusive of service receipt from libraries and health departments. Priority populations include mothers of NAS infants and pregnant women at risk for or with a history of addiction.

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

Self harm: On average from 2017-2021, suicide was the 10th leading cause of death in Virginia. Suicide continued to be the 11th leading cause of death in Virginia since 2020 due to COVID-19 rising to the top ten causes of death statewide. The average number of deaths by suicide in Virginia from 2012-2021 was 1,128 deaths each year, with an increase of 12% from 2012 to 2021. In 2021, deaths by suicide among Virginians resulted in 35,101 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 was an average of 2,806 nonfatal self-harm hospitalizations each year in Virginia from 2017-2021, costing an average of over $37,000 and a length of stay of over four days per hospitalization, with a total cost of over $537 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. Work has also included the Virginia Suicide Prevention Plan across the Lifespan, which has resulted in a partnership with James Madison University to ensure a comprehensive suicide prevention program statewide by increasing the number of gatekeepers serving disparate populations.

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, pregnancy loss, home visiting, Resource Mothers, adolescent family life programs, and CYSHCN child development centers work. A recent survey that was implemented to ascertain how prepared youth (14-22) are to transition to adult care identified mental health as a prevalent issue among respondents. Local health districts will also continue to have the opportunity to focus on mental health in their MCH work plans for FY24. In addition, the MCH Epidemiologist Lead and IVPP Senior Epidemiologist participated in the Policy Center for Maternal Mental Health Governmental Fellows Program, representing the Virginia Department of Health. This 12-months-long learning collaborative brought fellows from agencies across the nation in order to assist localities in closing gaps in maternal mental health using a multi-agency approach. The deliverable from this participation was an office-specific maternal mental health action plan that serves as a guide to break silos, build staff capacity, and close gaps to reduce and prevent adverse health outcomes associated with maternal mental health. Additional funding opportunities have also been sought to support maternal mental health and substance use initiatives.

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 Resources 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. Current work of the Governor includes the Right Help, Right Now initiative to address the behavioral health care challenges facing the Commonwealth, and it is designed to address issues involving mental health and substance use.

Organizational Structure

The Health and Human Resources 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/MCH 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 Connection for Children Centers, and Bleeding Disorders programs in Virginia. The Operations Division of the Office of Financial Management has a grant fiscal team that submits fiscal reports on behalf of agency programs. Title V funding supports a dedicated grant fiscal team member 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, prioritizes 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 Connection for 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:

2023 Application/2021 Annual Report – Needs Assessment Update

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

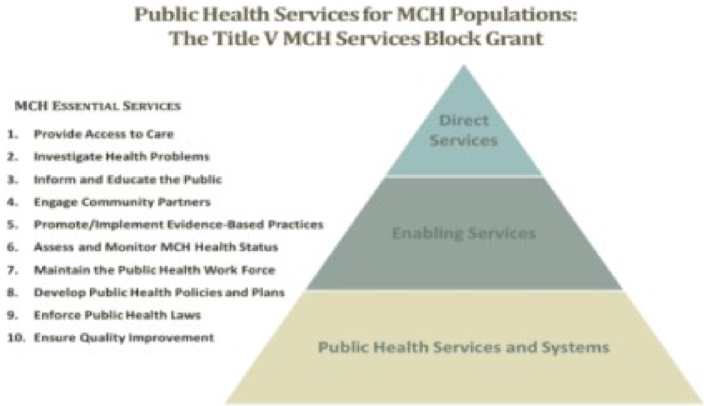
	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$12,287,553	$11,750,864	$12,287,553	$12,375,275
State Funds	$9,215,665	$6,169,903	$9,215,665	$9,282,539
Local Funds	$0	$0	$0	$0
Other Funds	$1,618,704	$1,625,174	$1,618,704	$1,702,690
Program Funds	$2,086,819	$1,547,972	$2,086,819	$1,707,091
SubTotal	$25,208,741	$21,093,913	$25,208,741	$25,067,595
Other Federal Funds	$16,989,838	$14,682,649	$0	$14,300,655
Total	$42,198,579	$35,776,562	$25,208,741	$39,368,250

	2022		2023	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$12,457,398	$12,457,398	$12,457,398	
State Funds	$6,092,387	$9,344,139	$5,933,268	
Local Funds	$0	$0	$0	
Other Funds	$1,702,690	$1,702,690	$1,702,690	
Program Funds	$1,547,972	$2,250,433	$1,707,091	
SubTotal	$21,800,447	$25,754,660	$21,800,447	
Other Federal Funds	$17,859,944	$14,896,683	$13,734,376	
Total	$39,660,391	$40,651,343	$35,534,823	

	2024	
	Budgeted	Expended
Federal Allocation	$12,692,968	
State Funds	$9,520,837	
Local Funds	$0	
Other Funds	$1,702,690	
Program Funds	$2,250,433	
SubTotal	$26,166,928	
Other Federal Funds	$16,104,022	
Total	$42,270,950	

III.D.1. Expenditures

Block grant funding and expenditures are reported in Forms 2 & 3 of this report and represent the actual expenditures for Federal MCH Grant Year 2022 – October 1, 2021 through September 30, 2022. Title V funds sustain core state MCH infrastructure and over 75 contracts with health systems, health districts, and community partners to support regional and local MCH systems-building, clinical services, and education. The 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. Virginia aligns 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.



Form 2

For FY22:

- Virginia received a total federal allocation of $12,457,398 with matching expenditures totaling $11,046,829 (Match and Other – Newborn Screening Services).
- Virginia expended $9,344,139 of State MCH Funds and $1,702,690 in Other Funds (to perform newborn screening services, as required by the Virginia General Assembly).
- In addition, a total of $2,250,433 in program income was generated from insurance billings for assessments and reinvested in delivery of Title V MCH services. FY22 expenditures for the state-federal Title V partnership totaled $25,754,660. 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 $13,297,262 (i.e. state, other, and program income funds), Virginia has exceeded this requirement.
- Variances between the budgeted and expended amounts in Care for Children costs and Children with Special Health Care Needs costs were a result of a realignment of domains in order to more adequately address the needs of children needing MCH services and strategic efforts to broaden the impact of Title V initiatives.
- Admin costs were lower than budgeted because fewer employees (12 instead of 15) were actually paid out of admin funds.
- State Match funds increased to include more match funds (entire 75% match of $9,344,139) in addition to

other funds (Newborn Screening of $1,702,690) and Program income (Child Development Assessment Clinic Assessments of $2,250,433), which also increased from $1,707,091.

- Reported expenditures comply with the 30%-30%-10% requirements as specified in Section 501(a)(1)(D) with expenditures for children being reported at 40% and expenditures for children with special healthcare needs being reported at 33% with administrative expenditures being 8%.

The table below lists the sources of other federal funds noted on Form 2-line 9.

OTHER FEDERAL PROGRAMS UNDER MCH OVERSIGHT				
TITLE	**GRANT YEAR**	**DIRECTOR/MANAGER**	**FFY22 AWARD**	**FFY22 EXPENDITURES**
EHDI (0000117665)	07/01/21-06/30/22	Daphne Miller	160,000.00	150,953.08
SEXUAL RISK AVOIDANCE (0000114453)	10/01/20-09/30/21	Emily Yeatts	1,376,062.00	1,169,000.53
MIEC HV (0000108583)	09/30/20-09/29/21	Andelicia Neville	7,622,952.00	7,377,935.44
U NEWBORN SCREENING (0000111673)	03/30/21-03/31/22	Daphne Miller	332,487.00	219,054.00
HEALTHY START (0000115142)	03/31/21-03/31/22	Pamela Hanks	1,144,121.00	879,856.75
TITLE X FP (0000114397)	04/01/20-03/31/21	Emily Yeatts	5,015,050.00	4,568,385.28
VMAP (0000114485)	09/30/20-09/29/21	Bethany Geldmaker	453,350.00	431,288.51
SSDI (VDH93998)	12/01/21-11/30/22	Dane De Silva	100,209.12	100,209.00
TOTALS			**16,204,231.12**	**14,896,682.59**

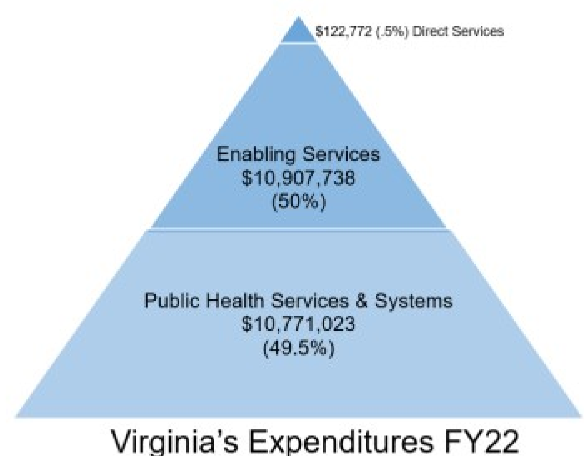
Form 3

Expenditure data was captured and grouped into categories of people served (Women, Infants < 1 year old, Children and Children with Special Health Care Needs).

- A total of $1,947,681 in federal funds was expended for preventive and primary care services for all pregnant women, mothers, and infants up to age one with general funds of $904,432 being expended.
- $5,033,530 in federal funds was expended for preventive and primary care services for children with $1,808,048 in general funds being expended.
- $4,144,950 in federal funds was expended for services for CSHCN with $6,143,157 in general funds being expended [as specified in section 501(a)(1)(D) "family-centered, community-based, coordinated care (including care coordination services) for children with special health care needs (CSHCN) and to facilitate the development of community-based systems of services for such children and their families"].

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 and totaled $113,493 for federal (31,490 for Pharmacy, 1,492 for DME and Supplies, 71,833 for Medical and Dental Supplies and 8,678 for Lab Services) and $9,279 for general funds (5,220 for Pharmacy and 4,059 for Physician Services). Reported services include: pharmacy, physician/office services, hospital charges (child emergency only), dental care (does not include orthodontic services), and laboratory.
- Enabling Services totaled $6,240,308 in federal expenditures and $4,667,430 in general expenditures.
- Public Health Services and Systems federal expenditures totaled 6,103,593 with general fund expenditures being $4,667,430.



Virginia's Expenditures FY22

III.D.2. Budget

Virginia's Title V program budget includes the mandated state match of 4-to-3 ratio of federal to state funds [Section 503(a)] and meets the maintenance of effort ("MOE") threshold of 8,718,003 established in 1989) [Section 505(a)(4)].

The FY24 budget complies with both the state match and MOE mandates, as below:

FY24 Anticipated Federal Allocation: $12,692,968
FY24 Budgeted State Match: $9,520,837
(Virginia's 1989 MOE Threshold: $8,718,003)

It is anticipated that the Title V MCH Block Grant budget for the FY24 application will exceed the FY23 allocation of $12,692,968, but as the FY23 federal allocation is the most current federal allocation figure, this will be used for budgeting purposes. Matching general funds estimated at 9,520,837 will be used for general fund budgeting.

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 listed in expenditure narrative), and varied family, maternal, and child health initiatives that bolster protective factors and mitigate risk factors. Other services provided include population-based maternal child health systems coordination such as 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 showing the greatest need and strive to "meet people where they are" via web-based community outreach, education through social media and online training modules for families. Some examples of these initiatives are pregnancy loss initiative and black maternal health week sponsorships.

The FY24 Budget anticipates approximately $1,984,512 in federal funds to be expended for preventive and primary care services for all pregnant women, mothers, and infants up to age one with anticipated general fund expenditures of $921,534. $5,128,714 in federal fund expenditures are estimated for preventive and primary care services for children with $1,842,238 in general fund expenditures being estimated. $4,223,332 in federal fund expenditures are estimated for services for CSHCN with $6,259,325 in general fund expenditures being estimated.

A sum of 1,702,690 in Other Funds is included for newborn screening services, as required by the Virginia General Assembly. These funds not only sustain the program but ensure early screening, testing, and referral for all infants.

Services for CYSHCN 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 such as autism, ADHD, depression/anxiety and speech and language issues. If a diagnosis is made, the child development clinic will provide short-term care coordination by connecting the child/family to services. VDH has a relationship with 5 funded partners across the Commonwealth. More than 2,700 evaluations were done in state fiscal year 2022. More information about this program to include data can be found here: https://www.vdh.virginia.gov/child-development-services/. Program-generated income of 2,250,433 from insurance billings for assessments is anticipated and will be reinvested in delivery of Title V MCH services.

Virginia's Title V Program budgets 30 percent or more of our federal allocation for preventive and primary care services for women, infants and children. An additional 30 percent or more of federal funding is budgeted for

services for CYSHCN. 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 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 throughout 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

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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. Virginia's Title V organizes and sustains a portfolio of programs aligned with the findings from the MCH five-year needs assessment. Title V contextualizes and convenes a shared vision around the MCH priorities, ensuring that national and state performance measures are widely known and accepted as performance indicators for all MCH programming within the state, regardless of the source of funding. Title V serves as hub, bridging and synthesizing relationships for common purpose.

THE OFFICE OF FAMILY HEALTH SERVICES (OFHS) houses four divisions, all of which partner closely to ensure successful implementation and oversight of Title V-funded programs.

The Division of Child and Family Health (DCFH) houses both the Title V and CYSHCN directors who serve as the state level administrators of the Title V MCH Block Grant, ensuring that the responsibilities set forth by HRSA's Maternal and Child Health Bureau are met. The Reproductive Health Unit includes programs dedicated to Title V populations and priorities, including the Title X Family Planning Program, the Contraceptive Access Network, the Virginia Contraceptive Access Initiative, the Adolescent Health Program, Resource Mothers, the Doula Certification Program and Task Force, and the Pregnancy Loss Services Initiative. DCFH has a robust Newborn screening and followup program, which includes birth defects surveillance, CMV follow-up, and Early Hearting Detection & Intervention (EHDI) programs. The Maternal Infant Health Consultant focuses on maternal mental health and substance use/abuse, and partners with statewide stakeholders to address the maternal and infant morbidity and mortality. MIECHV, Healthy Start, the Early Childhood Comprehensive Systems (ECCS) grant, Virginia Mental Health Access Program for children (VMAP) comprise the infant health program as School Health are also in DCFH.

The Division of Population Health Data (DPHD) provides deliberative epidemiological support across all DCFH Title V-funded programs. The MCH Epidemiology team supports the MCH Block Grant, SSDI Grant, Title X/Family Planning, Oral Health Workforce, Newborn Screening, Sickle Cell programs, and CYSHCN. PRAMS, YRBS, and BRFSS are also housed in DHPD, as well as Overdose Data to Action, Rape Prevention and Education, Firearm Injury Surveillance, Chronic Disease and Tobacco surveillance, all of which influence Title V programmatic planning and implementation.

The Division of Prevention and Health Promotion houses the Injury Prevention Team, which supports Title V efforts regarding safe sleep, child safety, and suicide and violence prevention. Additionally, the Oral Health team supports statewide efforts to increase dental visits for pregnant women, and children and adolescents, including CYSHCN.

The Division of Community Nutrition, the home for Virginia's WIC program, partners at the local level where local health districts implement Title V programs in collaboration with their WIC programs. Additionally, the Statewide Breastfeeding Coordinator is located in this division, and is a key collaborator with Title V.

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. This critical partnership ensures strong connectivity for Virginia's CYSHCN program as well as shapes and informs Title V's programmatic family centeredness.

Virginia's 35 Local Health Districts (LHDs) engage in MCH activities – providing services through home visiting programs, prenatal care, family planning services, WIC, and immunization clinics. The LHDs provide the true synergistic interaction between Title V administration and the community.

Together, these programs, partnered with key internal, external, community, state, and federal stakeholders, implement Virginia's Title V program, ensuring programmatic success across all six domains. Core programs identified for the current five-year cycle are:

CORE PROGRAMS BY DOMAIN

Women/Maternal Health
- Reproductive Health Partnership
- Doula Expansion
- Pregnancy Loss Project
- MMRT & VPNC Partnerships
- Oral Health Initiatives

Perinatal/Infant Health
- Five-Star Breastfeeding
- Home Visiting – BabyCare Program
- Safe Sleep Initiatives
- CFRT Partnership
- Perinatal Mental Health
- Substance-Exposed Infants

Child Health
- Developmental Screenings
- Child Safety Seat Program
- Injury Prevention Curriculum
- Oral Health Initiatives

Adolescent Health
- Comprehensive Sex Education
- Suicide Prevention Trainings
- School Health & Immunizations
- Oral Health Initiatives

CYSHCN
- Child Development Centers (CDCs)
- Care Connection for Children (CCCs)
- Pediatric/Adult Sickle Cell Programs
- Virginia Bleeding Disorders Program

Cross-Cutting - Systems Building
- Youth Advisors
- Family Engagement
- Newborn Screening & EHDI
- Racism/Equity Initiatives
- Workforce Development

Virginia's Framework for Improving Outcomes for MCH Populations

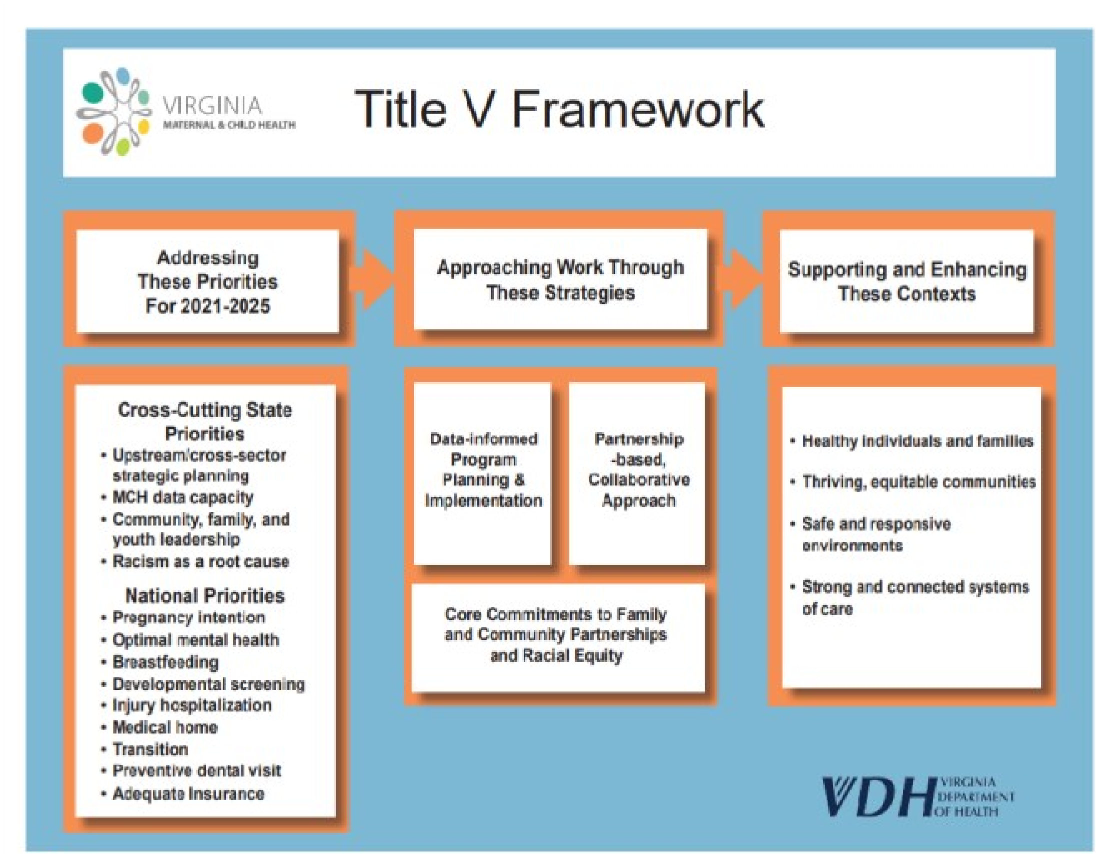
Virginia's Title V Program acknowledges that although the state is often at or above the national average for key measures of maternal and child health, there are profound and avoidable health disparities and inequities across the state's MCH population. The qualitative and quantitative approach to the 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.
- ***Partnership-based, collaborative approach:*** Title V partners with organizations that work directly with communities at the community, local and state levels. These agencies, which includes the local health districts, are well positioned within the communities they serve, providing MCH services across all the population domains.
- ***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.



VIRGINIA
MATERNAL & CHILD HEALTH
Title V Framework
Addressing These Priorities For 2021-2025
Approaching Work Through These Strategies
Supporting and Enhancing These Contexts
Cross-Cutting State Priorities
• Upstream/cross-sector strategic planning
• MCH data capacity
• Community, family, and youth leadership
• Racism as a root cause
National Priorities
• Pregnancy intention
• Optimal mental health
• Breastfeeding
• Developmental screening
• Injury hospitalization
• Medical home
• Transition
• Preventive dental visit
• Adequate Insurance
Data-informed Program Planning & Implementation
Partnership -based, Collaborative Approach
Core Commitments to Family and Community Partnerships and Racial Equity
• Healthy individuals and families
• Thriving, equitable communities
• Safe and responsive environments
• Strong and connected systems of care
VDH VIRGINIA DEPARTMENT OF HEALTH

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

In Virginia, approximately 31% of Title V block grant federal funding supports 153 positions across four Central Office Divisions of VDH, and MCH staff in all 35 Local Health Districts. Specifically, there are 58 funded positions in the VDH's Central Office, all of which provide varying levels of support to MCH programs and/or services. This includes 7 CYSHCN Care Connection Clinic staff working either in a health district or hospital-based clinic. Currently, there are 8 vacant positions, all currently under recruitment. Additionally, Title V funding supports approximately 95 MCH staff across all 35 Local Health Districts (LHDs), where services include prenatal care (5 districts) BabyCare (9 districts), and population health-based efforts (21 districts). Staff are experienced and committed, bringing passionate, unique, and diverse professional and personal life experiences to their work in maternal and child health. Staff have various backgrounds including: Medicine, public health, social work, epidemiology, nursing, nutrition, health care administration, education, finance, and administrative support. The diversity of education, generation, and qualification creates a workforce that is knowledgeable and skilled to meet the needs of the MCH population. All strive towards positioning themselves as collaborative statewide leaders and subject matter experts in their professional domains.

Virginia's MCH/Title V and CYSHCN Directors report to the Director of Division of Child and Family Health (DCFH). Currently, the CYSHCN Director has 9 direct reports, including 7 staff who work in regional Care Connection for Children programs. The MCH/Title V Director does have direct reports under the current Division structure. This affords a high level of bandwidth for complex and strategic support, oversight, and alignment of Title V funded programs, and relationship and partnership building and support.

The following is a summary of Title V supported positions in VDH's Central Office:

OFFICE OF FAMILY HEALTH SERVICES		
Position	**Direct reports**	**Updates**
*Policy Analyst		***Vacant**
*OFHS Program Support		***Vacant**

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

DIVISION OF CHILD AND FAMILY HEALTH (DCFH)		
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 (7)	
DCFH Program Support		
NEWBORN SCREENING		
Birth Defects Surveillance Program Coordinator	Critical Congenital Heart Disease Coordinator	
Early Hearing Detection and Intervention (EHDI) Program Coordinator	cCMV Follow-up Coordinator EHDI Program Support	
MATERNAL AND INFANT HEALTH		
Maternal Infant Health Consultant	*Substance Exposed Infants Program Coordinator	***Vacant**
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**

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

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

OFFICE OF CHIEF MEDICAL EXAMINER (OCME)		
Position	**Direct reports**	**Updates**
Director, Division of Death Prevention		
Maternal Mortality Program Manager	Maternal Mortality Research Associate	
Family Violence Programs Manager	*Child Fatality Research Associate *Violent Death Epidemiologist	***Vacant**

OFFICE OF FINANCIAL MANAGEMENT		
Position	**Direct reports**	**Updates**
Fiscal Grant Manager, Operations		

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 whose 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 the interview process has been strengthened by the incorporation of situational interviewing. The incorporation of situational interviewing assesses for alignment with Title V's leadership competencies, provides work-related performance predictability, and supports strong hiring decisions. Annual professional development plans and opportunities support tailored growth beyond baseline VDH performance expectations.

Turnover has been minimal in FY23, with several critical positions filled after lengthy vacancies in DCFH, including the Maternal Infant Health Consultant and Adolescent Health Coordinator positions. DPHD created and filled the MCH Epidemiology Coordinator position, bringing additional targeted support to the Title V Director and Child Health Domains. Current critical vacancies under recruitment are: 1) Director, Division of Population Health Data; 2) OFHS Policy Analyst; and, 3) Substance Exposed Infants Program Coordinator. All open positions are in recruitment.

Three new OFHS Central Office positions will be created for FY24. To support the MCH/Title V Director, a new position will be created to specifically focus on strategizing, organizing, and supporting the 35 local health districts.. The second position, a new CYSHCN Team member, will engage in program administration of the Child Development Clinics, and support the Bleeding Disorders Program. The third position, a second senior epidemiologist on the MCH Epidemiology Team, will help restructure the MCH Epidemiology Unit, providing epidemiological support for specific population domains, and streamlining reporting of other mid-level epidemiologists. This position will report to the MCH Epidemiologist Lead.

STAFF TRAINING AND WORKFORCE DEVELOPMENT

OFHS utilizes a "team of teams" model for monthly staff meetings, allowing division leadership to provide updates and successes over the last month, as well as providing a forum for requests of information or support from other divisions. OFHS leadership 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.

The MCH/Title V Director hosts monthly team meetings for Title V-related staff. Sessions include invited topical speakers whose work align with the state action plan, and is followed by data presentation from the MCH Epi Team, reflection, and connection.

EHDI Diversity and Inclusion Training: In order to thoroughly address DEI in EHDI systems, it was essential to consult with experts within this field of work. In partnership with Virginia Commonwealth University (VCU), Partnership for People with Disabilities, VA EHDI worked with the Virginia Center for Inclusive Communities (VCIC) to establish the first series of DEI training for EHDI stakeholders. From January to May of 2022, VA EHDI and CFI hosted a webinar series in two cohorts: *Your Role in Workplace, Diversity, Equity & Inclusion.* These included the following webinars: Foundations of Diversity and Inclusion and Inclusion/ Unconscious Bias 101, Unconscious Bias 201, Cycle of Prejudice, Microaggressions, Exploring Race and Racial Equity, and Exploring Socioeconomic Status. Due to resounding positive feedback, in the

October to December 2022, VA EHDI hosted the *Diversity, Equity and Inclusion Lunch and Learn Workshop* series, which included the following sessions: Intersectionality, Fostering LFBTQ+ Inclusion, Microaggressions, Building Facilitation Skill for Dialogue, Creating Upstander/Active Bystander Cultures, Creating a Sense of Belonging.

Additionally, pre- and postnatal education are important aspects of increasing awareness of hearing screening prior to birth, allowing families to be prepared with next steps if their child fails the initial hearing screening. In 2019, the EHDI team launched a pilot program with Home Visiting agencies in Northern Virginia to provide education for prenatal mothers regarding newborn hearing screening. Survey results highlighted that many families were not aware that their child would be getting a hearing screening after birth. This pilot highlighted the need for continued prenatal education and identified a gap in existing prenatal education regarding newborn screening programs. In Early 2020, the VA EHDI program created a DEI plan that outlined improvements to the program which support intentional changes to ensure inclusion and diversity in all areas of the program. One major change includes the development of a plan is to collaborate with the Dried Blood Spot Screening program in Virginia to increase prenatal outreach regarding the newborn screening programs.

DPHD Journal Club: The MCH Epidemiologist Lead implemented a bi-monthly cross-unit journal club within DPHD, with participation from epidemiological units from MCH, Prevention and Health Promotion, and Cancer. The journal club allows for a discussion of papers and methods and encourages collaboration across epidemiology units by facilitating new projects using existing data sources and identifying research gaps. The journal club also allows epidemiologists to present work at upcoming conferences and new data releases, such as the most recent year data from BRFSS and PRAMS.

PARTICIPATION IN NATIONAL LEARNING COMMUNITIES

Advancing Equity Learning Community (AELC) through National MCH Workforce Development Center: Virginia's Title V participated in the AELC, a uniquely designed learning opportunity designed to increase Title V teams' knowledge, skills and abilities to systematically and consistently integrate equity across key workflows. Virginia's AELC Team includes: Title V Director, MCIEHV Director, State Resource Mothers and Doula Certification Program Supervisor, and representatives from three LHDs (Mount Rogers, Blue Ridge, and Central Virginia). The Team traveled to the four-day skills institute, participated in the monthly learning webinars, and monthly coaching sessions. This learning community served as an opportunity to build capacity to grow and support the doula community, as Virginia became the fourth state to offer a Medicaid doula benefit. This team continues to meet monthly, has expanded to include several new members, including partners from DMAS.

2023 National MCH Workforce Development Center Learning Community: Virginia's Title V Program is currently participating in the 2023 Learning Community, with the goal of transforming and strengthening the programmatic relationship between Title V, Reproductive Health, and Injury/Violence Prevention, both internally and with external stakeholders.

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 teams selected national for the CityMatCH Alignment for Action Learning Collaborative (AAC), a two-year initiative, which began in March 2021, and continued through March 2023. Title V leadership team participates in this highly engaged effort to address racism and implicit bias in the Charlottesville maternal and child health care community. This collaborative is detailed in the CC/SB Annual Report.

National Academy for State Health Policy (NASHP) MCH Policy Innovations Program Policy Academy: Facilitated by DMAS, MCH Team, members of Virginia's Title V Team and state CBO MCH leadership participated in this two-year Policy Academy, that ended March 2023.The Team focused on two new Medicaid member benefits – the expansion of services for one-year postpartum, and the new doula benefit. Title V Director and MIH Consultant will join DMAS partners to participate in NASHP's PIP Alumni Policy Academy to Advance Perinatal Systems of Care that will begin in Fall 2024.

YOUTH ADVISOR PROGRAM

The Youth Advisor Program was established in 2021 to ensure youth voice expertise, guidance, and feedback on current and future public health initiatives. The program model allows for two part-time youth advisors with one-year terms. The first youth advisors served from January 2021 through May 2022, and their work is summarized in the Cross-Cutting/Systems-Building domain report. For the next round, the Adolescent Health Coordinator began to screen the pool of applicants and interviews were held in April 2023. One candidate has accepted the role and will begin in late May 2023.The other Advisor position is currently open until filled. Once on board, the Advisors will begin recruitment for the statewide Youth Advisory Group and serve as subject matter experts on issues impacting young people.

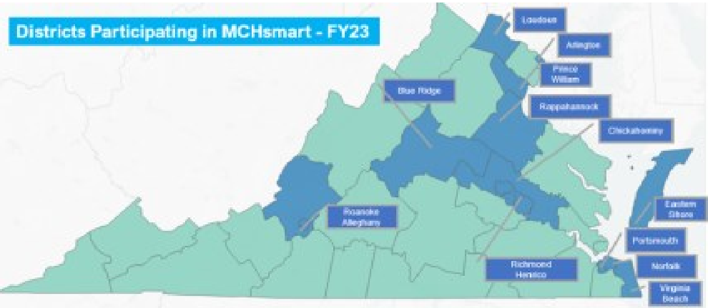
LOCAL HEALTH DISTRICTS

Work Plan Improvement: 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 now lifted, the LHD MCH workforce has returned to pre-pandemic operations; however, it is imperative to create the supportive structures to ensure that the LDH workforce remains in alignment with the Title V mission and receives enhanced support, education, and TA for their success. Five of the 35 LHDs continue to provide prenatal care to their communities, nine districts provide BabyCare, and the remaining 21 districts engage in a variety of MCH-related activities. To accommodate the variance across the districts, beginning FY23, the LHD work plan was transformed with the creation of activity bundles that are aligned with the current State Action Plan, and transformation to quarterly reporting of activities and data. Training details and activity selections are included in this grant report as an attachment.

District Learning Communities: The first district learning community was created for the three districts (Blue Ridge, Roanoke/Alleghany, and Cumberland Plateau) who selected the Community Engagement activity bundle. Monthly meetings are facilitated by Dana Yarbrough, Virginia's Family Leader, who shares subject matter expertise around best practices, tools for district implementation, and provides guidance or TA regarding the Districts' use of best practices to bring the voices of people with lived experiences into their current local programmatic work. Because this model has been so successful, additional learning communities will be offered to the districts for FY24.

MCHsmart Asychronous Learning: Beginning FY23, the LHDs were given the opportunity to participate in the MCHsmart asynchronous learning environment available through the MCH Navigator. Twelve of the 35 districts selected this activity for FY23. An initial TA call was held with the districts and leadership from The National Center for Education in Maternal and Child Health (NCEMCH), who oversees the MCH Navigator, and participants were given a special passcode to use at registration.

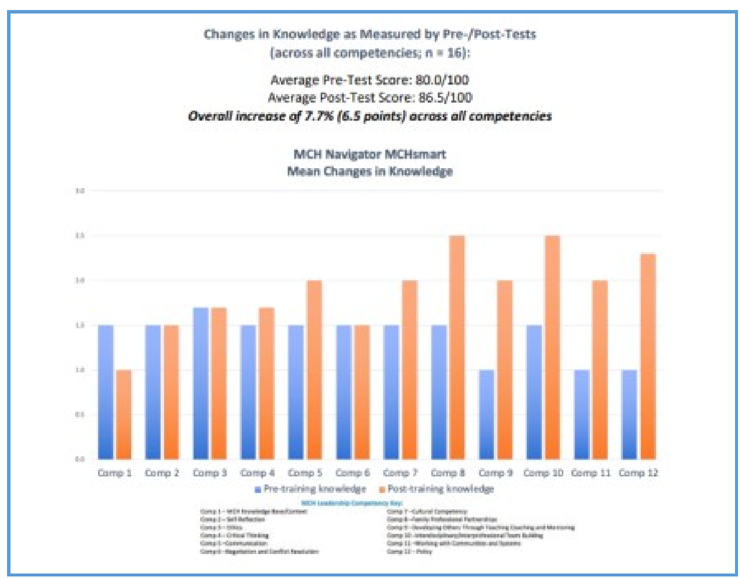
In total, 40 LHD MCH professionals participated in some aspect of the course and 16 completed the full curriculum, giving insight into levels and changes in knowledge as measured by pre- and post-tests as well as trends in knowledge, skills, and perceived efficacy as measured through self-reflection questions. **NOTE:** District participation in MCHsmart is aligned into Virginia's State Action Plan as a cross-cutting/systems building strategy, with the following objective: By 2025, provide dedicated space, technical assistance, and learning opportunities that advance racial equity across MCH workforce. This is measured through SPM3: MCH workforce development (racial equity).

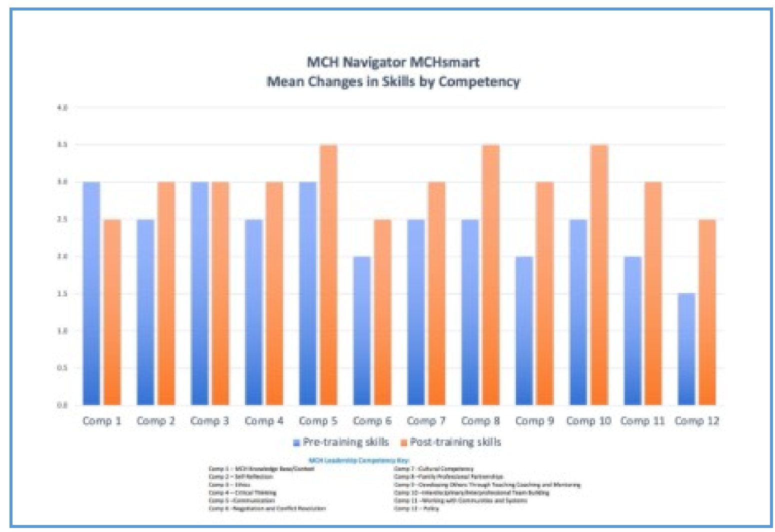


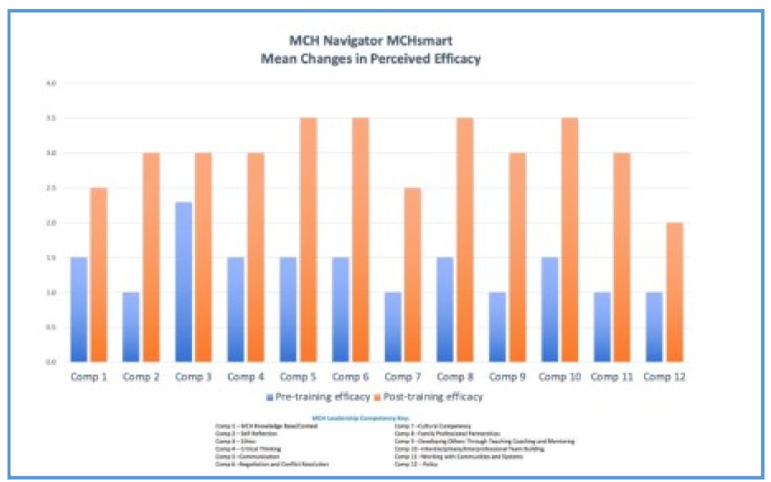
Trend #1: Learners consistently scored higher on post-tests than on pre-tests in all competencies with an overall increase of 7.7%. However, self-reported knowledge and skills for Competency 1 (MCH knowledge base and public health context) actually decreased by the end of the curriculum. This could be attributed to the Dunning-Kruger Effect, in which individuals overestimate their initial knowledge of a topic before learning more in that area. As one user reported, “I didn’t know that there was so much to MCH that I wasn’t aware of.” However, balancing this trend, self-perceived efficacy for Competency 1 increased from 1.5 to 2.5 (on a scale of 3.0) over the course of the curriculum.

Trend #2: For other competencies related to “self” (Competencies 2-4), there were negligible or small gains in knowledge, while larger gains in knowledge were observed in competencies related to those involving others (Competencies 5-10) and the wider community (Competencies 11-12). This could indicate a need for increased learning opportunities in these “advanced” competency areas.

Trend #3: The largest increases across all competencies were related to self-perceived efficacy. An explanation of this dramatic increase is that the act of completing the online course and acquiring new knowledge boosted individual's self confidence. They may feel more empowered, capable, and self-assured in their understanding of topic areas, leading to a higher level of self-reported efficacy. Another theory is that learners become more aware of their progress and growth. Through the online course, they may have gained a clearer perspective on their strengths and weaknesses, allowing them to assess their own abilities more accurately.







MCHsmart continued efforts in FY24: Recognizing the importance of ongoing MCH Leadership development, pleased with the participation in MCHsmart in FY23, and capitalizing on the excellent partnership with the MCH Navigator team at NCEMCH, MCHsmart will remain an available activity on the District work plans for FY24. Those districts whose team members did not complete the learning competencies can continue, and districts that did not participate last year can engage across FY24. The MCH Navigator Team will once again provide TA to all districts once selections are made. Additionally, staff in the CYSHCN programs and home visiting programs, including MCIEHV and Resource Mothers, will be invited to participate in these modules in FY24. Lastly, Title V Leadership Team plans to review the data from MCHsmart, and incorporate competency-building information into all Title V-led trainings going forward.

INVESTMENT IN FUTURE MCH WORKFORCE

National MCH Workforce Development Center Internship Program

Virginia's Title V Program participates in the Internship Program through the National MCH Workforce Development Center. The ten-week long virtual internships provides opportunity for team of two students to work on a project of high importance to the advancement of MCH in Virginia.

2023 Internship Project:

Title V Preceptors: Cindy deSa, MCH/Title V Director; Dr. Dane De Silva, MCH Epidemiology Lead; Mr. Kelly Conatser, MCH Epidemiology Coordinator
Interns: Emily Lasher, Master of Science in Public Health Student at Johns Hopkins Bloomberg School of Public Health, and Olgaaurora Rodriguez, Doctor of Pharmacy and Master's of Public Health Student at University of Arkansas for Medical Sciences
Project Details: Virginia's BabyCare program provides expanded prenatal services and case management for families with children up to the age of two who are not enrolled in Managed Care. Each of the 9 BabyCare programs is tailored to the district's unique needs, with wide variance in program structure and measurement methods. The Interns conducted evaluations of each program's existing data collection methods, and created reporting toolsfor programmatic planning and CI efforts at the district and statewide level. The Interns trained the district teams on the reporting tool at the end of their internship in mid-August 2023.

Continued Development of 2022 Internship Project:
During Summer 2022, two MCH interns supported Title V and Family to Family Health Information Center at VCU in defining equitable engagement with families. Following the internship, the Family to Family Health Information Center contracted with one of the interns, Pooja Deshpande for 9 additional months to pilot test a tool developed by the Wisconsin Title V program that focuses on assessing engagement with community members, families, and youth. Pooja led the small research study by developing an IRB application (UNC), converting the tool to Qualtrix platform, analyzing data from 35 of 70 staff across Virginia Title V, home visiting, and early intervention programs (50% response rate), and writing a report entitled *Assessing Professionals' Perceptions of Success in Family Engagement Using the Wisconsin Community Engagement Assessment Tool.* She found that there is incredible potential to use the Wisconsin CEAT for determining gaps in service provision and engagement with key program stakeholders.

CYSHCN 2023 Intern: Ryan Malpaya, and Army veteran, is a graduate of Old Dominion University and a current graduate student at Walden University, studying public health (MPH). The CYSHCN Program onboarded him in the Spring of 2023 and his internship will continue until mid-August 2023. Ryan's projects include: 1) Leading an assessment tool revision for Care Connection for Children; 2) Supporting our sickle cell program to design public service announcements about sickle cell disease that will air on local radio stations managed by Radio One on World Sickle Cell Day, June 19, 2023; 3) Proofreading the CYSHCN block grant application and annual report.

Internship development with Virginia Commonwealth University School of Social Work
VCU offers a dual degree program for Master's in Social Work and Public Health. Title V Director is currently working with the Interim Dean and Field Placement Director at the School of Social Work to develop internship opportunities within OFHS that will bring focus to maternal and child health in the dual degree program. Three OFHS team members currently serve as adjunct instructors in the School of Social Work, bringing high passion and commitment to this new state-academic partnership.

TRAINING MODULES: PROMOTING HEALTHY COMMUNITIES

Title V partners with University of Virginia Office of Continuing Medical Education to sustain Promoting Healthy Communities, an online learning consortium for continuing education opportunities for MCH-related content, providing 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. www.promotinghealthycommunities.org

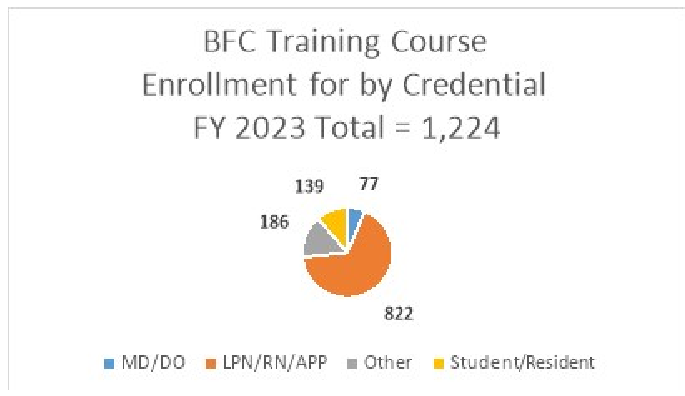
Currently, Promoting Healthy Communities offers 12 CE modules in three categories. MCH Staff meet bi-monthly with UVA to review participation, content relevance, accuracy, and update needs. Impacted by Covid, enrollment numbers across all modules low; however, the Breastfeeding Friendly and Newborn Screening modules have remained relatively consistent. An estimated 85-90% of learners are Virginia providers. Plans for FY24 are to increase traffic to these sites through targeted marketing initiatives lead by UVA. Title V Staff also plans to explore the possibility of intra-

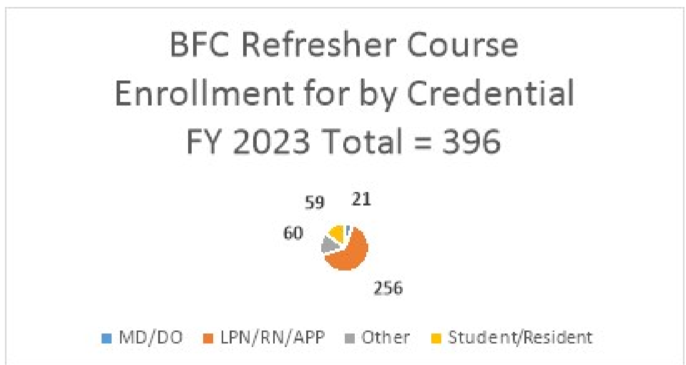
state educational partnerships with other Region III Title V Programs.

Content for the Breastfeeding modules will be updated in FY24 to align with new guidelines from Breastfeeding Friendly USA. The transition modules will be updated in FY24 in collaboration with GotTransition and the Blueprint for Change.

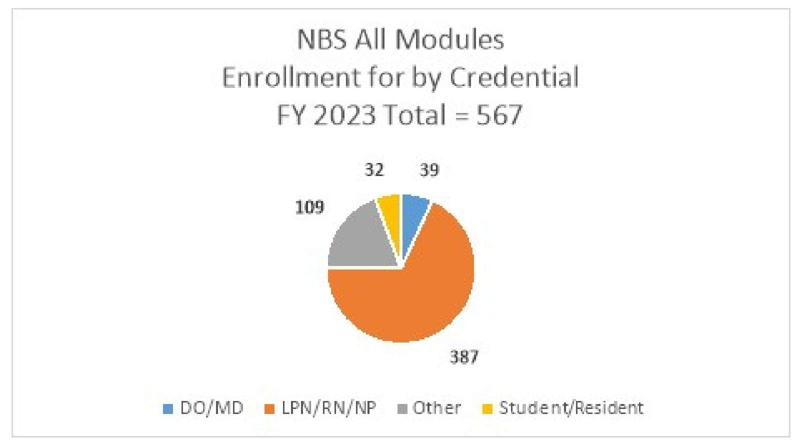
	Module	Enrollment Totals 7/1/20 – 6/30/21	Enrollment Totals 7/1/21 – 6/30/22	Enrollment Totals 7/1/22 – 6/30/23
Breastfeeding Friendly Consortium	Breastfeeding Training	2,362	969	1224
	Breastfeeding Refresher	203	48	396
	Breastfeeding Performance Improvement	97	32	104
Newborn Screening	Critical Congenital Heart Disease Screening	193	140	101
	Critical Congenital Heart Disease Screening – What parents need to know	93	92	77
	Introduction to Virginia's Early Hearing Detection & Intervention	8	70	66
	Newborn Dried Blood Spot Screening	425	263	271
	Newborn Screening SMA & X-ALD	NA	18	52
Medical Home Education	Healthcare Transition for Healthcare Providers	49	14	4
	Healthcare Transition for Families	43	3	0
	Medical Home for Healthcare Providers	43	11	3
	Medical Home for Families	20	0	7

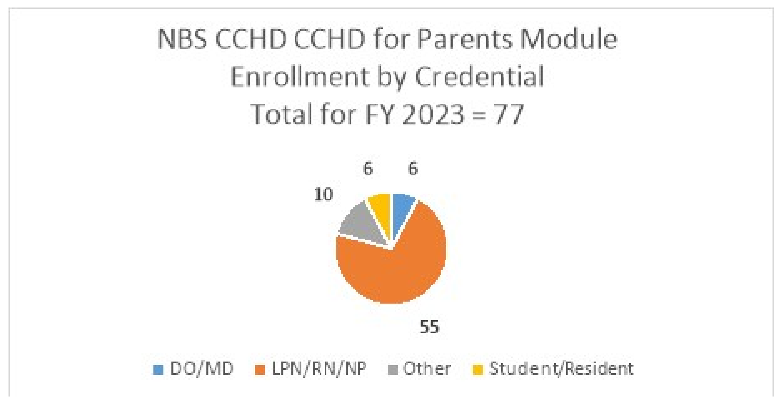
BREASTFEEDING MODULES ENROLLMENT

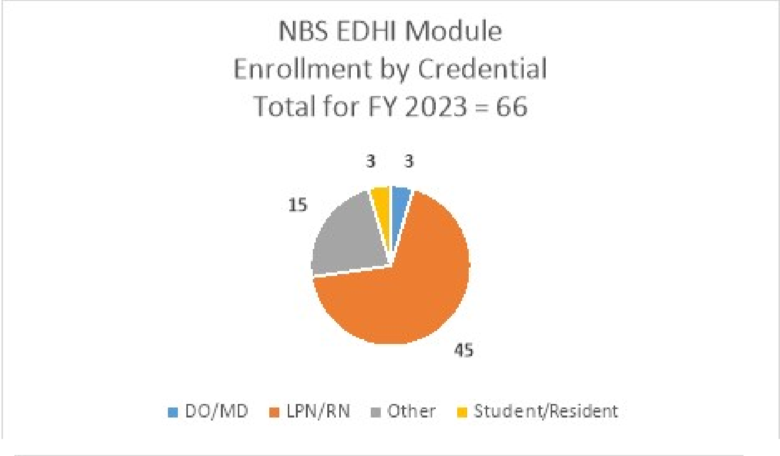


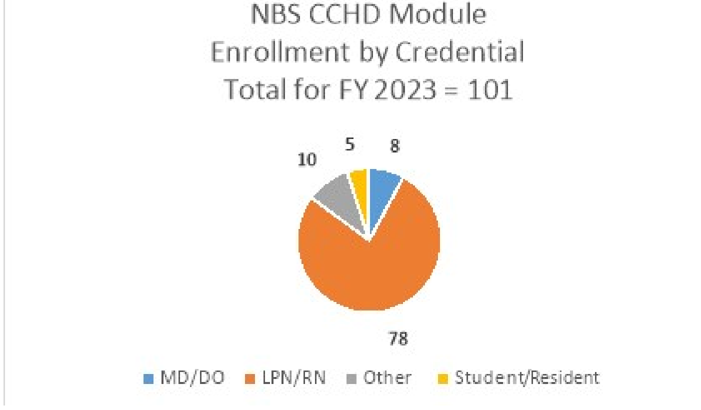


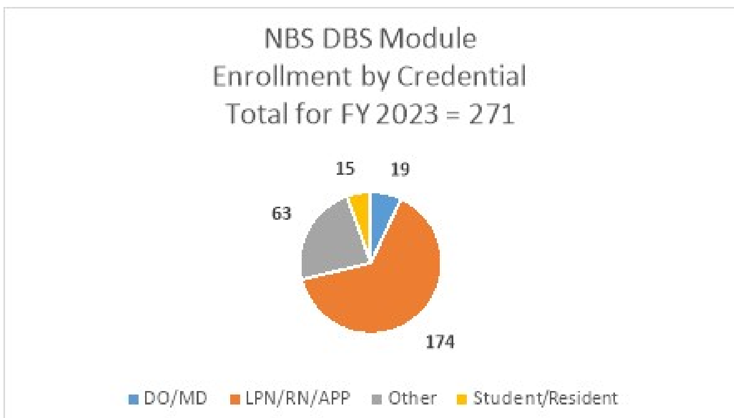
NEWBORN SCREENING MODULES ENROLLMENT

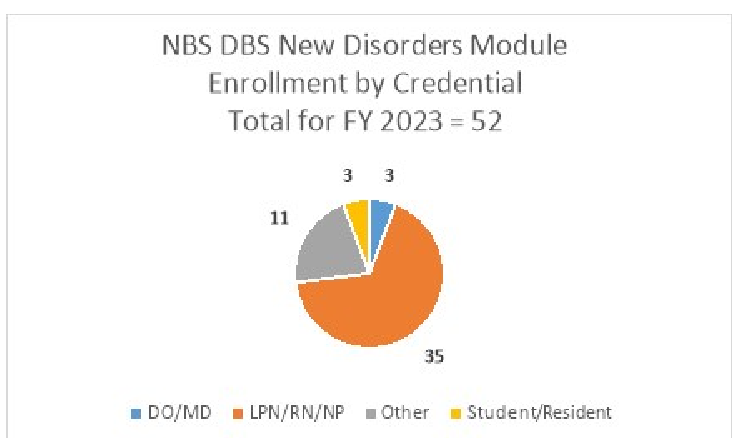



NBS CCHD CCHD for Parents Module
Enrollment by Credential
Total for FY 2023 = 77
6
6
10
55
DO/MD
LPN/RN/NP
Other
Student/Resident


NBS EDHI Module
Enrollment by Credential
Total for FY 2023 = 66
3
3
15
45
DO/MD
LPN/RN
Other
Student/Resident


NBS CCHD Module
Enrollment by Credential
Total for FY 2023 = 101
5
8
10
78
MD/DO
LPN/RN
Other
Student/Resident


NBS DBS Module
Enrollment by Credential
Total for FY 2023 = 271
15
19
63
174
DO/MD
LPN/RN/APP
Other
Student/Resident


NBS DBS New Disorders Module
Enrollment by Credential
Total for FY 2023 = 52
3
3
11
35
DO/MD
LPN/RN/NP
Other
Student/Resident

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

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

OFHS provides a number of opportunities for engaging and partnering for family input into MCH and CYSHCN programs, including: Parent feedback survey that assesses services provided by Care Connection for Children Centers; Contractual relationships with Parent to Parent of Virginia and the Family to Family Network of Virginia who provide outreach, mentoring and training to parents; Parents hired as family specialists/care coordinators at Care Connection for Children centers; Family representatives on the Virginia Early Hearing Detection & Intervention Advisory Committee and the Virginia Genetics Advisory Committee; and collaboration with the Virginia Leadership Education in Neurodevelopmental Disabilities, 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. Principal investigator for Virginia's infant mental health endorsement program
3. Principal investigator of Virginia's Learn the Signs. Act Early! project
4. Co-lead with VDH's state genetics team with NYMAC regional genetics center
5. Co-lead with VDH'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 15 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. 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 15 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 diverse parents provide family to family support, support an online facebook support group with over 160 participants, develop materials in English/Spanish, and continue to grows a video library of unbiased information for families.

- 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. In addition, Ms. Yarbrough brings back information to Virginia from her service to AMCHP on committees (Family LEAD, Governance) and as a reviewer for the MCH Innovative Hub.
- Establishment of **Genetic Navigator** program. Co-led by Ms. Yarbrough and OFHS' director of newborn screening this year is 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 continued support of a **MCH intern**. Through funding support from the Family to Family Health Information Center, a MCH intern developed a research protocol for examining the use of Wisconsin Title V's community, family and youth engagement assessment tool with Title V funded projects.

The **Early Childhood Comprehensive Services project** has six family leaders serving on its state advisory committee. Family leadership development is a key goal of the ECCS project and leadership behaviors are addressed through formal family leadership training to Ready Region family councils, 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 Inova employs a parent coordinator with lived experience. She is bilingual and has created a wonderful support group for parents in the LatinX community. Families are able to meet and share with one another regarding supporting their children and to partake in fun and enriching activities with each other. This work has led to bonding and a sense of community among parents of Children and Youth with Special Health Care Needs.

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

The **wind down of the changes to Medicaid during the Pandemic** such as continuous coverage enrollment and Appendix K flexibilities, have created anxiety for families who may lose access to healthcare coverage or expanded

coverage.

There is an increasing number of **children with mental health needs** and positive ways to recover and/or cope successfully with their emotional state.

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

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

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.

Non-communicable disease epidemiologists and evaluators, including core Title V MCH Data Support Workforce, are housed within the Office of Family Health Services (OFHS) Division of Population Health Data (DPHD). The division director provides general oversight. Under their direction sits the MCH Epidemiology and Evaluation Unit, a centralized epidemiology unit headed by the MCH Epidemiology Supervisor who serves as the Lead Epidemiologist and provides direction for the State Systems Development Initiative (SSDI). 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.

Vacant – 0.65 FTE Director, Division of Population Health Data	
Funding	Title V MCH Block Grant; Cancer Registry; Environmental Tracking
Education and Training	<u>Preferred qualifications:</u> An advanced or doctorate degree in Public Health and/or equivalent training & experience. Experience administering a public health program & managing projects and employees. Ability to conduct research, make recommendations and apply findings. Develop and execute goals and objectives; develop and conduct training; interpret and implement policies and procedures; provide technical assistance.
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 Project Director**	
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).

Kelly Conatser – 0.80 FTE **MCH Epidemiology Coordinator (Epidemiologist Senior); SSDI Coordinator**	
Funding	Title V MCH Block Grant; State Systems Development Initiative (SSDI); MIECHV
Education and Training	MPH (Epidemiology and Biostatistics), University of New England BS (Biological Sciences), Old Dominion University
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 (Research in Practice), 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 – 0.40 FTE **Reproductive and Perinatal Health Epidemiologist**	
Funding	Title X Family Planning; Title V MCH Block Grant; Pregnancy Risk Assessment Monitoring System (PRAMS)
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, CPH – 0.25 FTE Injury and Violence Prevention (IVP) Senior 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.

Julia Mogren, MPH, CHES – 0.25 FTE Substance Use Prevention Epidemiologist (Epidemiologist Mid-Level)	
Funding	Title V MCH Block Grant; CDC Overdose Data to Action
Education and Training	MPH (Epidemiology), Liberty University BS (Public Health), Liberty University
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

For mid-level or above epidemiologist positions in the DPHD, it is expected that individuals 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 MCH epidemiology coordinator, dental, NBS, and RPH epidemiologists, and program evaluators report to the MCH Epidemiologist Lead. The IVP Senior Epidemiologist and Substance Use Prevention Epidemiologist both sit in the Prevention and Health Promotion (PHP) Epidemiology Unit for cross-cutting support. The Substance Use Prevention Epidemiologist reports to the IVP Senior epidemiologist, who reports to the PHP Unit Supervisor.

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). MCH Smart is another self-paced learning tool that the MCH workforce has begun using. The DPHD has a peer group philosophy for cross-training and problem solving, with an emphasis on learning. For example, the MCH Epidemiologist Lead 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, 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 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 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 since 2019), 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 (MCH Epidemiologist Lead) provides oversight, the SSDI Coordinator (MCH Epidemiology Coordinator) ensures implementation, with support from the other members of the epidemiology and MCH teams.

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

Unit, Center for Community Health Improvement 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. Pre-planning is underway for the next five-year MCH Needs Assessment.

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 statistically 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 data products (e.g., epi reports, 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, such as conducting the Five-Year Needs Assessment, implementing the Five-Year State Action Plan, data dissemination, 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 partnering with mySidewalk to build out a public-facing visualization as an ongoing needs assessment tool that will be updated annually and will help inform the next Five-Year Needs Assessment. Additionally, the team has an upcoming partnership with

	Molina to conduct a few focus groups of the Medicaid population across three regional communities to inform the MCH Needs Assessment process.
Data Dissemination	MCH Epidemiology under the previous SSDI cycle 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. This cycle, the team is currently working on expanding the current information available on the public facing portal to have race/ethnicity stratifications, and develop an infant mortality report/visualization. The team is also working with the VDH Center for Public Health Informatics to ensure accessibility and feasibility of visualizations created/posted. MCH Epidemiology support has led and collaborated on multiple projects that have been presented internally (e.g., at the VDH All-Epidemiology Quarterly Meeting) or submitted and/or presented externally at conferences (CSTE, CityMatCH, AMCHP) and are in the process of developing several manuscripts. The NBS epidemiologist presented work related to prenatal care utilization and loss to follow-up in the VEHDI program at the 2022 CityMatCH conference. The CSTE Fellow in the DPHD recently presented work related to food insecurity and birth outcomes at the 2022 CityMatCH conference, and a short epi report was released in March 2023. The CSTE Fellow also presented work using PRAMS, as well as work on redlining and birth outcomes at the AMCHP 2023 annual conference. In June 2022, the DPHD onboarded a Graduate Students in Epidemiology intern, where a time series analysis was done examining severe maternal morbidity before and during the COVID-19 pandemic. This work was presented at the AMCHP 2023 annual conference. The RPH epidemiologist and NBS epidemiologist will also be presenting work at the 2023 CityMatCH Conference.

III.E.2.b.iii.c. Other MCH Data Capacity Efforts

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, Firearm Injury, Cancer, CYSHCN and Sickle Cell and PRAMS. Additionally, to prepare for the upcoming 2025 MCH Needs Assessment, a partnership with mySidewalk was pursued as a platform to highlight publicly-available and in-house indicators related to maternal and child health. This platform will be a launched in fall 2023.

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 bi-monthly 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. Additionally, Phase 9 of PRAMS will be launching in the summer of 2023, and discussions with multidisciplinary stakeholders were held to finalize questions to be included in the standard questionnaire.

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 Task Force will also explore the role of implicit bias training for providers. The first Task Force meeting launched in March 2022 and continues throughout 2023, with a final report of recommendations due in December. The MCH Epidemiologist Lead serves as a subject matter expert/member on this Task Force.

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

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 on child fatality come from V-MEDS, an OCME-managed database, and an upcoming CFRT report focused on adolescent suicides will be released in fall 2023. Data on maternal mortality come from comprehensive record reviews for each decedent, which is entered into CDC's MMRIA database, funded under ERASE MM. Surveillance data include demographics, cause and

manner of death and expanded information on precipitants of and circumstances surrounding the death, and social determinants of health, as well as recommendations from the MMRT. ERASE MM funding will also support development and implementation of interviews to capture qualitative data of lived experiences by those who have been affected by maternal deaths, and will support the evaluation of programs and policy that have come out of prior MMRT reports. The latest triennial report from the Maternal Mortality Surveillance Program is forthcoming, and a new legislative mandate in 2023 has required reports to be released annually to increase reporting timeliness.

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, which provides for state government's response to emergencies and disasters wherein assistance is needed by affected state, tribal, and local governments in order to save lives, protect public health, safety, and property, restore essential services, and enable and assist with economic recovery. A Revision Appendix was added on 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 an individual has an access or functional need. Individuals with access and functional needs may include individuals from diverse cultures, races, and national origins; people with limited English proficiency; those who do not read; and those who have physical, sensory, behavioral, mental health, intellectual, developmental, and cognitive disabilities including individuals who live in the community and individuals who are institutionalized; women who are in late or high-risk pregnancy; and individuals who have acute and chronic medical conditions.

OFFICE OF FAMILY HEALTH SERVICES EMERGENCY RESPONSE PLAN

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

III.E.2.b.v. Health Care Delivery System

III.E.2.b.v.a. Public and Private Partnerships

Public and Private Partnerships and Key Collaborations

Other MCHB Investments	
State Systems Development Initiative (SSDI)	SSDI enables the MCH Epidemiology & Evaluation Team to build & expand MCH data capacity to support Title V's data driven decision-making
Maternal, Infant and Early Childhood Home Visiting (MIECHV)	MIECHV & Title V collaborate to strengthen VA's home visiting system, develop the home visiting workforce, and expand evidence-based home visiting services. Three home visiting programs in VA are: Healthy Families, Parents as Teachers, & Nurse-Family Partnership
Healthy Start	VA's two Healthy Start sites are known as Healthy Start Loving Steps - Eastern Virginia Medical School serves Norfolk and Portsmouth; City of Hopewell serves Hopewell and Petersburg
Other Federal Investments	
Nutrition Program for Women, infants & Children (WIC)	WIC is co-located with Title V in the Office of Family Health Services and is a key collaborator with Title V
Early Hearing Detection and Intervention Program (EHDI)	Provides information and referral to families regarding newborn hearing screening, follow-up testing, and early intervention services.
Virginia Congenital Anomalies Reporting and Education System (VaCARES)	Registry of children under the age of two with birth defects that partners very closely with CSHCN Care Connection for Children Clinics
Pregnancy Risk Assessment Monitoring System (PRAMS)	Located the Division of Population Health Data, VA PRAMS provides data support a& strategic collaboration with Title V
Early Childhood Comprehensive Systems (ECCS)	Roadmaps early childhood success by informing & advocating for policy & budget decisions, stewarding equity, providing research-based expertise, and nurturing innovation; forges public and private partnerships at the state and regional levels that build and sustain capacity for equitable opportunities
Pediatric Mental Health Care Access Program (VMAP)	Supports health care providers to take better care of children & adolescents with mental health conditions through provider education & increasing access to child psychiatrists, psychologists, social workers, & care navigators
Sexual Risk Avoidance Education	Prevent unintended pregnancies among adolescents by funding evidence-based positive youth development interventions
Title X Family Planning	Network includes two grantees: VDH & Virginia League for Planned Parenthood. VDH's Title X grant funds 25 local health districts and 3 federally qualified health centers. VLPP's Title X network funds Planned Parenthood health centers in two Commonwealth regions. Title X family planning funds support clinical family planning services to all Virginians regardless of ability to pay
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.
Other VDH Programs	
State Resource Mothers Program	Seeks to lower infant death & low birth weight rates among pregnant and parenting teens and prevent rapid repeat unintended pregnancy
Adolescent Health Program	Empowers youth with the information, resources and access they need to make informed decisions about their health
Contraceptive Access Initiative	Partners with 18 health organizations to offer all FDA-approved methods of contraception to uninsured patients under 250% of the federally poverty level
School Health Program	Supports infrastructure-building services and workforce development opportunities to public, private, and parochial school-age healthcare providers

Oral Health Program	Expands access to dental homes & oral health promotion programs for high-risk pregnant women, children, adolescents, & individuals with special health care needs
Injury & Violence Prevention Program	Delivers statewide programs that provide infant & child injury prevention, and youth suicide prevention
Office of the Chief Medical Examiner Maternal Mortality Review Team	Identifies & reviews of all pregnancy-associated deaths in the Commonwealth; develops recommendations for interventions that reduce preventable deaths

Professional education programs and Universities

Title V and CYSHCN 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, including VCU and UVA's LEND and Ryan White Programs**. CYSHCN partners with:** Carilion, Accessia Health, INOVA, CHKD, UVA, Children's National Medical Center, Pediatric Specialists of Virginia, Division of Consolidated Laboratory Services.

Boards, Councils, Committees, Collaboratives, Teams, and Work Groups

Name of Group	MCH Team Representation	Population Impacted
Task Force on Maternal Health Data and Quality Measures	Director, DPHD MCH Epidemiology Lead Maternal Infant Health (MIH) Consultant	W/MH
Doula Task Force	Director, DCFH RH Unit Supervisor Resource Mothers and State Doula Certification Coordinator	W/MH P/IH
Virginia Neonatal Perinatal Collaborative (VNPC)	Director, DCFH Title V Director MIH Consultant MCH Epidemiology Lead	W/MH P/IH
Breastfeeding Friendly Designation Program	Director, DCFH Title V Director MIH Consultant	W/MH P/IH
Ryan White/Title V Statewide Collaboration	Director, DCFH Title V Director RH Unit Supervisor	W/MH P/IH
March of Dimes Maternal Infant Health Equity DMV Coalition	MCH/Title V Director MIH Consultant MCH Epidemiology Lead Director, DPHD	P/IH
Rare Disease Council	Director, DCFH Birth Defects Surveillance Program Supervisor	P/IH
Early Hearing Detection and Intervention (EHDI) Advisory Board	Newborn Screening and Birth Defects Surveillance Program Manager EHDI Program Supervisor CYSHCN Director	P/IH
Newborn Screening Advisory Committee	Newborn Screening and Birth Defects Surveillance Program Manager Newborn Screening Dried Blood Spot Program Supervisor	P/IH CYSHCN
Child Fatality Review Team	Director, DPHP	P/IH CH AH
Early Impact Virginia	ECH Team	P/IH CH AH CYSHCN

Children's Health Insurance Program Advisory Board (CHIPAC)	Director, DCFH	P/IH CH AH CYSHCN
Virginia Interagency Coordinating Council (VICC)	Blood Disorders Program Coordinator ECH Consultant	CH
Department of Education (DOE) Early Childhood Advisory Committee	Director, DCFH SH Nurse Consultant	CH
Head Start Collaborative	ECH Team	CH
Advisory Board and Head Start State Health Advisory Committee	ECH Consultant	CH
Early Childhood Mental Health Advisory Board	ECH Consultant MIECHV Project Director	CH
Infant Toddler Specialist Network Advisory Board	ECH Consultant	CH
Virginia School Nurse Association	School Health (SH) Nurse Consultant	CH AH CYSHCN
Annual Meeting of Virginia Chapter of the American Academy of Pediatrics (VA-AAP)	SH Nurse Consultant Adolescent Health (AH) Coordinator	CH AH
Summer Institute for School Nurses	SH Nurse Consultant	CH AH
Virginia Food Security Leadership Team	Director, DPHP Director, DCFH	W/MH P/IH CH AH CYSHCN
Sister Agency Monthly Team	Director, DCFH Director, DPHD MCH/Title V Director MCH Epidemiology Lead MIH Consultant MIECHV Director Maternal Mortality Projects Manager	W/MH P/IH CH AH
Virginia Catalyst (Oral Health)	Dental Health Programs Manager	W/MH P/IH CH AH CYSHCN
Unite Us Virginia Committee	MCH/Title V Director	W/MH P/IH CH AH CYSHCN
Suicide Prevention Interagency Advisory Group	Suicide Prevention Coordinator Injury Violence Prevention (IVP) Senior Epi	CH AH
Injury and Violence Prevention Subcommittee	IVP Senior Epi	W/MH P/IH CH
Association of Maternal and Child Health Programs (AMCHP)	Title V Team	W/MH P/IH CH AH CYSHCN
Got Transition- Cabinet Executive Team	CYHSN Director	CYSHCN

Virginia Interagency Coordinating Council (VICC)	Blood Disorders Coordinator	CH CYSHCN
Learning Communities/Collaboratives & Workforce Development		
AMCHP Healthy Beginnings with Urban Baby Beginnings	Director, DCFH Title V Director MCIEHV Director Resource Mothers & State Doula Certification Coordinator OFHS Policy Analyst	W/MH P/IH
CityMatCH Learning Collaborative – Alignment for Action Learning	Director, DCFH Title V Director Director, DPHD Blue Ridge Health District MCH	W/MH P/IH
MCH Workforce Development Center – Accelerating Equity Learning Community	Director, DCFH Title V Director MCIEHV Director Resource Mothers & State Doula Certification Coordinator LHD Teams	W/MH P/IH
MCH Workforce Development Center – Family Engagement Transformation Cohort	ECH Consultant Family/Youth Leader	CH
MCH Workforce Development Center – Maternal, Reproductive Health & Injury Prevention Cohort	Title V Director MCH Epidemiology Lead MIH Consultant Reproductive Health Unit Supervisor Family Planning Quality Assurance Nurse Supervisor IVPP Senior Epidemiologist	W/MH P/IH
MCH Workforce Development Center – MCH Summer Internship Program 2023	Title V Director MCH Epidemiology Lead	W/MH P/IH
2022-2023 cohort of the Maternal Mental Health Government Agency Fellows program	MCH Epidemiology Lead IVPP Senior Epidemiologist	W/MH
CityMatCH – 2022 Training Course in Maternal and Child Health Epidemiology	MCH Epidemiology Lead	W/MH P/IH CH AH CYSHCN

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

Title V – Medicaid Memorandum of Understanding (MOU)

The Virginia Department of Health (VDH) Title V Program upholds a longstanding collaborative relationship with the Virginia Department of Medica Assistance Services (DMAS), which houses the state's Medicaid Program. 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. The purpose of the MOU is to enable Virginia's Medicaid and Title V programs to carry out the mandate of the cooperation contained in the related provisions of the federal statutes and regulations and to achieve their shared goal of improving the health of women, children, adolescents, children and youth with special healthcare needs, and families in Virginia. Specific purposes are to:

- Develop and implement initiatives that address the underlying causes of preventable diseases; Increase coordination/collaboration between the Title V Program and Medicaid
- Support a system of care across various agencies providing services for the maternal, child, adolescent, and children/youth with special health care needs populations
- Formalize the responsibilities of each agency
- Hold agencies accountable for their roles and responsibilities
- Ensure policy continuity over time
- Provide methods for communication and information exchange
- Meet the requirements of both Title V and Title XIX

In early 2022, members of both VDH and DMAS convened to review the current MOU Sections related to maternal and child health and CYSHCN. Since that time, Title V Leadership is undertaking revisions on Section III: Maternal and Child Health Collaborations (pages 13 – 26): A. BabyCare; B. Children with Special Health Care Needs Program; C. Early and Periodic Screenings, Diagnosis and Treatment Services (EPSDT); E. Plan First; F. Maternal and Child Health Collaboration (Perinatal Health). Title V and DMAS leadership are jointly revising the BabyCare Section. Significant revisions will be made to the Plan First section, and a new section regarding Doula Benefit is under development and will be added.

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 2.2 million individuals and is delivered to individuals through two models: fee-for-service (10% of enrollees) and managed care (90% of enrollees). Approximately 27.5% (585,768)[1] of Virginian Children ages 0-19 and 34.1%[2] of children with special healthcare needs are receiving 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. This includes expanded 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 2021, Virginia Medicaid covered approximately 36,480 births, including 1,930 births for members enrolled in limited benefit programs and members who were only eligible for emergency-only benefits.

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 & 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. **BabyCare Program:** BabyCare is DMAS' case management program, providing 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 during pregnancy and through the 60th post-partum day; infants are eligible up to age two. Eight Local Health Districts health currently maintain robust BabyCare programs through which Title V funding supports their efforts. BabyCare is also administered in several rural health clinics and FQHCs.
2. **Children with Special Health Care Needs Program: Care Connection and CCC Plus Managed Care (Care Coordination)**- CYSHCN program maintains a strong relationship with DMAS to address issues related to the CYSHCN Population. Current collaborations include the resolution of and ongoing monitoring of 1) Access issues to low protein foods for Medicaid recipients; 2) Billing issues for Licensed School Psychologists that are evaluating clients at Child Development Clinics.
3. **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 VDH and DMAS collectively provided input and direction into both the state certification and reimbursement processes. Both initiatives went into full effect in early 2022. The first 4 state certified doula supported births were delivered in October 2022. To date, there are over 100 state certified doulas approved by the state.
4. **CMS- Low-Risk Cesarean Delivery Affinity Group:** Beginning September 2022, Title V Leadership joined DMAS Low-Risk Cesarean Delivery Affinity Group, working with Mathematica to continue efforts to address the role of LRCD in maternal and infant health, and to present strategies that state Medicaid can use to reduce LRCD births.
5. **Regional Maternity Meetings:** As DMAS continues to strategize a long-term and collaborative approach to increasing prenatal and postpartum outcomes for moms and babies, their MCH team will coordinate four maternity listening sessions around the state to understand regional opportunities, concerns, and factors impacting member health and access to care. Title V's MCH leadership will assist with coordination and utilize this opportunity to learn from the community as well as find additional points of collaboration with DMAS. These meetings are targeted to begin in April 2023.

Recent Medicaid expansion updates that impact Title V population

PRENATAL AND POSTPARTUM COVERAGE EXPANSIONS: Effective July 1, 2022, Virginia became one of the first

states to expand continuous full-benefit Medicaid and FAMIS MOMS coverage across eligibility categories for full 12 months postpartum.

Virginia Medicaid Covid Response

UNWINDING & RETURN TO NORMAL OPERATIONS:
Beginning April 1, 2023, DMAS and Virginia's Department of Social Services (DSS) resumed its normal renewal process for all 2.2 million members after more than two years of continuous health coverage regardless of changes in members' circumstances. Over the course of 12 months, starting in April 2023, redeterminations will occur for all current enrollments. Virtual Town Halls were held throughout the month of March 2023 for Medicaid Providers, and Toolkits and materials in English and multiple languages about the Medicaid renewal process to prepare and support members for their Medicaid Renewal.

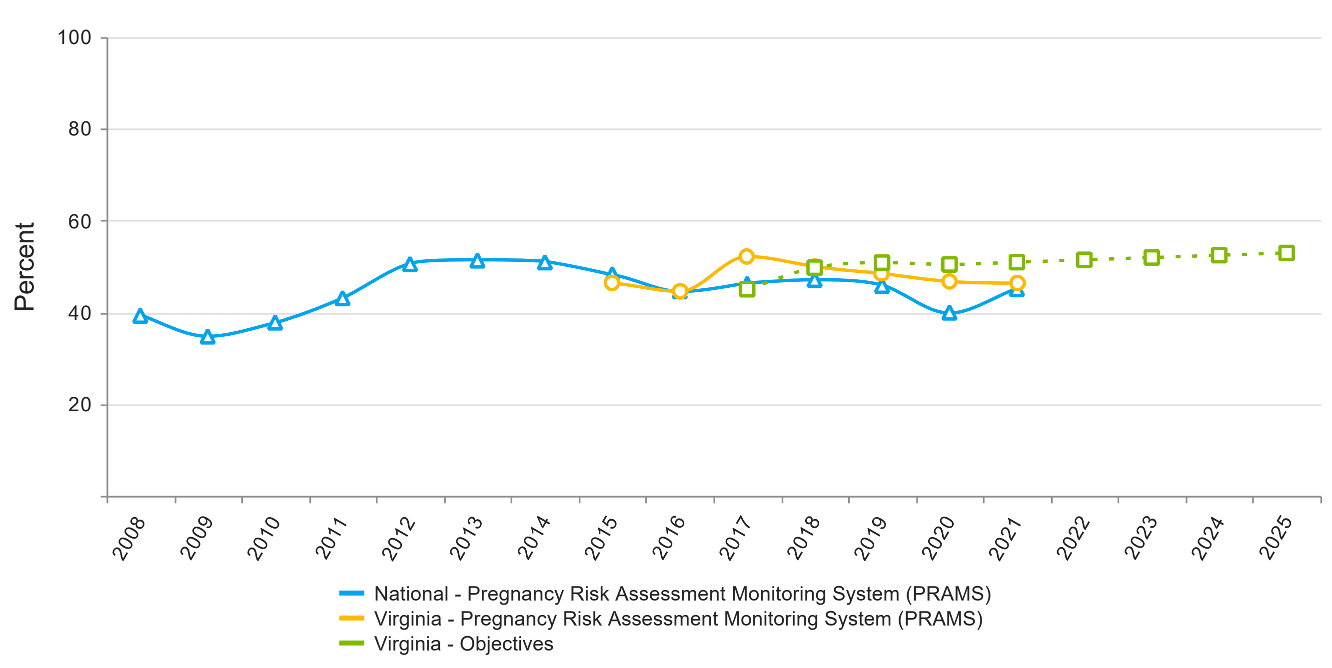
Sources:
1. ACS 2021 5-year estimate
2. NSCH – 2020-2021
3. BabySteps VA Maternal Health Annual Report 2021
4. https://www.dmas.virginia.gov/media/4638/dmas-maternity-report-2021.pdf

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

Women/Maternal Health

National Performance Measures

NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy
Indicators and Annual Objectives



Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2018	2019	2020	2021	2022
Annual Objective	49.7	50.8	50.4	50.9	51.4
Annual Indicator	44.7	49.9	48.4	46.7	46.3
Numerator	42,882	46,558	43,840	41,629	41,487
Denominator	95,839	93,304	90,596	89,193	89,630
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2016	2018	2019	2020	2021

Annual Objectives			
	2023	2024	2025
Annual Objective	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					
	2018	2019	2020	2021	2022
Annual Objective		6	6	6	6
Annual Indicator	3	4	8	7	6
Numerator					
Denominator					
Data Source	VDH Oral Health Program documentation	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	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	6.0	7.0	7.0

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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	2022
Annual Objective			23.8	23.3
Annual Indicator	25.3	27.1	25.1	19.8
Numerator				
Denominator				
Data Source	VA PRAMS	VA PRAMS	VA PRAMS	VA PRAMS
Data Source Year	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives

	2023	2024	2025
Annual Objective	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

State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	42.9	71.4
Numerator	15	25
Denominator	35	35
Data Source	OFHS MCH Program Documentation	OFHS MCH Program Documentation
Data Source Year	2021	2022
Provisional or Final ?	Final	Final

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	2022
Annual Objective			2.8	2.4	2.1
Annual Indicator	1.9	2.2	2.7	2.1	2.2
Numerator	52.6	32.4	38.2	49.1	55
Denominator	27.7	14.5	14.1	23.7	24.6
Data Source	National Vital Statistics System	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	2018-2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

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

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

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

WOMEN/MATERNAL HEALTH DOMAIN SUMMARY/OVERVIEW FY22 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

DOMAIN OVERVIEW

MATERNAL INFANT HEALTH (MIH) CONSULTANT: The MIH Consultant position was vacant from February 2020 through August 2022. The MIH Consultant serves as subject matter expert 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 facilitates the monthly Sister Agency meeting that includes representatives from Department of Medical Assistance Services (DMAS), Department of Behavioral Health and Developmental Services (DBHDS), and Department of Social Services (DSS), MMRT, and VPNC. The MIH Consultant consults with LHDs regarding perinatal health work and provides support where possible. In addition, the MIH Consultant analyzes proposed maternal child health legislation and budget requests, and is responsible for resulting requirements upon passage such as work groups or task forces where appropriate. The MIH Consultant builds and sustains a variety of partnerships that serve Title V priorities and seeks out additional funding to expand the MCH work in Virginia.

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.

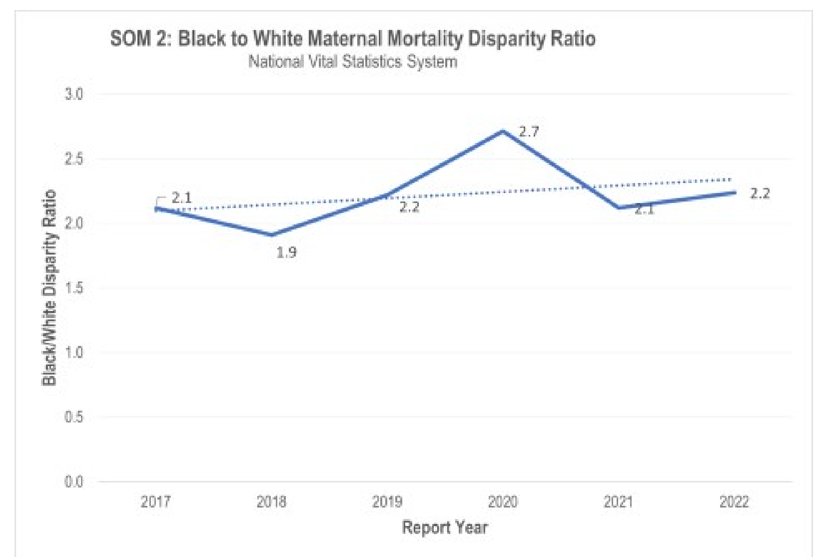
MCH EPIDEMIOLOGY: The MCH Epidemiology and Evaluation Unit is a centralized epidemiology unit within the Division of Population Health Data headed by the MCH Epidemiology Supervisor who serves as the Lead Epidemiologist for Title V. The team has additional capacity available through a MCH Epidemiology Coordinator, 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.

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.

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.

STATE ACTION PLAN UPDATES

Maternal/ Infant Mortality Disparity	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 Disparity Ratio



National maternal mortality data from 2018 indicate that Virginia's maternal mortality rate of 16 per 100,000 livebirths largely mirrors the national mortality rate of 17.4 per 100,000 per livebirths; however, more recently, the 5-year (2017-2021) maternal mortality rate of black women (55 per 100,000 livebirths) is over two times higher than that for white women (24.6 per 100,000 livebirths). PRAMS data from 2021 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 pregnancy-associated mortality rate over twice that of their white counterparts (51.4 versus 25.1 per 100,000 live births, 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

During the current reporting period, the Virginia Board of Health finalized regulations to guide the State Doula Certification designation, triggering the launch of the State Doula Certification program and subsequent Medicaid billing process. To date, VDH has certified over 100 community-based doulas, and DMAS has stewarded the majority of them in becoming Medicaid providers. With Virginia Medicaid covering one in three births in the Commonwealth, this represents a significant opportunity for vulnerable families to benefit from doula services. VDH and DMAS are collecting data about the certification process, service delivery, and maternal and infant health outcomes to understand the impact of these programs on the community. This work actively works to address the racial maternal and infant mortality disparities in Virginia, as Black birthing people are significantly more likely to experience poor outcomes than their White counterparts. VDH continued to provide administrative support the Doula Task Force, the purpose of which 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 is Chaired by Kenda Sutton-El (Birth in Color RVA) and Stephanie Spencer (Urban Baby Beginnings), and its membership includes doulas, consumers, providers, hospitals, legislators, DMAS, and VDH.

EQUITY CENTERING: Community-based doulas are grounded in the communities they serve and offer culturally congruent care. VDH's State Doula Certification Program aims to help patients find a doula that meets their needs and support doulas in earning a living wage for their services.

CHALLENGES: After offering the State Doula Certification Program for a year, VDH recognizes a need to increase the number of approved doula training entities. VDH also sees an opportunity to build the capacity of community doulas to participate in the doula certification program and to connect with resources necessary to support their practice. VDH intends to leverage its partnerships with the Doula Task Force, DMAS, and other stakeholders to explore these opportunities moving forward.

SUCCESS STORY: Two testimonials from doulas who have achieved State Certification and become Medicaid Providers:

"Years ago, I learned about the massive disparities in healthcare, and specifically maternal healthcare, in the US and how those disparities put people of color on the receiving end of lower quality care, treatment, and support by the healthcare system. Soon after, I read about the positive impact that doulas can have on birth outcomes. That's when I knew I wanted to begin learning about birth, birth support, and organizations that offered doula training. Being able to offer the resource of doula care to EVERYONE is extremely important to me and to Birth in Color RVA. I would recommend doula work for anyone who may already find themselves as a naturally supportive person, one who can advocate for themselves and others, and enjoys propelling others to see their own power and greatness."

"My passion for birth work started 25 years ago when I was an Air Force medic and was doing my maternity rotation in tech school. This was the first time I had ever experienced a live birth and the moment the baby was born and in his mother's arms, I was in love and hooked! I chose to become a doula because I want everyone to have the birth they desire, I want to educate them on all of their choices so they can make informed decisions, and I want them to feel confident to speak up for what they want during their pregnancy and delivery. My hope as a doula is for everyone to feel supported and heard, and to leave their birth satisfied with the decisions they made for themselves during their pregnancy and labor. This work is rewarding, challenging, intriguing, spontaneous, and absolutely POWERFUL! Doulas are changing the way we birth in this country and it is very important work, we are pioneers, we are saving lives."

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. Throughout FY22, VNPC continued to lead the statewide Sister Agency Monthly call, with Title V participation alongside MCH representation from all state-level agencies. In FY22, VNPC organized 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. The 5th Annual VNPC Summit was held virtually on October 29, 2021, themed "Fostering Community Partnerships to Improve Maternal and Infant Health Outcomes". The Perinatal and Infant Mortality Summit occurred on May 16, 2022, and was also virtual. Both summits had over 200 virtual attendees from state, district and local community organizations.

Strategy 3: Local Health Districts (LHD): Develop, mobilize, and participate in strong interagency, multisector, and community partnerships to address disparities in maternal and infant mortality rates

Beginning State FY 23 (July 2022), Virginia's LHDs were transitioned to a new work plan structure more closely aligned with the State Action Plan. Each district was required to select from a list of measurable activities, and then report quarterly to those activities. Twenty-two 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. Detailed District reporting will occur in FY23 block grant report.

MCH Data Capacity	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 disparity 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, Overdose Data to Action project, and the ERASE MM project. The division is 100% federal funded through grants and cooperative agreements through the Centers and Disease Control and Department of Justice.

The MMRT is current reviewing maternal deaths that occurred in 2021 (n=108). The 2023 triennial report was written and submitted to Virginia's Secretary of Health and Human Resources, and at this time is in the final review stages. It is anticipated that this report will be published in the mid-late summer 2023. Through Plan-Do-Study-Act (PDSA) evaluations, it was determined that several changes needed to be made to the structure, operation, and facilitation of the MMRT and those changes are currently being discussed among OCME and OFHS. We anticipate a roll-out of updated procedures to assist with more timely review in September 2023.

Other activities included the MMRT coordination and facilitation of bi-monthly MMRT 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 MMRIA database (funded and maintained by CDC under the ERASE MM cooperative agreement) by the MMRT staff. 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 MMRT. The MMRT consists of the following team members: the Chief Medical Examiner, the Director of the Office of Family Health of the Department of Health, the State Registrar of Vital Records, and the Commissioner of Behavioral Health and Developmental Services. Additional team members include: local law enforcement, local fire departments, local emergency medical services providers, local departments of social services, community services boards, attorneys for the Commonwealth, the Medical Society of Virginia, the Virginia Hospital and Healthcare Association, the Virginia College of Emergency Physicians, the

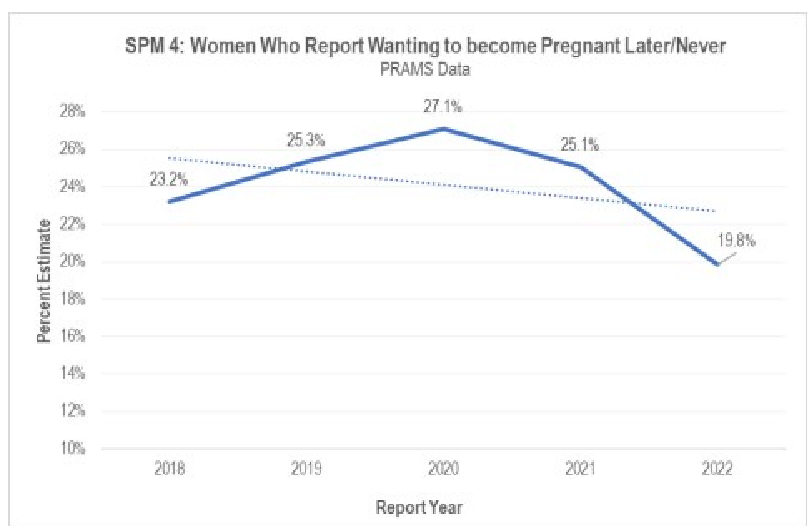
Virginia Section of the American College of Obstetricians and Gynecologists, the Virginia Affiliate of the American College of Nurse-Midwives, the Virginia Chapter of the Association of Women's Health, Obstetric and Neonatal Nurses, the Virginia Neonatal Perinatal Collaborative, the Virginia Midwives Alliance, and the Virginia Academy of Nutrition and Dietetics. The Chief Medical Examiner and the Director of the Office of Family Health of the Department of Health serve as co-chairs of the Team and may appoint additional members of the Team as may be needed to complete maternal death reviews.

The Maternal Mortality Programs Manager sits on numerous committees and boards including the Virginia Neonatal Perinatal Collaborative, the Maternal Health Data Quality Committee, and the Perinatal Cannabis Workgroup. They also provide data to community stakeholders and leaders as requested.

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 and PRAMS Principal Investigator serve as a subject matter experts/members on this Task Force. A final report is due to the General Assembly by December 1, 2023.

Reproductive Justice and Support	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 Virginia Contraceptive Access Initiative, the Title X Family Planning Program, the Adolescent Health Program, Resource Mothers, the State Doula Certification Program and Task Force, the Pregnancy Loss Services Initiative, and the State Funding of Certain Abortions Program.

The Contraceptive Access Network was 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 was facilitated by VDH, met twice a year, and included over 70 members from a variety of community-based health centers, governmental organizations, hospital systems, payers, and community members. The network stopped meeting officially in 2021, but informal collaboration continues among some members around specific projects. Two such projects include the Contraceptive Access Initiative and Prescribing Authority.

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. During SFY 21 (July 1, 2021-June 30, 2022), the expanded program provided 6,678 no-cost visits to eligible patients. Title V funds support VDH staff time spent administering this program. VDH's Title X Family Planning program provides comprehensive family planning services at 109 clinical sites across the Commonwealth, including 25 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 is partnering with Vanderbilt University to formally evaluate the impact of VDH's family planning efforts on unintended pregnancies in the Commonwealth, and the results are expected during the upcoming reporting period.

During the 2020 General Assembly Session, Virginia legislators passed a law to allow pharmacists to dispense

contraception to low-risk patients aged 18 or older. VDH and other stakeholders worked with the Board of Pharmacy to finalize protocols later that year, but pharmacists still are not taking advantage of this program in a significant way. The primary reason is tied to billing; Virginia Medicaid does not recognize pharmacists as medical providers, and therefore pharmacists cannot be reimbursed for medical services they offer. In order to dispense contraception under the approved protocols, pharmacists must have a consultation with the patient to identify the appropriate contraceptive method and determine that the patient does not have any medical contraindications that would prevent her from safely taking hormonal methods. Because Virginia has no mechanism for compensating pharmacists for this consultation, commercial pharmacies do not have a financial incentive to offer this service. As a result, Safeway is the only commercial pharmacy prescribing contraception in Virginia. Safeway charges the patient $35 for the consultation, and its locations are only located in the northern part of the state. VDH is working with Safeway to learn best practices for implementing this program, but all acknowledge that the $35 consultation fee is a barrier for low-income patients. Based on VDH's conversations with the Virginia Pharmacists Association and DMAS, until pharmacists are recognized as medical providers and compensated accordingly, pharmacies will not offer this service in a significant way.

EQUITY CENTERING: Countless programs have shown that when financial barriers to contraception are removed, more people use contraception consistently and correctly, and unintended pregnancy rates drop as a result. VDH's famil planning programs, including those supported by Title V, intend to remove financial varriers for patients to allow them to use the method that is best for them, not just the method that is the most affordable. When the Contraceptive Access Initiative was launched, the Virginia General Assembly limited the program to hormonal LARCs. VDH believes that expanding the program to include all FDA-approved methods was an important step towards equity. While making some methods of contraception available at no cost, particularly the most expensive methods, can increase access, this approach has the potential of being coercive because a patient may feel pressured to choose the free method over the one that bes meets their needs.

CONTRACEPTIVE ACCESS INITIATIVE

A Public Health Program for Women in Need

Overview

The Contraceptive Access Initiative (CAI) began as a pilot program in 2018. That year, the Virginia Department of Health (VDH) was tasked by the Commonwealth of Virginia to design a two-year pilot program to increase access to hormonal long acting reversible contraceptives (LARCs) among women up to 250% of the federal poverty level. In 2020, this program was extended an additional two years and expanded to cover all FDA-approved methods of contraception rather than only hormonal LARCs. The CAI is funded by Temporary Assistance for Needy Families (TANF) with an annual budget of $4 million.

Health providers participating in the program include:

- Seven federally qualified health centers
- Three private women's health clinics
- Four hospital systems
- Two free clinics
- Two Planned Parenthood affiliates

Funds are ***only*** used for LARC insertions, LARC removals, and contraceptives.

Public Health Impact

Improved Health Outcomes

When Colorado provided contraception at no cost, the state saw a **significant reduction** in:

- Teen births,
- Abortions, and
- Rapid repeat births

While Colorado's initiative was larger than Virginia's, Virginia expects to see similar outcomes due to this program.

Cost Savings

- It is estimated that every $1 invested in family planning services saves $7.09 in public expenditures[1]
- Colorado's Family Planning Initiative saved $66.1-69.6 million in Medicaid, TANF, SNAP, and WIC expenditures[2]

VDH.Virginia.gov

[1] *(Frost, J. J., et al. (2014). Return on investment: A fuller assessment of the benefits and cost savings of the US publicly funded family planning program. The Millbank Quarterly. doi: 10.1111/1468-0009.1208).*

[2] *(Finer, L. B. and Zolna, M. R. (2011). Unintended pregnancy in the united states: Incidence and disparities, 2006. Contraception, 84(5), 478-485).*

CONTRACEPTIVE ACCESS INITIATIVE

Program Impact:

October 1, 2018-June 30, 2022

The Contraceptive Access Initiative has covered 17,445 contraceptive visits since its inception. When the program expanded to include all methods of contraception in July 2020, program utilization increased significantly.

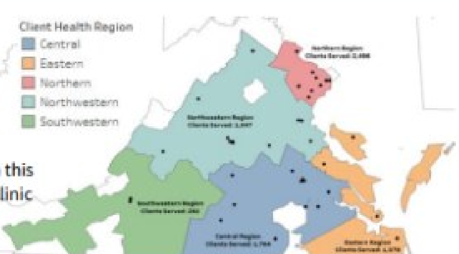
*Indicates program expansion on July 1, 2020

- 96% of women served are between 15 to 44 years of age.
- 59% of women served are 100% or below the federal poverty level, which is $23,030 for a family of three.
- The contraceptive implant (Nexplanon) is the most popular method, followed by the contraceptive injection (Depo Provera).

CAI Patients and Providers

(July 1, 2021 – June 30, 2022)

CAI providers are located as far north as Winchester, as far east as Virginia Beach, and as far west as Roanoke. Patients travel to the most convenient location to receive services. The map shows the regional distribution of patients who received services through this program during the most recent year. The black dots indicate the clinic locations. *Note: The numbers listed on the map do not equal 6,678 because some patients chose not to share this information.*

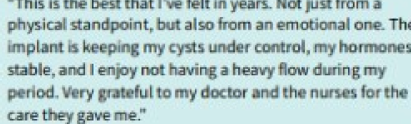


Patient Testimonials

"They were able to provide the birth control I wanted and gave it to me at no fee which was unexpected. Very grateful!"

"This is the best that I've felt in years. Not just from a physical standpoint, but also from an emotional one. The implant is keeping my cysts under control, my hormones stable, and I enjoy not having a heavy flow during my period. Very grateful to my doctor and the nurses for the care they gave me."

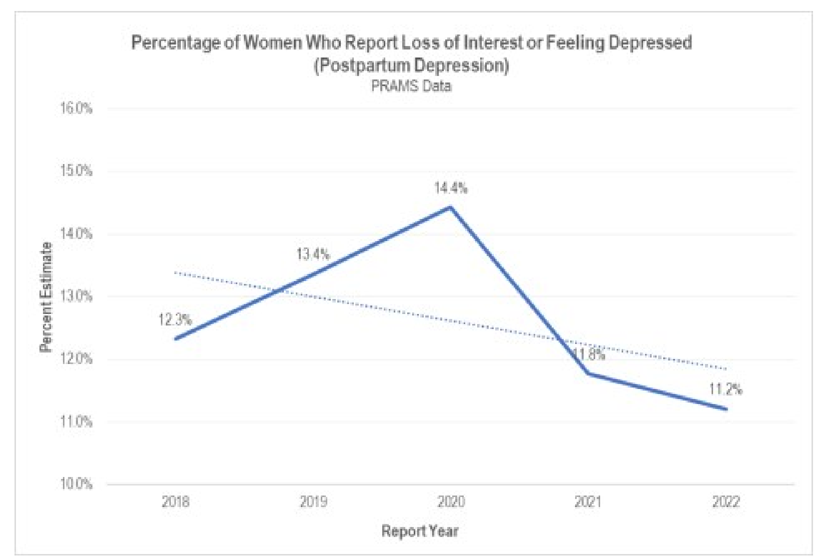
"I am so glad that I don't have to worry about getting pregnant or have to remind myself to take medicine."



"Great care with dignity and respect."

VDH VIRGINIA DEPARTMENT OF HEALTH
VDH.Virginia.gov

Mental Health	PRIORITY 4 Mental Health: Promote mental health across MCH populations, to include reducing suicide and substance use
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



Maternal mental health (MMH) conditions, including perinatal mood and anxiety disorders, are one of the most common complications in pregnancy, affecting 1 in 7 birthing individuals in the United States; however, MMH affects birthing individuals who are members of vulnerable groups, marginalized and underserved communities are affected at a much higher rate. MMH 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, 11.2% of 2021 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

The purpose of VDH's Pregnancy Loss Services Initiative is to build the capacity of community organizations to provide pregnancy loss support 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, sudden, unexpected death of an infant, and pregnancy after loss. 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 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.

On January 1, 2022, VDH initiated contracts with the following organizations to offer pregnancy loss services:

- Birth in Color RVA
- Full Circle Grief Center
- Kennedy's Angel Gowns
- Sisters in Loss
- VCU OBGYN Department

These organizations achieved the following outputs during the reporting period:

- Offered over 100 grief groups to individuals who have experienced loss, with an average of 4 people attending each group.
- Distributed material support ("angel boxes") to 75 families
- Hosted 9 community conversations/informational events
- Create one public resource list and one informational video about pregnancy loss

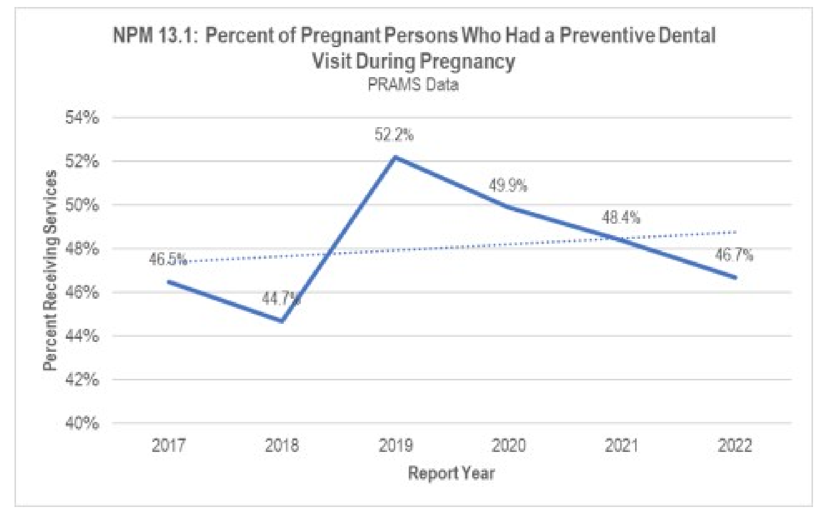
In addition, VDH worked with partners to build capacity to meet the needs of families of color who have experienced loss and train future providers about this issue. Participant feedback about the program has been overwhelmingly positive, and VDH's MCH team is partnering with the Reproductive Health team to more intentionally collect information about participant experience moving forward. During the current reporting period, VDH facilitated a workshop titled "Cultivating State Support for Pregnancy Loss" at the AMCHP conference and is working with the MCH Learning Institute to integrate these efforts into an overall maternal mental health strategy for Virginia.

EQUITY CENTERING: VDH's Pregnancy Loss Initiative recognizes that Black women experience pregnancy loss at higher rates than White women, and as a result, aims to build the capacity of community-based organizations to support families of color.

Strategy 2: Local Health Districts (LHD): Strengthen early identification, supports, and referrals for mental and behavioral health needs of people of reproductive age

Beginning State FY 23 (July 2022), Virginia's LHDs were transitioned to a new work plan structure more closely aligned with the State Action Plan. Each district was required to select from a list of measurable activities, and then report quarterly to those activities. Twenty-three 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. Title V plans to partner very closely with Postpartum Support VA to provide training to the districts teams regarding screening and referrals, as well as to assist in the Districts' ability to develop and sustain relationships with their community mental health providers. Detailed District reporting will occur in FY23 block grant report.

Oral Health	PRIORITY 5 Oral Health: Maintain and expand access to oral health services across MCH populations
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

Birth in Color RVA is a non-profit organization dedicated to raising awareness about maternal health and reproductive justice. Through their comprehensive program, they provide training, mentorship, culturally-centered birth services, and support to Black pregnant individuals and their families while also offering racial bias training for healthcare professionals. With funding from the MCH block grant as a micrograntee, BIC educated doulas and birth workers about the importance of oral health and routine dental care for their clients. Additionally, BIC provided dental supplies, oral health education and referrals to participants of bi-monthly support groups.

Through this work, Birth in Color RVA contributed to the national performance measure (NPM) 13.1, which monitors the percentage of women who had a preventive dental visit during pregnancy. This initiative aligned with the organization's broader mission of promoting improved oral health and overall well-being for pregnant individuals and their children in the regions of Hampton Roads, Richmond, and Lynchburg.

Birth in Color RVA successfully integrated oral health education into their doula and birth worker training curriculum, empowering these providers to educate their clients effectively. By providing dental supplies, resources, and education to pregnant individuals and their families, the organization fostered awareness and prioritization of oral health during pregnancy. Through their comprehensive efforts, Birth in Color RVA contributed to the overall improvement of maternal health and reproductive justice in their target regions.

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

(See Below)

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

All of Catalyst’s strategies within the MCH program are designed to influence changes to the system that promote more equitable and easier access to oral health services for pregnant people and children and safe, trusted, fluoridated drinking water. Catalyst’s Future of Public Oral Health (FPOH) workgroup was a collaborative project that implemented work plans to increase dental visits among pregnant people and children by focusing on technology and innovative, replicable quality improvement projects with safety net clinics. Our school-based oral health programs continued to bring together various partners who were previously unconnected to help school age children get direct access to necessary oral health care. For example, conversations spurred by Catalyst opened the door to continued collaborations that can provide medical care and

vaccinations to the 6,000-plus children in the Harrisonburg school district and help replicate these partnership models across the state.

Many activities occurred during the reporting period as outlined in the monthly reports. In summary, these activities included conducting community outreach events to increase awareness of program services, training staff and stakeholders on evidence-based practices, working with clinics to implement telehealth services to improve access to care, and collaborating with community partners to enhance service delivery.

All activities were designed to influence performance measures to increase dental visits among pregnant people and children and collaborative projects. Across the board, we positively influenced those measures through MCH-focused dental education programs, regional activities, and several active workgroups like FPOH, Water Equity Taskforce (WET) and the Early Dental Home (EDH) workgroup.

Our partners across grassroots projects, alliances, and workgroups continued to identify barriers to accessing oral health care including myriad COVID-related repercussions so that we could implement work plans to address access issues at the community-level. Our strategies to provide MCH-related education, foster regional programs, and convene statewide partners were all met through various activities like fluoride varnish and special needs dentistry trainings, completion of the 2022 Oral Health Report Card and Teledentistry Toolkit, and successful convenings for the FPOH, WET, and EDH workgroups.

In addition to the 2022 Oral Health Report Card and Teledentistry Toolkit, the program has produced various deliverables, including reports on program progress and service utilization, stakeholder meeting summaries, and additional training materials for staff and stakeholders. The program also provided technical assistance to partners and stakeholders, including training on evidence-based practices and implementation support for telehealth services. Additionally, Catalyst held the 11th Annual Summit, which brought health equity to the forefront and provided a forum for education and networking to hundreds of stakeholders.

The program has had several successes and impacts. For example, the program has increased community awareness of program services through high-touch technical support to increase care coordination, resulting in increased service utilization among community partners. The program has also trained staff and stakeholders on evidence-based practices, which has led to improved service quality and outcomes for program participants. Notably, Catalyst increased workgroup membership, adding new perspectives that have enhanced the work plans' abilities to address topics like telehealth, health equity, and school-based oral health care. For example, a new FPOH technology workgroup member created a teledentistry workflow to share with school nurses so they can use teledentistry in their programs. Additionally, 90% of participants at Catalyst's Annual Summit participants reported that the sessions were informative for their work; session topics covered the future of equitable public oral health care, improving care for Virginia's LGBTQ community, leveraging social determinants of health, the history of racism in healthcare, and creating equitable policies in Virginia.

EMERGING ISSUES

During the 2023 General Assembly session, Virginia legislators passed SB1538, which will require DMAS to reimburse pharmacists for medical services provided. this bill directly addresses the main barrier to making contraception available under the Board of Pharmacy protocols finalized in 2020. VDH anticipates that implementing SB1538 will take at least a year, but when the process is established, pharmacists will have a mechanism to bill Medicaid for contraceptive counseling provided when prescribing contraception to eligible patients.

WOMEN/MATERNAL HEALTH DOMAIN
FY24 APPLICATION YEAR

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 1.23 (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 expand access to doula services among women of color in Virginia, VDH intends to continue managing the State Doula Certification Program and providing administrative support to the Virginia Doula Task Force during the upcoming funding period. The 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's steering and executive committees, as well as participate in workgroups regarding the fourth trimester and eliminating bias in the dyad care. MCH Epi Team will continue to provide data support as requested or required to meet the needs of VNPC's external grant funding reports.

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 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 that the birthing community has access to doula support if desired.

   Additionally, beginning in Fall 2024, all health districts will be required to participate in activities designed to gain understanding of district-led capacity to achieve post-partum visits for all postpartum people in their districts.

PRIORITY 2	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 1.23 (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/or MMRT Research Associate. The Programs Manager is also responsible for maintaining the recommendations from each review meeting and compiling and review the recommendations quarterly for applicability and appropriateness based on the review topic and current data trends.

   MCH Data Capacity: Using data from the Maternal Mortality and Child Fatality Review Programs, the OCME will provide data Title V, community-based, and Virginia Department of Health partners when requested. The surveillance data from these programs is the hallmark data program for maternal and child 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 review team meetings, and other activities where appropriate. This is work is done through the Maternal Mortality Review Team and Child Fatality Review Teams. The MMRT 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 CFRT is chaired by the Chief Medical Examiner and includes representation from education, social services, community-based agencies, psychiatry, law enforcement and other relevant agencies. The purpose of the teams is to review maternal and child fatality cases and work to provide policy and programmatic recommendations to address the studied topic. Furthermore, the Maternal Mortality and Family Violence Programs Managers sit on a variety of community boards and workgroups addressing maternal and/or child death.

   Upstream/Cross Sector Strategic Planning: The goal of the MMRT and CFRT 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 and CFRT will be align goals, as they are able with Title V investments and ensure the recommendations continue address community, environmental, community, and healthcare setting factors identified in the review. This is already an activity in the Maternal Mortality and Child Fatality Review Teams. The MMRT and CFRT 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.

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	SPM4: Pregnancy Intention: Mistimed or unwanted pregnancy (wanted to become pregnant late 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.

PRIORITY 4	Mental Health
OBJECTIVE	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%.
PERFORMANCE MEASURE	SPM 6 - Promotion and strengthening of optimal mental health and well-being through partnerships and programs

STRATEGIES:

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

   VDH intends to continue the Pregnancy Loss Support program in FY24. VDH partners with four community-based agencies and one hospital system to offer support services, including grief counseling, to individuals and families experiencing pregnancy loss. VDH will evaluate program data to determine immediate program impact and insight about additional needs among this population. VDH will additionally identify opportunities for system-level initiatives through this project.

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 Postpartum Support Virginia 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

STRATEGIES:

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

   During FY24, VDH's Dental Health Program will retain employment of a full time Program Consultant who will work to identify opportunities to leverage other federal funds to include MCH populations and to integrate MCH-focused dental education programs into all federally funded projects. Activities include, but are not limited to, oral health integration into primary care settings, and oral health education for home visitors, school aged children, and adolescents. Oral health topics will include oral health for total wellness, oral care for caregivers, dental sealants, fluoride varnish, and oral injury prevention.

2. **Continue to facilitate and support regional efforts to improve oral health for all Virginians, with emphasis on pregnant people and their infants**

   During FY24, VDH's Dental Health Program will continue to partner with the Virginia Health Catalyst to foster regional efforts and initiatives by supporting the implementation of regionally identified projects, through a micro-grant program, that focus on systems change and data sharing to improve the oral health of all Virginians, with emphasis on pregnant people and their children. Activities include supporting development and implementation of regionally-identified projects, through a micro-grant program; leveraging Catalyst's Clinical Advisory Board (CAB) and expert consultants to provide clinical guidance and education to the micro grantees; assisting micro grantees with developing an evaluation component for their projects; sharing regionally-specific data and other information to meet partner needs; enabling information-sharing among state and local partners and regional alliance members to inform the plans and implementation of local and statewide activities; and ensuring alignment between regional and statewide initiatives, as applicable.

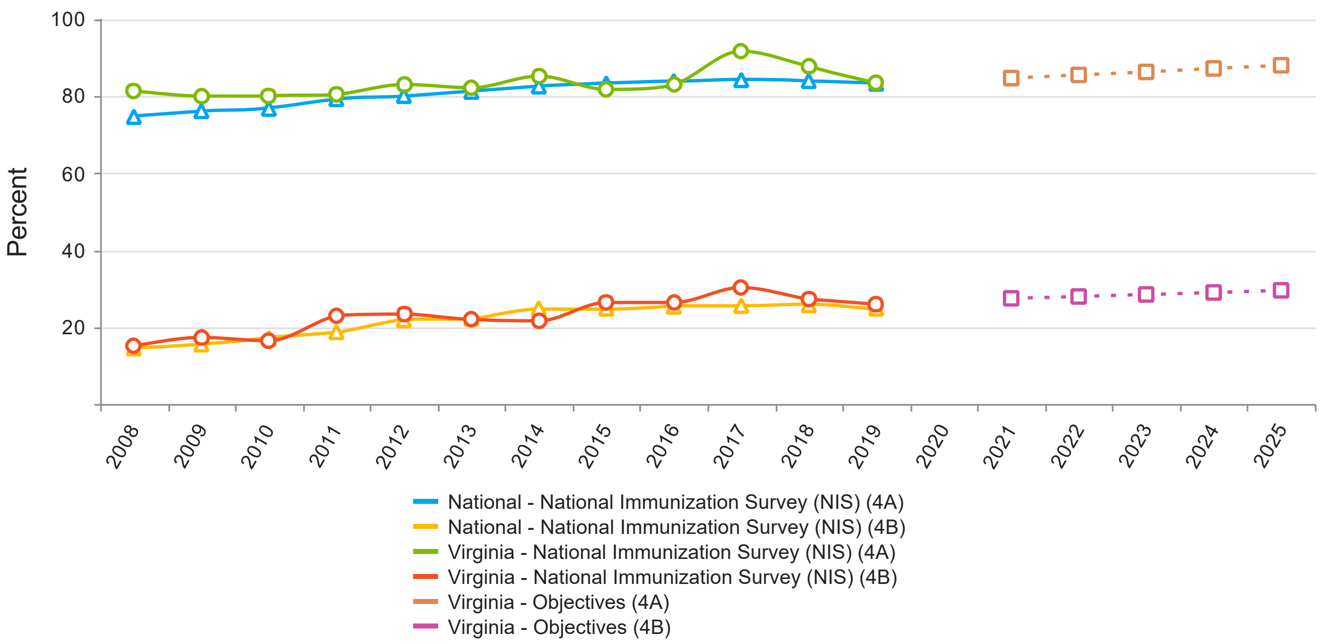
3. **Convene statewide groups focused on issues that impact oral health and facilitate collaboration and work plan development and provide leadership and oversight to guide initiatives**

   During FY24, VDH's Dental Health Program will partner with the Virginia Health Catalyst to convene statewide groups focused on targeted oral health issues to advance health equity, care coordination, and systems-change approaches that increase access to integrated, comprehensive care and facilitate collaboration and work plan development, and provide leadership and oversight to guide initiatives that include oral health care for children under 17, pregnant women and their families. Activities include continuing to convene the Future of Public Oral Health Taskforce (FPOH) and its related workgroups, focused on the future of oral health care delivery in Virginia following the COVID pandemic and considering other environmental changes, upcoming trends in healthcare, and policy forecasts; continuing to identify and engage partners to participate in taskforce and workgroups to develop and implement workplans for FPOH workgroups; engaging clinical expertise to offer additional technical assistance and guidance to all Catalyst workgroups, including CAB and FPOH; continuing to convene the Water Equity Taskforce (WET), including subgroups focused on consumer literacy, the consumer confidence report, and affordability/accessibility; developing and implementing work plans for the WET and its subgroups, considering a post-COVID environment and new/existing health equity concerns; Continuing to convene 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; continuing to identify and collaborate with existing groups working on HPV to ensure oral health is integrated into their approach and goals; workplans and projects, with specific focus on dental visits and oral cancer education and screenings for children under 17.

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	2022
Annual Objective			84.6	85.4
Annual Indicator	82.9	91.7	87.5	83.3
Numerator	73,338	84,128	78,142	65,318
Denominator	88,459	91,769	89,302	78,385
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2016	2017	2018	2019

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			27.5	28
Annual Indicator	26.4	30.4	27.5	25.8
Numerator	22,710	27,265	23,681	19,388
Denominator	85,942	89,656	85,967	75,148
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2016	2017	2018	2019

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			Yes	Yes
Annual Indicator			No	No
Numerator				
Denominator				
Data Source			OFHS MCH Program Documentation	OFHS MCH Program Documentation
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	Yes	Yes	Yes

State Performance Measures

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

Measure Status:	Active

State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	42.9	71.4
Numerator	15	25
Denominator	35	35
Data Source	OFHS MCH Program Documentation	OFHS MCH Program Documentation
Data Source Year	2021	2022
Provisional or Final ?	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	48.6	51.4	54.3

State Outcome Measures

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

Measure Status:	Active

State Provided Data

	2018	2019	2020	2021	2022
Annual Objective			1.8	2.1	1.9
Annual Indicator	2.2	2	2.3	2.2	2.2
Numerator	9.6	9.7	10.6	10.7	10.1
Denominator	4.4	4.9	4.7	4.8	4.6
Data Source	VDH Division of Health Statistics	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	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives

	2023	2024	2025
Annual Objective	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

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

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 rate of infants born with Neonatal Abstinence Syndrome (NAS) from 5.9 (2020) to 5.6 (2025) per 1,000 birth hospitalizations

Strategies

Develop, coordinate, and implement an action plan for substance exposed infants based on the 2020 Report to the General Assembly

Develop perinatal cannabis resources at the state level

Continue implementation and analysis of PRAMS supplement on perinatal cannabis use

State Action Plan Table (Virginia) - Perinatal/Infant Health - Entry 4

Priority Need

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

SOM

SOM 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

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Create and implement a system through which data from existing BabyCare programs is synthesized and utilized for data-driven decision making and program strengthening

PERINATAL/INFANT HEALTH DOMAIN SUMMARY/OVERVIEW FY22 ANNUAL REPORT

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 position was vacant from February 2020 through August 2022. The MIH Consultant serves as subject matter expert 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 facilitates the monthly Sister Agency meeting that includes representatives from Department of Medical Assistance Services (DMAS), Department of Behavioral Health and Developmental Services (DBHDS), and Department of Social Services (DSS), MMRT, and VPNC. The MIH Consultant consults with LHDs regarding perinatal health work and provides support where possible. In addition, the MIH Consultant analyzes proposed maternal child health legislation and budget requests and is responsible for resulting requirements upon passage such as work groups or task forces where appropriate. The MIH Consultant builds and sustains a variety of partnerships that serve Title V priorities and seeks out additional funding to expand the MCH work in Virginia.

INJURY 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 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.

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 MCH Epidemiology Coordinator, 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.

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

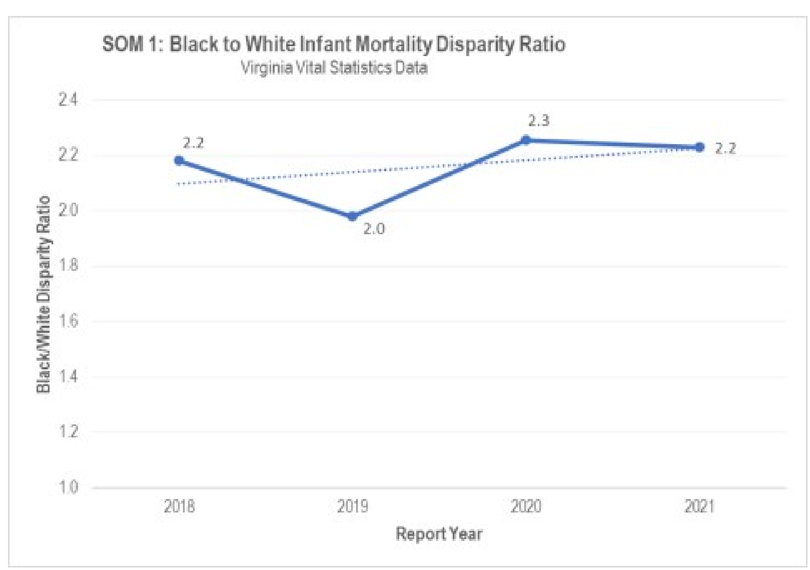
pregnancy-associated deaths in the Commonwealth and the development of recommendations for interventions in order to reduce preventable deaths. Each case is reviewed by the MMRT to determine the community-related, patient-related, healthcare facility-related and/or healthcare provider-related factors 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.

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.

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.

STATE ACTION PLAN UPDATES

Maternal/ Infant Mortality Disparity	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 (SOM 1) from 2.0 to 1.0 by June 30, 2025
OUTCOME MEASURE	SOM 1: Infant Mortality Disparity: Black/White Infant Mortality Ratio



Infant mortality is a hallmark of overall health status of a population, which is why it remains an objective of both Healthy People 2030 and Virginia's Title V. In 2021, 568 infants died before their first birthday in Virginia, making the overall infant mortality rate across all races 5.9 per 1,000 live births. This rate is an increase from 2020; however, since 2012, the overall

infant mortality numbers have remained relatively consistent, with a slight increased trend. Additionally, this rate varies by race and ethnicity. For example, the infant mortality rate among the non-Hispanic white population was 4.6, while the rate among non-Hispanic Black infants was 10.1, 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 infant mortality than their White counterparts. As such, one of Virginia's State Outcome Measures is to decrease the black/white infant mortality disparity ratio to 1.

Strategy 1: Develop and mobilize strong interagency, multisector, and community partnerships to address infant mortality due to preventable injury

The IVPP education package is an initiative advancing statewide delivery of prenatal and postpartum education on 1) general 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, 2) child maltreatment education in partnership with the Virginia Chapter of the Academy of Pediatrics and Virginia Commonwealth University, transportation safety education in partnership with the Virginia Chapter of the Academy of Pediatrics, and school aged injury prevention education, inclusive of concussion management in partnership with George Mason University. Priority populations are the general public of childbearing and childrearing age and caregiving age, students, and service delivery providers.

Due to the demands on health systems, community programs, and families during our statewide COVID-19 response continuing in FY22, the IVPP's general education initiative advanced to Version 2.0, transitioning from in person instruction to virtual for hospitals, libraries, health departments, and other prevention programs. After receiving input from maternity hospitals and health systems during the COVID-19 response, implementation of live in person injury prevention parental classes were not part of outpatient/community nursing education instruction. Version 3.0 is encompassing 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. During the reporting period, IVPP continued to undergo a transition to development of an Injury Prevention Education virtual room visual platform designed for parents as the audience in receiving the intervention, by partnering with a state approved audio/visual vendor. All modules have been created. 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. 100% of Virginia's maternity hospitals were offered the general injury prevention curriculum. In addition, 100% of youth services libraries were offered the curriculum through the LOVA. In future years, VDH IVPP staff will provide intensive technical assistance to have these curriculum sets permanently implemented.

Strategy 2: 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 COVID0-19 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 the implementation of the plan.

There were two significant disruptions to the progress of this plan starting in FY21 – COVID-19 and the vacancy of the Maternal and Infant Health Consultant position, which continued vacant throughout FY21 and FY22. With this critical position filled in August 2022, the MIH Consultant reviewed the plan, examining opportunities for revision, targeted partnerships with LHDs and community stakeholders in parts of the state where there are higher rates of NAS. Additionally, a position for Substance Exposed Infants Program Coordinator is under revision and projected to be posted and hired during FY24.

Strategy 3: Local Health Districts: Develop, mobilize, and participate in strong interagency, multisector, and community partnerships to address disparities in maternal and infant mortality rates

Beginning State FY 23 (July 2022), Virginia's LHDs were transitioned to a new work plan structure more closely aligned with the State Action Plan. Each district was required to select from a list of measurable activities, and then report quarterly to those activities. Thirteen of 35 local health districts prioritized maternal and infant mortality disparity. Local activities will 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. Detailed District reporting will occur in FY23 block grant report.

MCH Data Capacity	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 2.0 (2017) to 1.0 (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, Overdose Data to Action project, and the ERASE MM project. The division is 100% federal funded through grants and cooperative agreements through the Centers and Disease Control and Department of Justice.

Child Fatality Review Team: The CFRT finished its review of adolescent suicides and a report with recommendations is currently being drafted. The current focus on the team is deaths that occurred in daycare facilities throughout the state (n=48). The Infant and Child Fatality data collection tool was revised and implemented into the REDCap system and is currently being revised based on evaluation data and changes in the landscape related to child deaths. This is an unfunded activity, with the focus being on the facilitation of the CFRT. The CFRT also submitted recommendations from the Citizens Review Panel to the Department of Social Services for their 2023 report.

NOM 9.1-Infant mortality rate per 1,000 live births and NOM 9.5 Sudden Unexplained Infant Deaths (SUID) rate per 100,000 live births Other activities included 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.

Additionally under this program, the Family Violence Program strives to conduct epidemiological surveillance. Activities under this activity may include collection of comprehensive data using their-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, as able.

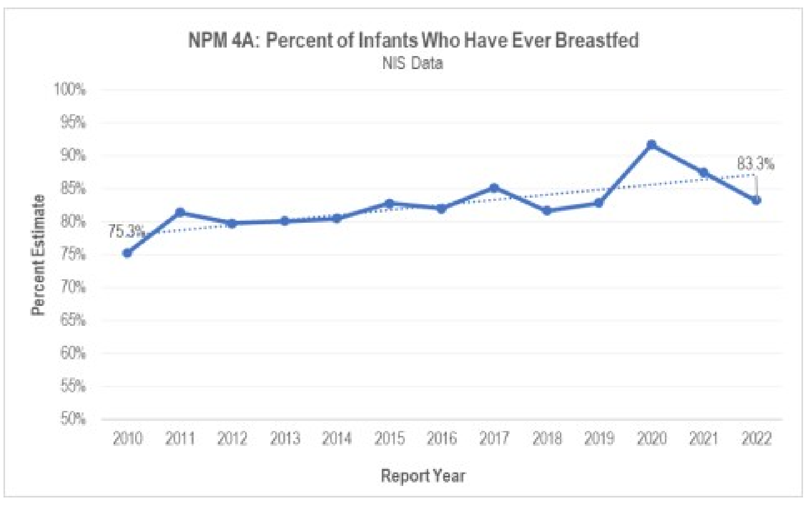
The goal of the CFRT and MMRT is to develop recommendations that are sustainable, attainable, and measurable. They are also vetted thoroughly to ensure that suggested agencies and programs support the recommendation and would work towards implementing all or some of the recommendation(s) in their scope of practice. During this grant cycle, one goal of the CFRT and MMRT will be to align goals, as they are able, with Title V investments and ensure the recommendations address community, environmental, and healthcare setting factors identified in the fatality review of adolescent suicides and 2021 maternal deaths. The Programs Managers will also analyze data to understand the impact of social determinants of health, and work with the CFRT and MMRT to continue to engage (and identify if needed) community partners that will address social determinants of health and work towards health equity.

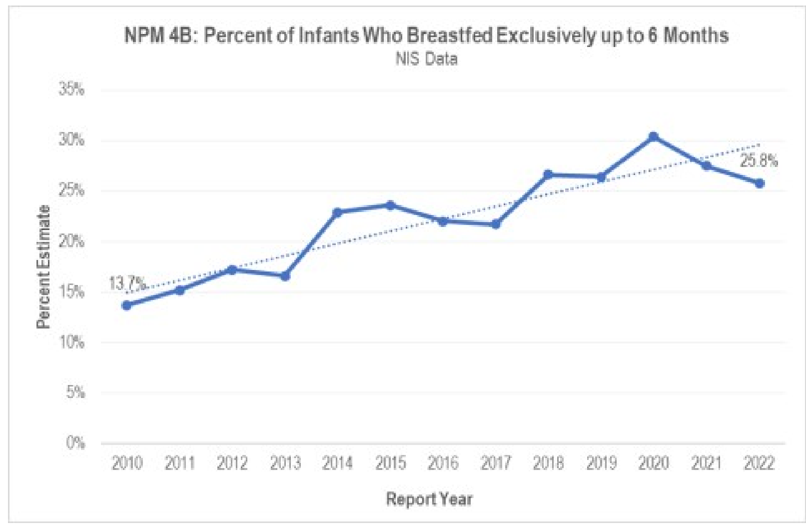
Strategy 2: Create a system through which data from existing BabyCare Programs is synthesized and reported

In Summer 2022, VDH's Title V program sponsored two interns through the National MCH Work Force Development 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.

During Summer 2023, VDH's Title V will host two additional interns through the National MCH Work Force Development Summer Internship program. The interns will be tasked with evaluating the data collection methods of all active BabyCare programs (approximately 10), identifying desired points of programmatic measurements, and create a reporting tool for collection and dissemination of data.

MCH Data Capacity	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: 1. Increase the percentage of infants ever breastfed from 82.9% (NIS2015) to 87.9% 2. Increase the percentage of infants exclusively breastfed through 6 months of age from 26.4% (NIS2016) to 29.6%
OUTCOME MEASURE	NPM4: A) Percentage of infants who are ever breastfed; B) Percentage of infants exclusively breastfed through 6 months of age
Evidence-based or informed strategy measure	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.

Strategy 2: Local Health Districts: Identify the LHD capacity to successfully implement 10 steps to Breastfeeding Friendly Health Department

The Breastfeeding Friendly Health Departments (BFHD) model was created and piloted by the Dakota County (Minnesota) Public Health Department and recognized as a Model Practice Program by the National Association of County and City Health Officials (NACCHO) in 2017. The BFHD Toolkit consists of ten steps that encourage local health departments to utilize evidence-based breastfeeding policies and practices, and can serve as a resource to help local public health departments develop the capacity to promote breastfeeding in communities. Additionally, the model is structured such that participating health departments can be acknowledged for participating and success at the bronze (5 steps), silver (7 steps), or gold (all 10 steps) levels.

In collaboration with VDH's WIC Breastfeeding Coordinator, a survey was designed to assess the current practices within each LHD that are similar to the Ten Steps recommended by the BFHD Toolkit. The survey was distributed to all 35 LHDs in October 2022. The results of the survey will influence the LHD work plans for FY24.

PERINATAL/INFANT HEALTH DOMAIN
FY24 APPLICATION YEAR

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
OUTCOME MEASURE	SOM 1: Infant Mortality Disparity: Black/White Infant Mortality Ratio

Strategy 1: 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. In the midst of Covid-19 gathering restrictions, this initiative underwent a transition to a fully virtual toolkit and this virtual approach will be sustained throughout FY24. Hospitals, local health departments, and prevention programs will have a full compendium of Baby TV materials in FY24, 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 2: Develop, coordinate, and implement an action plan for substance-exposed infants based on the 2020 Report to the General Assembly

The MIH Consultant will continue to revise and update the existing plan of care for substance-exposed infants, identify and cultivate targeted partnerships with LHDs and community stakeholders in parts of the state where there are higher rates of NAS. The position for Substance Exposed Infants Program Coordinator will be filled during FY24, and a will participate in the development and implementation of identified strategies.

Strategy 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 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 and implement a system through which data from existing BabyCare programs is synthesized and utilized for data-driven decision making and program strengthening

BabyCare is Virginia's 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 participating local health districts (LHDs), and in its current form, is not an evidence-based program.

In Summers 2022 and 2023, VDH's Title V program sponsored two sets of interns through the National MCH Work Force Development Summer Internship program. In 2022, the interns conducted an evaluation of Virginia's BabyCare Program, examining 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. A key finding was the need for stronger data collection and reporting.

The 2023 Interns will interview all eight BabyCare programs, reviewing their data collection processes, identify best practices around home visiting metrics, create a reporting tool using RedCap, and participate in training the district staff on its utilization.

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: 1. Increase the percentage of infants ever breastfed from 82.9% (NIS2015) to 87.9% 2. Increase the percentage of infants exclusively breastfed through 6 months of age from 26.4% (NIS2016) to 29.6%
OUTCOME MEASURE	NPM4: A) Percentage of infants who are ever breastfed; B) Percentage of infants exclusively breastfed through 6 months of age

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

LHDs working on selected efforts within this strategy will receive ongoing TA from Title V, WIC Breastfeeding Coordinator, and Maternal Infant Health Consultant regarding implementation of the 10 Steps to Breastfeeding Friendly Health Department.

PRIORITY 4	Mental Health: Promote mental health across MCH Populations, to include reducing suicide and substance use/abuse
OBJECTIVE	By 2025, reduce the rate of infants born with neonatal abstinence syndrome (NAS) from 5.9 (2020) to 5.6 (2025)
PERFORMANCE MEASURE	SPM 6: Promotion and strengthening of optimal mental/behavioral health and well-being through partnerships and programs

Strategy 1: Develop, coordinate, and implement an action plan for substance-exposed infants based on the 2020 Report to the General Assembly

VDH will strengthen and coordinate activity and measurement efforts regarding prevalence of substance exposed infants, including continued engagement and collaboration with VNPC as they pursue their Eliminating Bias in the Dyad Care initiative.

Strategy 2: Develop perinatal cannabis resources at the state level

The Maternal Infant Health Consultant now facilitates the state work group focusing on perinatal cannabis use, which was formerly facilitated by the VNPC and was 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. Continued coordination of this group will include a focus on both policy and education at the state level, as well as supporting healthcare provider education on the topic. FY22 will result in an online presence, likely in the form of a webpage, dedicated to perinatal cannabis education and resources. Title V staff will collaborate with Virginia’s Cannabis Control Authority to produce, share, and market the online resource. The work group will serve as a mechanism for feedback and collaboration in developing the content to be included and includes representation from a variety of providers, staff from

LHDs, and representatives from sister agencies in the state such as social services and behavioral health.

Strategy 3: Continue implementation and analysis of PRAMS supplement on perinatal cannabis use

In October 2021 the PRAMS team at VDH elected to add the cannabis supplemental questionnaire to the state's survey. The team will continue to collect this data, disseminate it to groups we work with on perinatal substance use, and use it to inform work within this field.

LEGISLATIVE MANDATES

Perinatal Hubs Study Group

In the 2023 General Assembly session for Virginia's legislature House Bill 1567 passed, requiring VDH to convene a work group with community partners for the purpose of studying the expansion of perinatal health hubs as a model of care. The work group is tasked with 1) analyzing federal and state regulations and funding mechanisms impacting establishment of perinatal health hubs, 2) reviewing evidence-based strategies for the implementation of these hubs and the community impact of existing hubs, and 3) projecting estimated costs of implementing the work group's recommendations for the next five years. The MIH consultant at VDH is responsible for facilitating this work group and compiling the final report and recommendations, due to the Chairman of the House Committee on Appropriations and the Senate Committee on Finance and Appropriations by December 1, 2023.

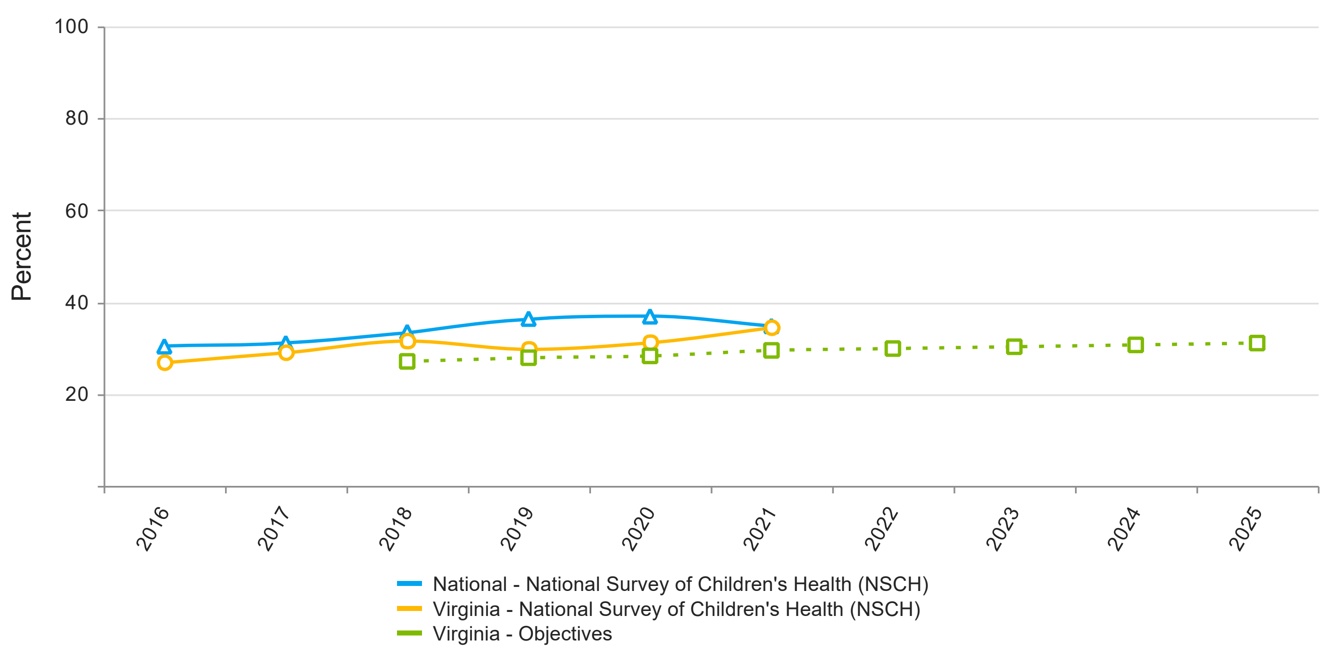
VNPC Study Group

In the 2023 General Assembly session for Virginia's legislature Senate Bill 1531 passed, also requiring a work group. This bill directs the Secretary of Health and Human Resources (SHHR) to convene a work group examining the state's perinatal quality collaborative, The Virginia Neonatal Perinatal Collaborative. SHHR has tasked the MIH Consultant with developing the plan to facilitate this work group, which is responsible for strengthening VNPC's ability to 1) successfully implement patient safety bundles from the Alliance for Innovation on Maternal Health and other maternal and newborn quality improvement initiatives across the state, 2) consider how to maximize private and public funding, 3) distribute grants in an effective and equitable manner, and 4) determine the best placement and structure for the collaborative. Recommendations on how to strengthen VNPC's work and any budgetary or state contractual changes to be considered during the 2024 General Assembly session are due to the Chairmen of the House Committees on Health, Welfare and Institutions and Appropriations and the Senate Committees on Education and Health and Finance and Appropriations by November 1, 2023. The MIH Consultant will compile this final report.

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)					
	2018	2019	2020	2021	2022
Annual Objective	27.1	27.9	28.3	29.5	29.9
Annual Indicator	29.1	31.4	29.9	31.3	34.4
Numerator	59,469	54,036	67,406	73,254	74,637
Denominator	204,083	171,987	225,762	234,340	216,844
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	2024	2025
Annual Objective	30.3	30.7	31.1

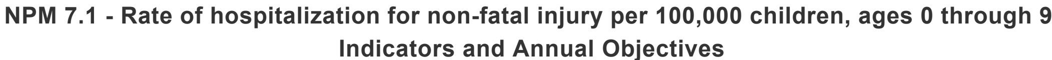
Evidence-Based or –Informed Strategy Measures

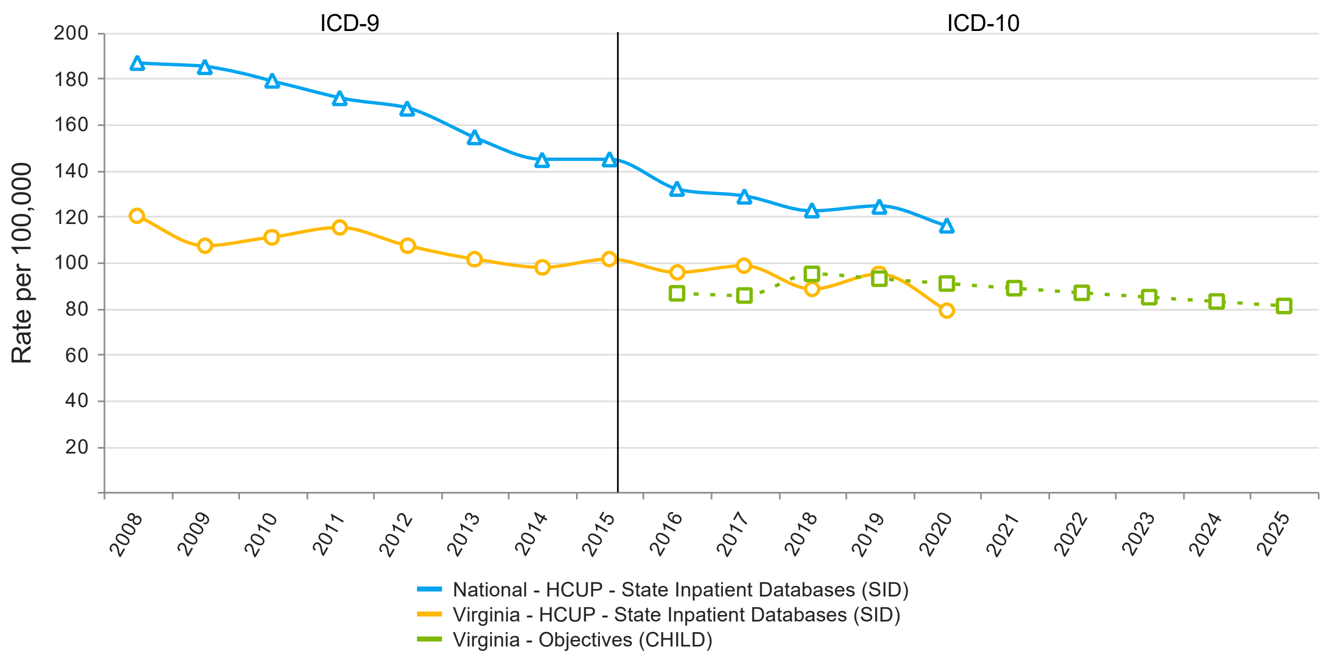
ESM 6.1 - Number of LHDs, community partners, and providers receiving developmental screening resources, training, or TA

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	15	20	25	35	50
Annual Indicator	30	30	30	50	100
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	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	94.9	92.8	90.7	88.7	86.7
Annual Indicator	95.4	98.6	88.4	95.1	79.1
Numerator	982	1,013	906	970	808
Denominator	1,029,557	1,026,897	1,025,381	1,020,363	1,021,604
Data Source	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD
Data Source Year	2016	2017	2018	2019	2020

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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:	**Inactive - Completed**		
State Provided Data			
	2020	**2021**	**2022**
Annual Objective			16
Annual Indicator	14	16	16
Numerator			
Denominator			
Data Source	VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program
Data Source Year	2020	2021	2021
Provisional or Final ?	Final	Final	Final

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

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective		2,549	2,549	2,549	2,549
Annual Indicator	2,596	1,560	1,738	426	104
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	VDH - Injury and Violence Prevention Program
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

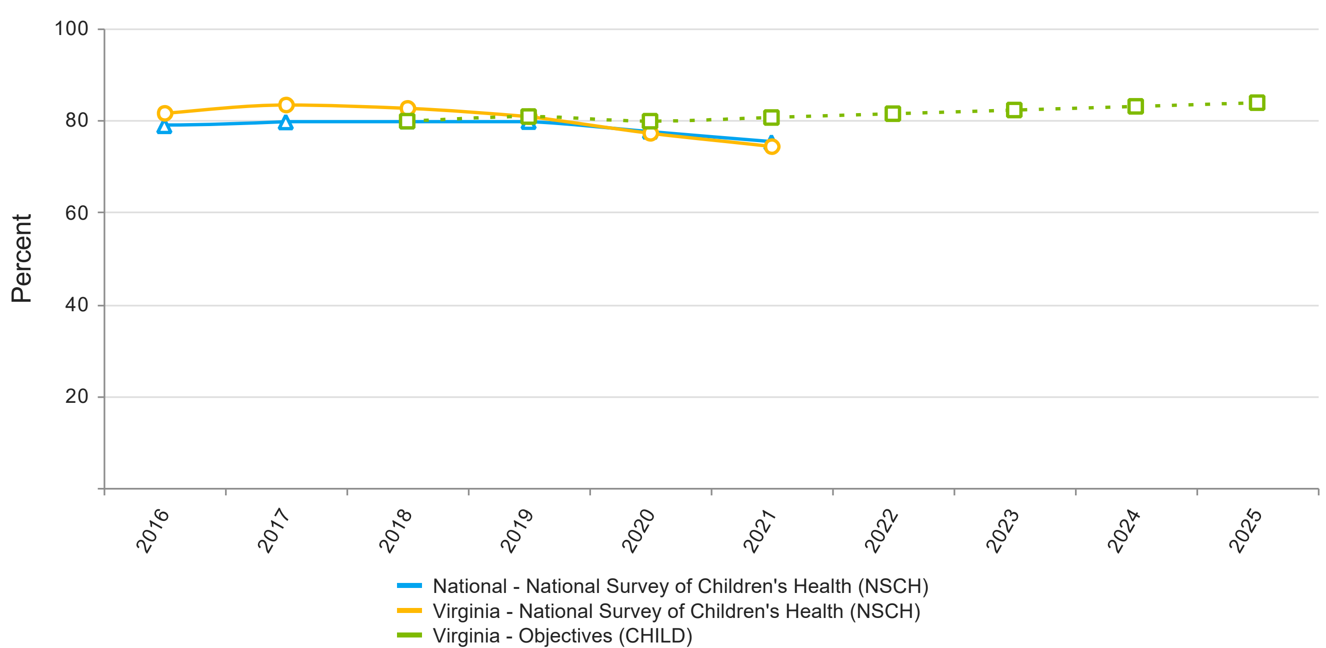
Annual Objectives			
	2023	2024	2025
Annual Objective	2,549.0	2,549.0	2,549.0

ESM 7.1.3 - Percentage of stakeholders that disseminated Virginia's injury prevention curriculum with fidelity

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives		
	2024	2025
Annual Objective	100.0	100.0



NPM 13.2 - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	93.2	94.3	89.1	90	81.3
Annual Indicator	83.1	82.4	80.5	77.1	74.2
Numerator	1,448,110	1,463,318	1,432,504	1,360,700	1,295,174
Denominator	1,741,839	1,775,616	1,778,464	1,763,868	1,744,544
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	79.7	80.7	79.7	80.5	81.3
Annual Indicator	78.4	78.9	77.6	74	80.4
Numerator					
Denominator					
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		6	6	6	6
Annual Indicator	3	4	8	9	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	VDH Oral Health Program documentation
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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	Inactive
ESM 7.1.2 - Number of child safety seats disseminated through the LISSDEP network	Active
ESM 7.1.3 - Percentage of stakeholders that disseminated Virginia's injury prevention curriculum with fidelity	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 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

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

CHILD HEALTH DOMAIN
SUMMARY/OVERVIEW
FY22 ANNUAL REPORT

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.

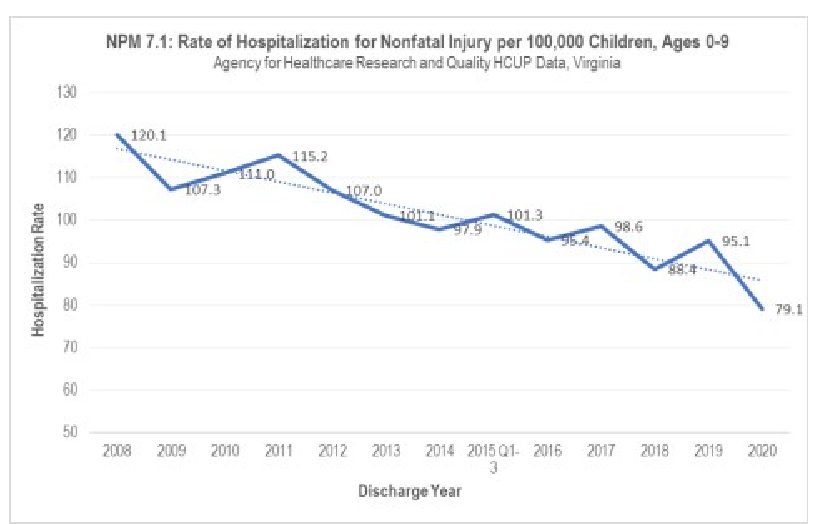
EARLY CHILDHOOD: Effective screening and referral systems improve outcomes for children and strengthen communities. VDH is investing Title V Funds in six Developmental Screening Initiative (DSI) Hubs, each led by a local coordinating partner. DSI Hubs bring together screening and referral stakeholders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

Finances as a Root Cause	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 126 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.

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. 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. high impact and low-income populations). During FY22, 104 seats were distributed to income eligible families (96 convertibles, 8 booster).

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.

EQUITY CENTERING: VDH IVPP addresses health opportunity by applying CDC's Core Principles Model. Activities support: 1) Improving access to services; 2) ensuring culturally appropriate services; 3) supporting healthcare providers to reduce stigma; 4) offering structural support, such as housing referrals and transportation assistance; 5) informing Virginias about risks that lead to injuries and violence in their communities; 6) linking people to care and recover, and lessening harms; and 7) improving access to programs that address other risk factors for injury. IVPP uses data to inform action.

CONSUMER/FAMILY ENGAGEMENT & PARTNERSHIP: VDH IVPP provides an opportunity for family and consumer input into LISSDEP. Staff continue to work with the Division of Population Health Data to construct an exit survey to evaluate programmatic education and technical support efforts.

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

SUCCESS STORY: LISSDEP migrated from required annual, in-person, technical training for site safety seat educators to a three-year certification period. LISSDEP introduced a web-based technical refresher training on TRAIN (VDH's Internal

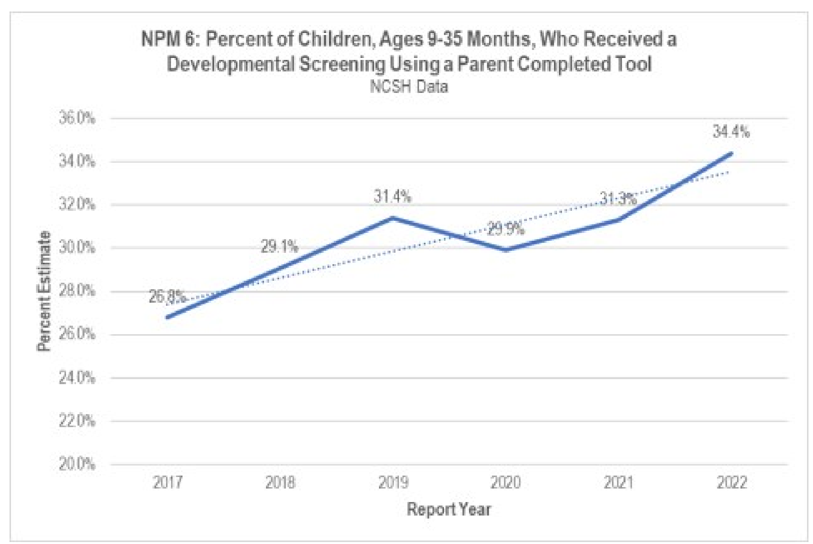
training portal for all VDH staff) for staff to revisit installation techniques during their certification period if desired; this is not a requirement. New staff to the program are required to successfully complete in-person technical training prior to providing education or issuance to seat recipients. LISSDEP is in the process of piloting hybrid training through REDCap for eligible seat recipients, to streamline processing and seat issuance for clientele and distribution site staff. Removing barriers, inclusive of lost work/school time and travel cost, will allow more families to access free safety seats and education in correct use and installation, thereby helping to reduce motor vehicle injuries.

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

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.

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), 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.

Strong Systems of Care	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

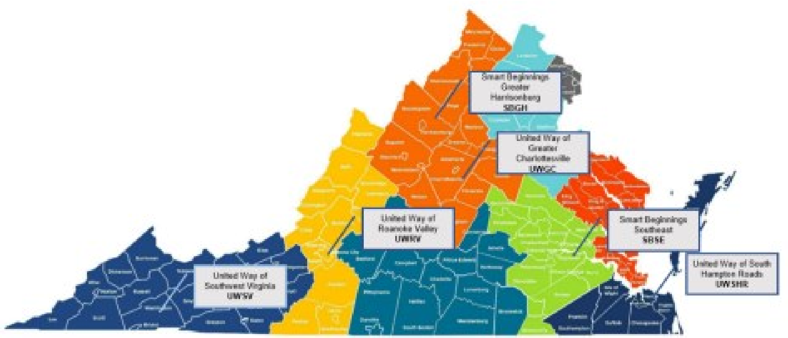


Strategy 1: Support the development of high functioning community/regional partnerships led by 6 Ready Region 'Hubs' that coordinate and improve local developmental screening and referral systems improvements

Virginia's Title V grant at VDH has a comprehensive strategic plan, based on Title V needs assessment results. Virginia's plan addresses priority needs, including improving developmental screening systems. Through this effort, the VDH is partnering with the Virginia Early Childhood Foundation (VECF) to pilot system improvements in six Ready Region Coalition hubs to improve early identification, family engagement, and developmental screening. In partnership with the VDH, Title V, VECF is supporting Ready Region partners in six communities across the Commonwealth to spearhead better understanding and ultimately better developmental screening and community partnerships. Important findings from the pilot sites may contribute to the current proposed implementation through Zero to Three. These include:

1. Continued identification and explication of community referral pathways and follow-up procedures; DSI hub progress working with partners to establish agreed-on systems of tracking, documenting, and analyzing/improving referrals pathways will provide a blueprint for effective screening and referral networks (Centralized System);
2. Ongoing emphasis on training and technical assistance that equips screening partners to use the Enterprise and Family Access systems with proficiency across a variety of early childhood settings, with an eye toward optimum timing and cycling of such training and assistance to align with anticipated staff turnover and bandwidth. Support for engaging pediatricians to be part of a larger screening initiative – DSI Hubs continue to report extreme difficulty in reaching pediatric practices, despite repeated outreach (Qualified Workforce, Centralized System);
3. Ongoing strategy development for increasing the use of digital screening tools by parents, recognizing the need to provide TA support and training for families to understand developmental screening, how to use the tools and talk with their primary care doctor when their child is screened (Family Participation). This is consistently supported over the past 5 years in the Children's National Survey for parent report for developmental screening (2018-2022);
4. Ongoing expansion and strengthening of partnerships to build collaborative systems within communities (Community Partnerships);
5. Provide family childcare programs with training in the ASQ tool and developmental milestones to support increasing the number of children screened and raising awareness about child development (Qualified Workforce).

PARTNERSHIPS: The six DSI Hubs in this report are identified as follows:



United Way of South Hampton Roads (UWSHR)
United Way of Greater Charlottesville (UWGC)
Smart Beginnings Greater Harrisonburg (SBGH)
United Way of Southwest Virginia (UWSWVA)
United Way of Roanoke Valley (UWRV)
Smart Beginnings Southeast (SBSE)

One hundred forty-one active partners were identified in FY23 Quarter 1, out of one hundred eighty-five total partners. This represents a significant drop from the FY22 Q4 report of 184 partners, as previous quarterly reports did not discern between active and paused or ended partnerships. This report corrects that omission. The most significant drop in partners actively participating in the DSI project was in Early Childhood Care or Education Providers. The breakdown of active partners provided by DSI Hub leaders is as follows: 2 Care Connection for Children; 0 Childcare Resource and Referral Regional Office; 0 Child Development Center; 20 Community Nonprofits; 58 Early Childhood Care or Education Providers (ECCE); 3 Early Intervention; 0 Family/Community Representative; 10 Head Start/Early Head Start; 2 Health Departments; 8 Home Visiting Programs, 1 Hospitals; 2 Infant and Toddler Specialist; 7 Local Department of Social Services; 3 Mental Health/Behavioral Health Providers; 4 Pediatricians/Pediatric Clinics; 1 Private therapy (OT, PT, speech, etc.) provider; 10 Virginia Preschool Initiative; 3 Virginia Quality; 7 Other.

As of this quarter, DSI Hubs report 40 MOUs (Memorandums of Understanding) in place with their active regional partners, with 30 pending, and 1 not indicated. Of the active partners, ninety-two (92) partners are administering screens, with an additional 21 planning to in the future. Data sharing agreements are in place with 31 partners, with 28 pending.
Of the 2,063 documented screens in FY23 Q1, 1,251 were in the healthy range, 656 were in the monitoring zone, and 156 were flagged for referral. Of those flagged for referral, DSI Hubs reported 141 were referred for services. This indicates a referral rate of 90% across all DSI Hubs, though individual rates of referral vary, and it is difficult to ensure accuracy of duplicated screens for individual children. For example, one site, UWRV, which reported the highest number of documented screens in the previous quarter, was unable to collect screening data from the two large pediatric practices that have recently joined their hub in time for this report. They would like to amend their numbers for this report when that data is available. Of note, while UWRV reported the highest number of total screens (3,644) in FY22 Q4, it reported the lowest numbers in the Monitoring Zone (4) and Referral Zone (2), and only 2 actual referrals: deeper investigation revealed this was a direct result of the two pediatric practices sharing screening totals, but not screening scores, with the UWRV DSI Hub. Thus, it is not possible to infer how many referrals resulted from the documented screens.

Highlights: The importance of nurturing relationships with community partners, even when there may not be an immediate return, continues to be a major theme across the hubs. SBGH reports that collaborating with Virginia Public Media, which has significant outreach capacity, is proving fruitful as they continue efforts to establish trust with hard-to-reach families who might not be participating in ECCE settings and/or may have language barriers. Across most DSI Ready Region Hubs, in-person outreach and/or technical assistance provision to community partners is beginning to occur, though the COVID-19 Pandemic continues to influence activities.

The number of screens documented by SBGH in FY23 Q1 increased 38% over FY22 Q1, which the DSI Hub leader attributes to relationship building and increased messaging efforts with local partners. Hub navigators have been able to interact with providers directly as classroom observers, which has allowed them to start conversations about using the ASQ

screening tool. Hub sites have also been engaging ECCE providers on an individual basis as part of its outreach strategy and reports an increase in the use of the ASQ tool due to provision of individualized technical assistance. The use of in-person site visits to check in with ECCE site administrators and provide technical assistance has helped with increasing screening.

The DSI Hub Leaders express the desire for continued guidance with messaging in their quarterly reports, in communications with the DSI Project Coordinator, and in peer learning sessions. The recommendation is continued exploration of strategies for increasing public awareness about developmental milestones and screening in FY23 through greater utilization of the LTSAE materials, which provide a comprehensive approach to messaging. Exploration of approaches taken by other states that have resulted in increased parental uptake of the ASQ screening tool is also recommended. In addition, we want to understand the differences more clearly between how DSI Hubs are messaging providers, and their messaging to parents to encourage the use of the ASQ screening tool in FY23.

During the last quarter of FY22, the project coordinator at VECF implemented “DSI Open Office Hours,” a non-mandatory, once-a-month peer learning session taking place on the third Thursday of the month, where DSI Hub Leaders and Navigators can informally share their current challenges and learning edges. For FY23, these successful learning sessions will continue, bringing in subject matter experts and/or representatives from VDH to help inform these discussions.

EQUITY CENTERING: The ECCS Advisory Council , subrecipient (Virginia Early Childhood Foundation (VECF), and Program Director, spent considerable time exploring the concept of equity. Equity, for the purposes of the Virginia developmental screening plan, is defined as: Individuals have access to the resources and services they need. Equity is addressed in several ways. It is first introduced through the definition section preceding the developmental screening plan. This intentionally grounds the reader and is meant to lay the groupwork for what means by the term. Secondly, it is threated throughout the goals and activities and remains a key value. The hub teams are committed to advance equity through its work and to ensure co-ownership and joint action. The purpose is to ensure that individuals have access to the resources and services they need.

FAMILY ENGAGEMENT/PARTNERSHIP: The importance of nurturing relationships with community partners, even when there may not be an immediate return, continues to be a major theme across the hubs. SBGH reports that collaborating with Virginia Public Media, which has significant outreach capacity, is proving fruitful as they continue efforts to establish trust with
hard-to-reach families who might not be participating in ECCE settings and/or may have language barriers. Across most DSI Hubs, in-person outreach and/or technical assistance provision to community partners is beginning to occur, though the COVID-19 Pandemic continues to influence activities.

CHALLENGES/BARRIERS:

- Support for engaging pediatricians to be part of a larger screening initiative - OSI Hubs continue to report extreme difficulty in reaching pediatric practices, despite repeated outreach.
- Ongoing strategy development for messaging outreach, particularly to historically excluded and/or hard to reach populations, and adapting to reduced opportunities for in-person contact with parents due to COVID-19 to aim toward consistent, effective messaging that build awareness about child development and the value of screening (Effective Messaging)
- Ongoing strategy development for increasing the use of the digital screening tool by parents, particularly given closure and/or reduced capacity of key screening facilities due to COVID-19 (Family Participation)
- A conflict emerged this quarter between some ECCE screening partners' capacity to conduct ASQ screening, and their adoption of the Virginia Kindergarten Readiness Program (VKRP) assessments, which are encouraged but not required in Mixed Delivery Grant programs for three- and four-year-olds in the fall and spring of FY23. This has resulted in several ECCE screening partners declining to continue to participate in the OSI project. Staff shortages combined with high staff turnover continue to affect the attempt to embed ASQ screening and referral within ECCE

settings, with most Hubs reporting a ripple effect of the pandemic on ECCE screening and referral system capacity. Further, the significant attrition of ECCE providers (a decline of twenty over the course of the project) and Head Start/Early Head Start (a decline of three), as well as lack of response to OSI Hub outreach to potential and/or prior partners speaks to the combined burden of low capacity, staff shortages and turnover, and multiple priorities in the Early Childhood Care and Education Sector generally. UWSWVA and UWRV were hit hard by this trifecta, losing 14 ECCE screening partners and 3 Head Start programs. UWSWVA and UWRV also report difficulties in engaging pediatric partners. Finally, UWSWVA's coordination of screening with Mount Rogers Health District has been slowed by the Health District's requirement of high-level approval before sharing screening counts with the OSI Hub.

SUCCESS STORIES:

"Progress continues to be made between OSI Hub and Early Intervention (EI) partners as well as acting as a liaison between EI and childcare partners. Due to the success of the virtual and in-person meet and greets between EI and childcare partners, the Hub will continue to offer these on an ongoing basis with options to meet at least twice a year."
UWSWVA

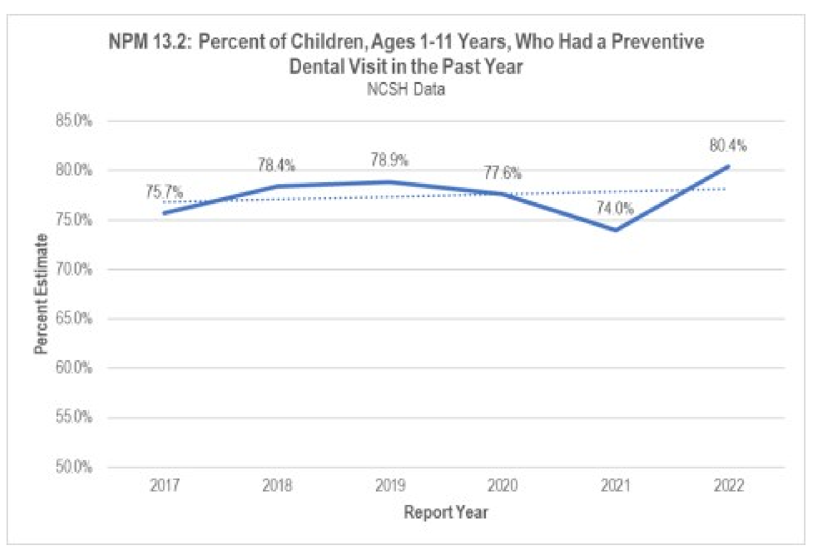
"We have been able to access and engage more childcare providers as we are CLASS observers. This has opened the door for conversations where directors ask questions and express concerns about children in their center with potential developmental delays. We have been able to offer this tool as a way to assess all of their children and to start the conversation with parents ."
SBSE

"An expansion of my position with Harrisonburg City Public Schools, will bring me into more direct contact with VPI (Virginia Preschool Initiative) community childcare partners, thus providing a broader opportunity for building relationships with the providers serving some of our neediest families. I'm also working with ITSN to build relationships with more providers in the Winchester area, which has a broad base of at-risk families struggling to access resources. In collaboration with the Early Education team at VPM (Virginia Public Media), we continue to work to reach employee families at Cargill and other at-risk sites, such as AVA Care."
SBGH

"Site visits were done to all sites that are screening in the online portal by the OSI manager to check in with the childcare site administration and see if any assistance was needed with ASQ assessments and to introduce herself to new Site Administrators in some of the facilities."
UWSHR

"Staff did outreach at the local Latina Health Initiative. Brochures, posters and electronic docs provided to Albemarle County Dept of Social Services for distribution to pregnant women and families with young children in their benefit programs (SNAP, childcare, TANF)."
UWCG

Oral Health	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: 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

The regional alliances continue to adapt to meet the needs of the regions they represent and the goals they serve. Members of all six regional alliances (Northern Virginia, Hampton Roads, Central, Southside, Roanoke, and SWVa) alliances are focused predominantly on ensuring Medicaid members are utilizing the new adult dental benefit that is available for them. To that end, they share Catalyst-created and regionally-specific resources with community-based service providers to share information about what services are covered and how to find a dentist that treats patients. Based on feedback from our alliance members, these resources have been translated into over ten languages to ensure a wide reach. To date, 177,000 Virginia adults and 7,000 pregnant members (these are two separate categories) have accessed services. Alliance members also continually share information with the state's Medicaid program to offer feedback about challenges members are experiencing accessing care. One of the biggest challenges is a limited provider pool. To address this, the Medicaid

agency has partnered with the Virginia Dental Association to create a recruitment campaign to draw new dentists to the Medicaid program. To date, nearly 100 new providers have enrolled. Alliance members identified the need for high-touch outreach for pregnant members. As such, Catalyst awarded a microgrant to Birth in Color to provide oral health education to the organization's doulas and pregnant participants. To date, 120 doulas have received oral health training (and indicated a commitment to include oral health education in patient engagement), and 250 pregnant clients received education and oral hygiene supplies. Members of regional alliances and the 127 members of the early dental home workgroup also share oral health information to their networks to aid pregnant and family members in accessing oral health services.

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

All of Catalyst's strategies within the MCH program are designed to influence changes to the system that promote more equitable and easier access to oral health services for pregnant people and children and safe, trusted, fluoridated drinking water. Catalyst's Future of Public Oral Health (FPOH) workgroup was a collaborative project that implemented work plans to increase dental visits among pregnant people and children by focusing on technology and innovative, replicable quality improvement projects with safety net clinics. Our school-based oral health programs continued to bring together various partners who were previously unconnected to help school age children get direct access to necessary oral health care. For example, conversations spurred by Catalyst opened the door to continued collaborations that can provide medical care and vaccinations to the 6,000-plus children in the Harrisonburg school district and help replicate these partnership models across the state.

Many activities occurred during the reporting period as outlined in the monthly reports. In summary, these activities included conducting community outreach events to increase awareness of program services, training staff and stakeholders on evidence-based practices, working with clinics to implement telehealth services to improve access to care, and collaborating with community partners to enhance service delivery.

All activities were designed to influence performance measures to increase dental visits among pregnant people and children and collaborative projects. Across the board, we positively influenced those measures through MCH-focused dental education programs, regional activities, and several active workgroups like FPOH, Water Equity Taskforce (WET) and the Early Dental Home (EDH) workgroup.

Our partners across grassroots projects, alliances, and workgroups continued to identify barriers to accessing oral health care including myriad COVID-related repercussions so that we could implement work plans to address access issues at the community-level. Our strategies to provide MCH-related education, foster regional programs, and convene statewide partners were all met through various activities like fluoride varnish and special needs dentistry trainings, completion of the 2022 Oral Health Report Card and Teledentistry Toolkit, and successful convenings for the FPOH, WET, and EDH workgroups.

In addition to the 2022 Oral Health Report Card and Teledentistry Toolkit, the program has produced various deliverables, including reports on program progress and service utilization, stakeholder meeting summaries, and additional training materials for staff and stakeholders. The program also provided technical assistance to partners and stakeholders, including training on evidence-based practices and implementation support for telehealth services. Additionally, Catalyst held the 11th Annual Summit, which brought health equity to the forefront and provided a forum for education and networking to hundreds of stakeholders.

The program has had several successes and impacts. For example, the program has increased community awareness of program services through high-touch technical support to increase care coordination, resulting in increased service utilization among community partners. The program has also trained staff and stakeholders on evidence-based practices, which has led to improved service quality and outcomes for program participants. Notably, Catalyst increased workgroup membership, adding new perspectives that have enhanced the work plans' abilities to address topics like telehealth, health

equity, and school-based oral health care. For example, a new FPOH technology workgroup member created a teledentistry workflow to share with school nurses so they can use teledentistry in their programs. Additionally, 90% of participants at Catalyst's Annual Summit participants reported that the sessions were informative for their work; session topics covered the future of equitable public oral health care, improving care for Virginia's LGBTQ community, leveraging social determinants of health, the history of racism in healthcare, and creating equitable policies in Virginia.

CHILD HEALTH DOMAIN
FY24 APPLICATION YEAR

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 FY24 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 2023-September 2024	IVP Supervisor; Transportation Safety Coord; 3 Non-MCH funded positions; Contractor company

Strategy 2: Partner with IVPP to focus on the intersection between child health and transportation

In FY24, 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	October 2023-September 2024	Transportation Safety Coord
Implement one pedestrian and bicycling safety activity plan	October 2023-September 2024	Transportation Safety Coord

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

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

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 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%
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

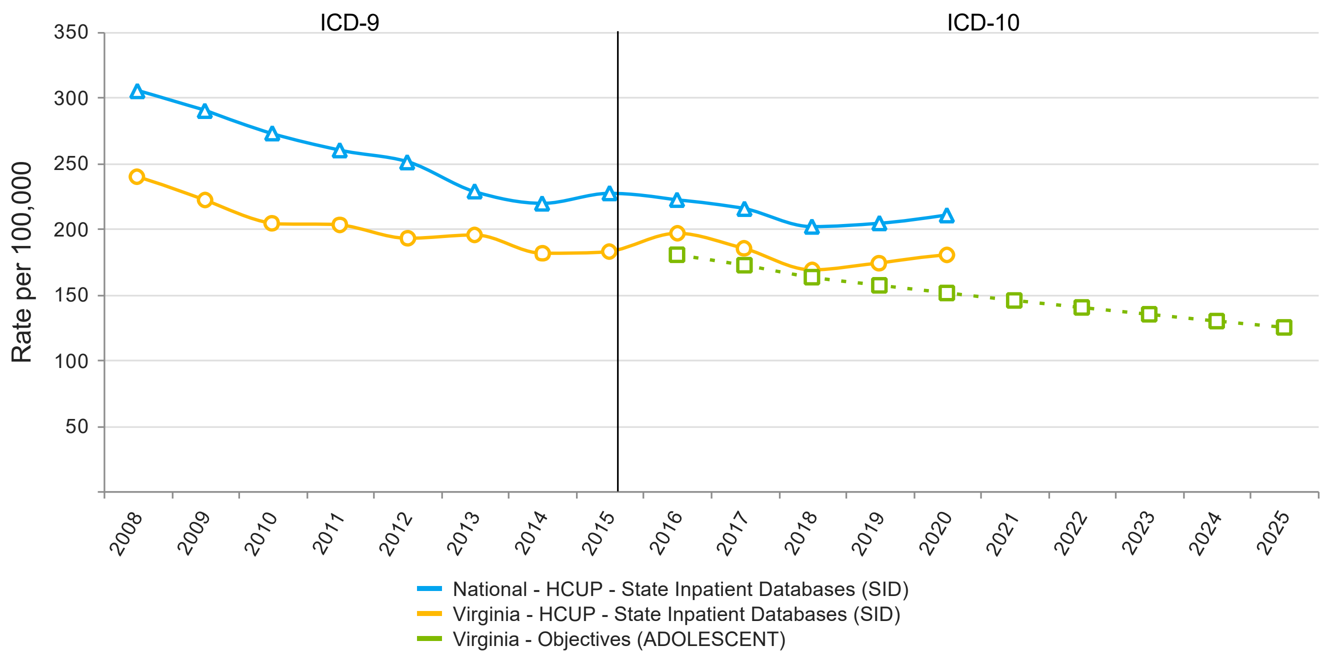
Strategy 2: Sustain network of regional Oral Health Alliances to foster regional efforts and initiatives throughout the Commonwealth and distribute mini-grants for implementation of systems change and data-sharing initiatives to improve the oral health of all Virginians, with emphasis on pregnant women, 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)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	162.9	156.8	151	145.3	139.9
Annual Indicator	196.3	184.5	168.1	173.7	180.2
Numerator	2,087	1,964	1,800	1,854	1,927
Denominator	1,062,972	1,064,407	1,070,646	1,067,063	1,069,640
Data Source	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2016	2017	2018	2019	2020

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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

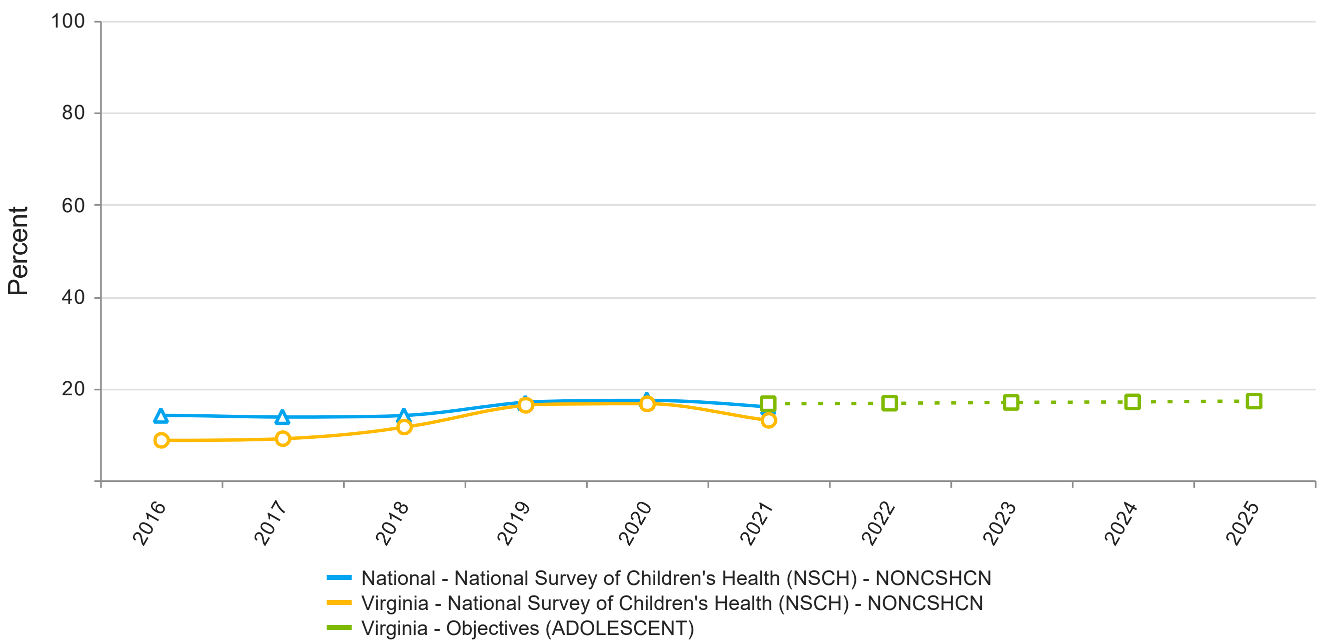
State Provided Data

	2018	2019	2020	2021	2022
Annual Objective		10	20	250	300
Annual Indicator	102	195	237	501	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	VDH - Injury and Violence Prevention Program
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives

	2023	2024	2025
Annual Objective	350.0	400.0	450.0

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**	**2022**
Annual Objective			16.7	16.8
Annual Indicator	11.6	16.5	16.6	13.0
Numerator	56,684	71,210	75,517	64,432
Denominator	489,697	431,868	455,838	493,986
Data Source	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-NONCSHCN
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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

	2018	2019	2020	2021	2022
Annual Objective	100	250	400	40	45
Annual Indicator	0	0	45	49	11
Numerator					
Denominator					
Data Source	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives

	2023	2024	2025
Annual Objective	50.0	55.0	60.0

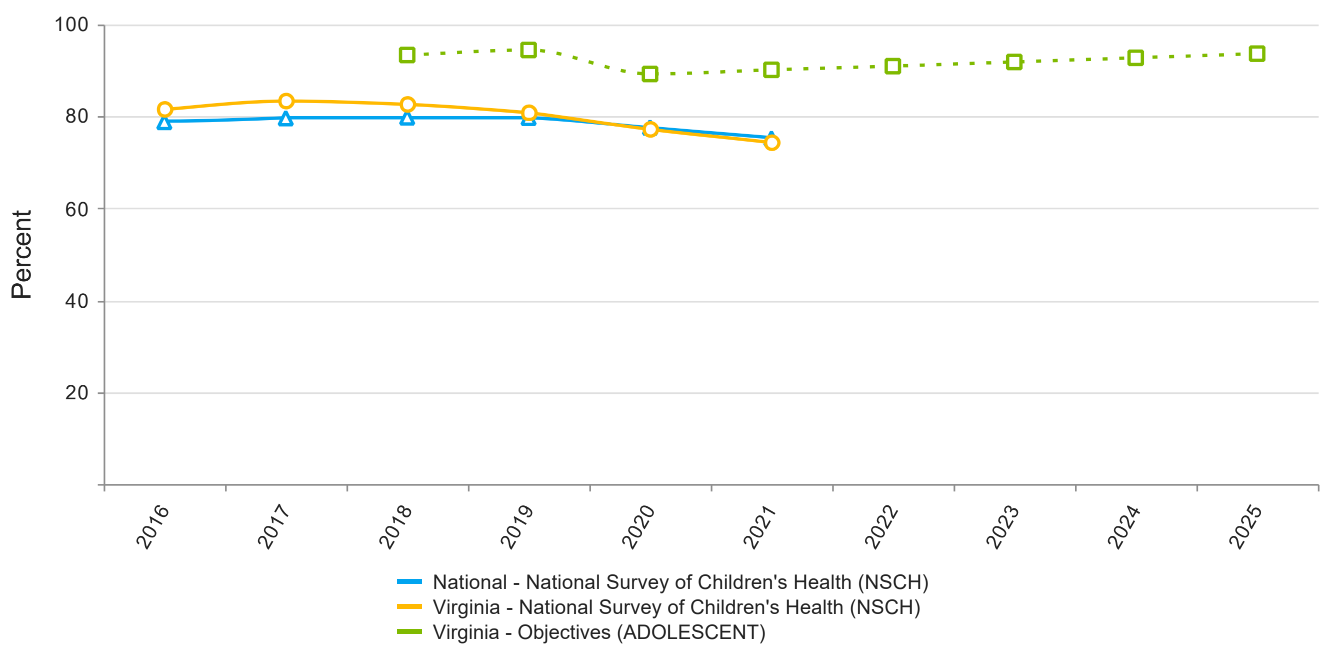
ESM 12.2 - Percentage of Virginia school divisions reporting into the VDOE school health data system

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			75	77
Annual Indicator		68.2	68.2	42
Numerator		90	90	55
Denominator		132	132	131
Data Source		VDH and VDOE School Health Nurse Documentation	VDH and VDOE School Health Nurse Documentation	VDH and VDOE School Health Nurse Documentation
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	79.0	81.0	100.0

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



NPM 13.2 - Adolescent Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	93.2	94.3	89.1	90	90.8
Annual Indicator	83.1	82.4	80.5	77.1	74.2
Numerator	1,448,110	1,463,318	1,432,504	1,360,700	1,295,174
Denominator	1,741,839	1,775,616	1,778,464	1,763,868	1,744,544
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	93.2	94.3	89.1	90	90.8
Annual Indicator	90.5	88.2	86.6	83.4	81.8
Numerator					
Denominator					
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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					
	2018	2019	2020	2021	2022
Annual Objective		6	6	6	6
Annual Indicator	3	4	8	9	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	VDH Oral Health Program documentation
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			23.8	23.3
Annual Indicator	25.3	27.1	25.1	19.8
Numerator				
Denominator				
Data Source	VA PRAMS	VA PRAMS	VA PRAMS	VA PRAMS
Data Source Year	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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

State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	42.9	71.4
Numerator	15	25
Denominator	35	35
Data Source	OFHS MCH Program Documentation	OFHS MCH Program Documentation
Data Source Year	2021	2022
Provisional or Final ?	Final	Final

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

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

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

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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

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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 FY22 ANNUAL REPORT

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
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 (SHNC) 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.

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.

STATE ACTION PLAN UPDATES	
Reproductive Justice and Support	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%
PERFORMANCE MEASURE	SPM 4 – Pregnancy Intention: Mistimed or Unwanted pregnancy (wanted to become pregnant later or never)

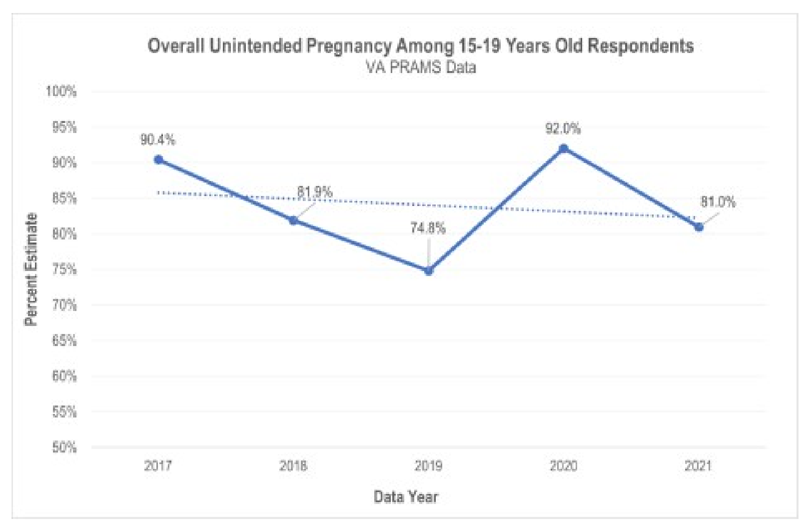
Adolescence and young adulthood are considered "critical periods" in the Life Course, and struggle with a wide range of health care needs related to social, economic, and environmental factors. Adolescents suffer from worsened health outcomes, particularly if they are of lower socioeconomic status, a 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.

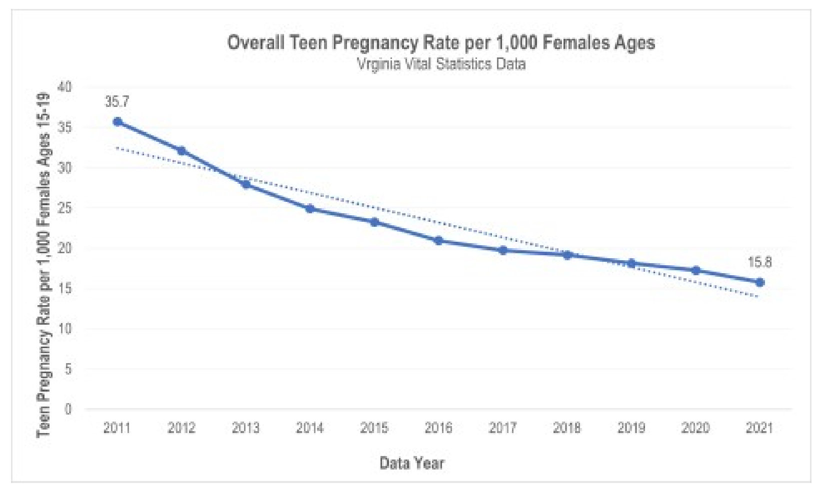
In Virginia, the 2021 adolescent pregnancy rate (aged 15-19) was 15.8 per 1,000 births (Virginia Vital Statistics System). According to PRAMS, births among adolescents 15-19 are largely unintended; however, the trend in unintendeness among this age group is on a decline. Although maternal deaths are rare among this age group, when compared with births among women aged 20 and over, infants of adolescents have a higher prevalence of preterm birth, low birthweight, and maternal complications, as well as higher rates of mortality.

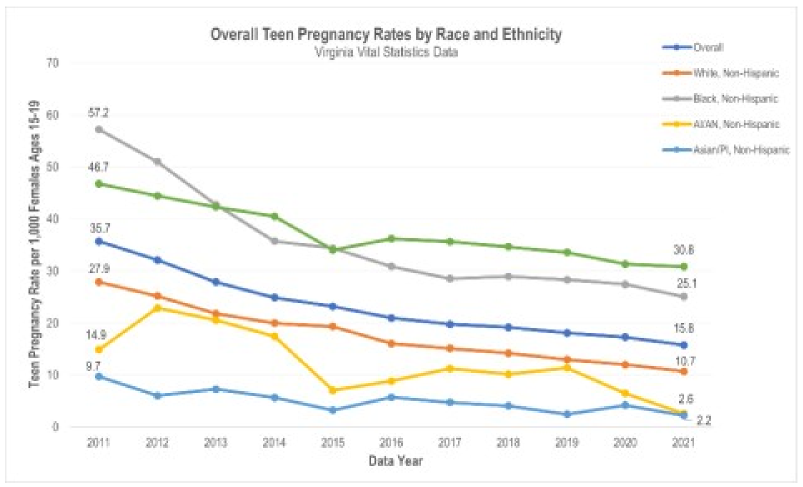
Five-year Virginia pregnancy-associated mortality rates for adolescents (age <20)			
	White	**Black**	**Other**
2017-2021	**3**	**4**	**1**

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. Nationally, in 2017–2018, infants of teenagers aged 15–19 had the highest rate of mortality (8.8 deaths per 1,000 live births) compared with infants of women aged 20 and over (NCHS Data Brief). Mortality rates were highest for infants of non-Hispanic black teenagers (12.5 per 1,000 live births) compared with infants of non-Hispanic white (8.4 per 1,000 live births) and Hispanic (6.5 per 1,000 live births) teenagers. The mortality rate of infants born to non-Hispanic black teenagers related to preterm birth and low birthweight (284.3 deaths per 100,000 live births) was more than double the rate of infants born to non-Hispanic white teenagers (119.2) and three times the rate of infants born to Hispanic teenagers (94.4).

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.

This program has been rigorously evaluated and is implemented in communities around Virginia. In the reporting period, sites served 620 students collectively. In the last fiscal year, the Virginia League for Planned Parenthood expected to serve 300 students with Get Real programs. Educators saw 295 middle school students and 69 high school students for a total of 364 youth served. Planned Parenthood of the Southeast Atlantic serves students in various locations across Virginia. The Roanoke and New River Valley programs of PPSAT sought to reach 50 students through Teen Connections this fiscal year. In total, educators taught 154 students. Eastern Virginia Medical School employed a strategy of training teachers to broaden reach has the goal of program sustainability. Last year, educators saw 86 students in their own programs. EVMS also began process of NPS School Board and Community review in fall 2022. In aggregate, VDH expects to serve 1,110 young people through comprehensive sex education in FY23. VDH also receives federal Sexual Risk Avoidance Education (SRAE) funds to support positive youth development programs at five program sites located primarily in southwest Virginia. SRAE funds support two evidence-based curricula: Project AIM and Teen Outreach Program (TOP). The objectives of positive youth development programs are The SRAE programs served approximately 1,179 youth during this reporting period.

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

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 AIM 4 Teen Moms (AIM4TM).

Funded through federal TANF funds allocated by the Virginia General Assembly, Resource Mothers is offered at seven local implementation sites, including five local health districts, one hospital system, and one community-based organization. Title V funds are utilized to support trainings, and in October 2022, 5 participants were trained in Growing Great Kids, and 5 were trained in AIM 4 Teen Moms.

The Growing Great Kids program had 1,685 encounters in FY22, and there were 88 AIM4TM encounters for FY22.

EQUITY CENTERING: Adolescence is a time of significant physical, social, and psychological development. For youth of color, these experiences can be compounded by racism and its impact. A history of school segregation has led to many communities of color being under-resourced, for example. Health equity is essential to our comprehensive sex education programs. While rates of teen pregnancy continue to decline, disparities persist. To begin to address this, we focus attention on those most impacted by inequitable systems. Grantees provide programming in a variety of settings, including with youth in out of home care like foster care, or juvenile detention centers - both of which disproportionately impact youth of color. One of our grantees has made specific efforts to "bring programming where the people are" and established partnerships with local affordable housing authorities. This greatly increased access to positive youth development opportunities. Finally, all of our grantees have sought out professional development opportunities around diversity, equity, and inclusion. Experiences in adolescence greatly impact development and health outcomes later in life. The Adolescent Health Program focuses attention on those most impacted by inequitable systems. Our program sites have partnered with youth in out of home care such as foster care or juvenile detention centers. While sometimes consisting of smaller groups, program staff report great engagement in these settings. EVMS has made efforts to reach more African American youth in both the Middle School and High School programs by working with schools and community partners serving low-income African American communities. This group realized they must bring programming to where the people are, and established partnerships with a local affordable housing authority. They also report that based on data from previous years, they expect to enroll a significant number of youth who do not consider themselves heterosexual or who report they are unsure or prefer not to answer regarding sexual orientation."

Additional highlights from the work of our program sites include:
• Translating parent information program Teen Speak for Muslim parents in the Central Shenandoah area.
• EVMS open calls - innovative way of engaging public, VDH staffed able to serve on steering committee
• Successful Get Real Summer Program at Central VA Juvenile Detention Center

CONSUMER/FAMILY ENGAGEMENT: The Adolescent Health Program continues to seek ways of supporting program sites. This year, the Program Evaluator began creating quarterly reports for program sites. This has helped track fidelity and ensured program sites are on target to reach program goals. Community engagement is a crucial component of program implementation. Without buy-in from community members, the program cannot be successfully implemented in a sustainable way. One of our grantees found very creative ways to engage with the community outside of formal programming. Eastern Virginia Medical School began several initiatives to increase community engagement. One initiative involved soliciting contributions from community members for an Open Call contest. They chose the theme of healthy relationships, and participants earned prizes for their creative submissions. EVMS also utilized "Design-A-Thons," and Training Bootcamps, all of which invite teens to participate in a meaningful way. This action brought awareness to the community, educating about some of the issues comprehensive sex education programs cover. The Norfolk Public School Board voted to approve the Get Real curriculum in partnership with EVMS, largely thanks to their commitment to community.

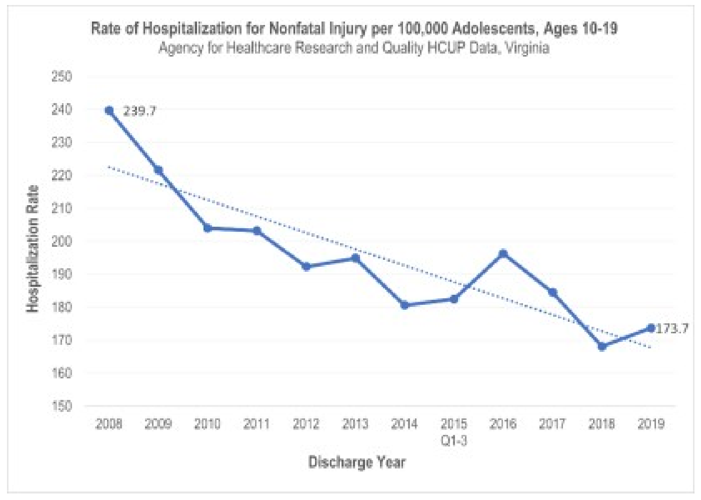
EMERGING ISSUES: Political pushback has emerged an especially stringent barrier to programming in recent months. As program sites seek to expand services, some publications have focused on the controversial aspects of programming. Program sites have done excellent work engaging in these conversations head on, and have provided their communities with information and transparency along the way.

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

In collaboration with the Adolescent Health Coordinator, during Fall 2022, a survey was designed to serve as an environmental scan of each LDH, assessing the community, public and private partners that provide outreach, education, and appropriate reproductive health services to adolescents. The survey was distributed to all 35 LHDs in January 2023. The results of the survey will influence the LHD work plans for FY24, and anticipated action includes the formation of a

workgroup led by the Adolescent Health Coordinator and interested LHDs to improve access to services as well as increase quality of interactions – ensuring positive medical care experiences after making the appointment. Other goals of this project are to help build skills in communicating with young people, and increasing youth voice in decision making.

Mental Health	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.

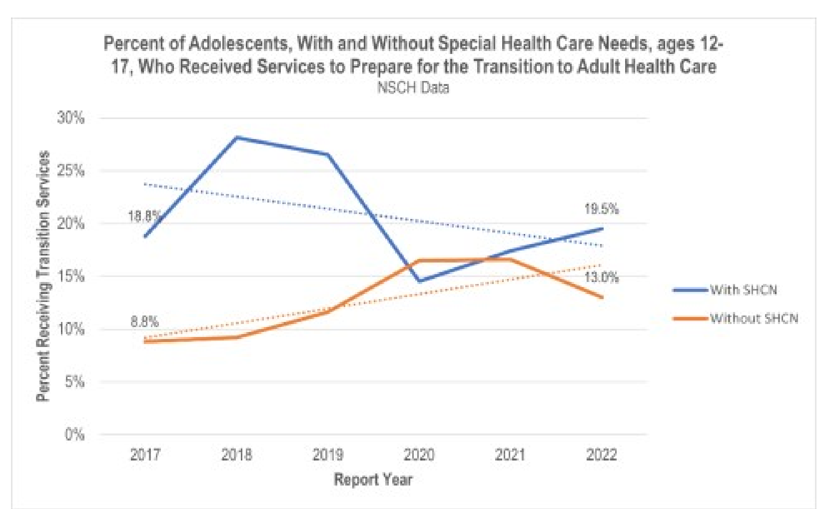
Reduction of suicide deaths is a continuing priority. However, death statistics vastly underestimate the burden of intentional self-harm injuries in youth. In 2001, the Virginia Department of Health (VDH) was designated as the lead agency for youth suicide prevention in Virginia pursuant to the Code 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, 1,404 gatekeepers across Virginia's campuses and universities were trained by the CSPCVA.

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

Strong Systems of Care	PRIORITY 3 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)
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



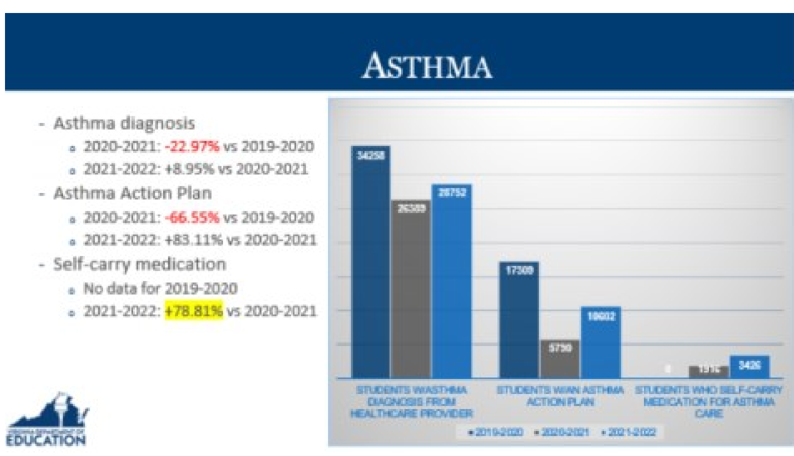
The Virginia Department of Health (VDH) School Health Nurse Consultant (SHNC), through interprofessional collaboration, supports VDH's goal of becoming the healthiest state in the nation. The School Health program collaborates with school nurses, school divisions, and community stakeholders to:

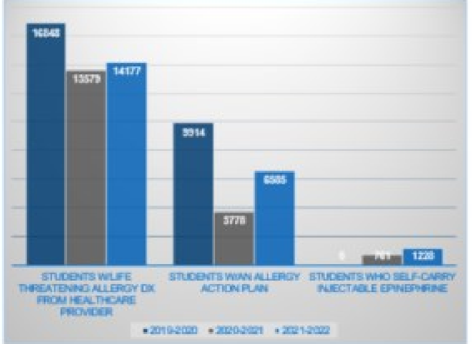
- Support school based initiatives with the implementation of evidence-based interventions to increase vaccination rates of Virginia's school age population
- Provide oral health services in the school setting
- Expand access to healthcare in schools
- Manage chronic conditions
- Improve access and care for youth mental health
- Address the social determinants of health to support Virginia's students be academically successful.

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

IMPROVED GUIDELINES FOR USE OF ABLUTEROL IN SCHOOL

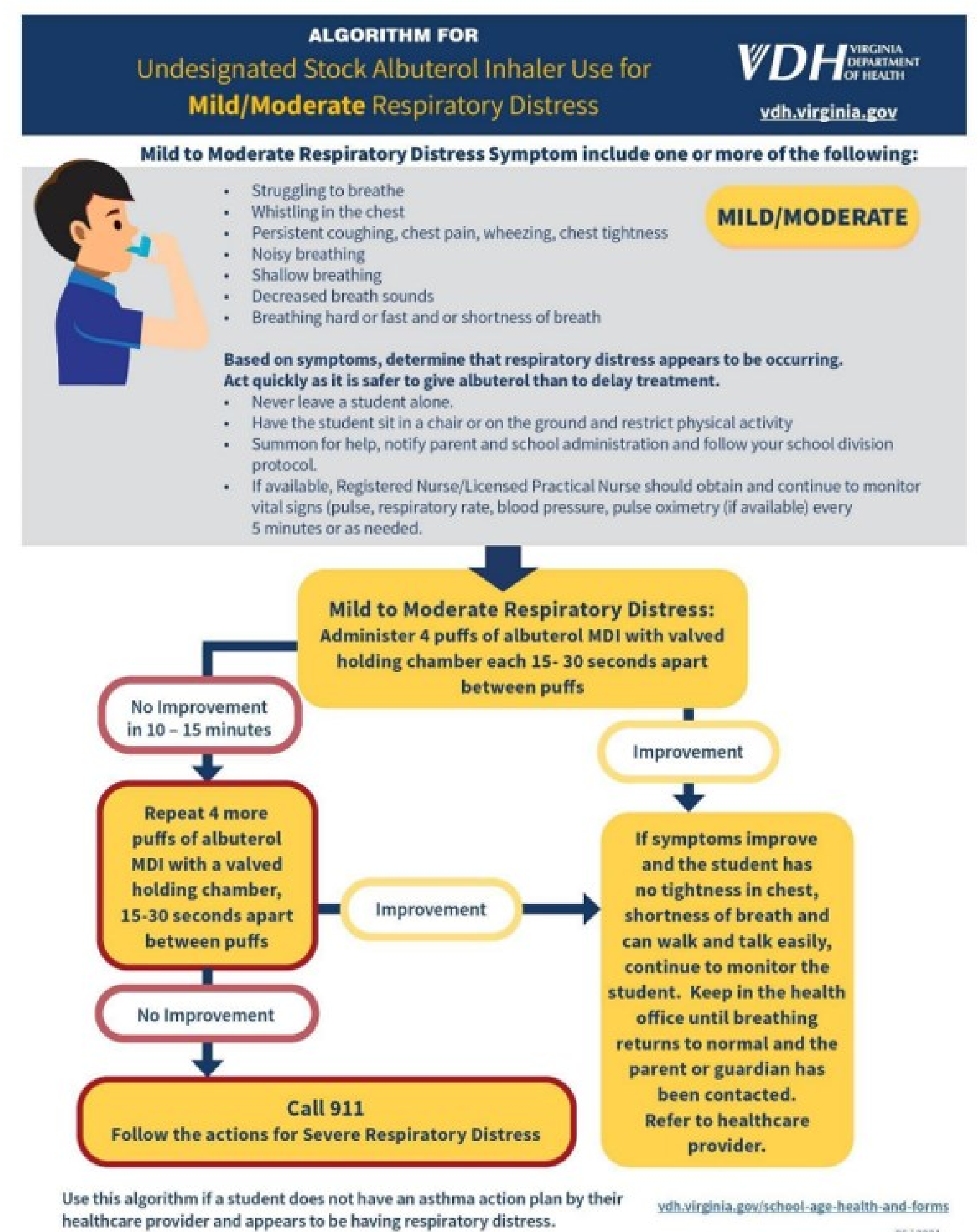
VDH's partnership with Virginia Department of Education (VDOE) supports all of Virginia's children and improves health outcomes: The 2021 General Assembly passed HB 2019, which amended and reenacted §§ 8.01-225, 22.1-274.2, and 54.1-3408 of the *Code of Virginia*, relating to public elementary and secondary schools' possession and administration of undesignated stock albuterol inhalers and valved holding chambers. VDOE, along with the SHNC, convened a group of stakeholders from the VDH Division of Pharmacy, school nurses, school staff, local health departments, Virginia Association of School Nurses and Virginia Chapter of the American Academy of Pediatrics and other community stakeholders to develop specific training need and requirements for the administration of undesignated stock albuterol. This workgroup was tasked with developing a model policy, best practices, albuterol standing order template, respiratory distress algorithms for school staff, procurement process for medication and training modules for school staff on the use of undesignated stock albuterol in the school setting.

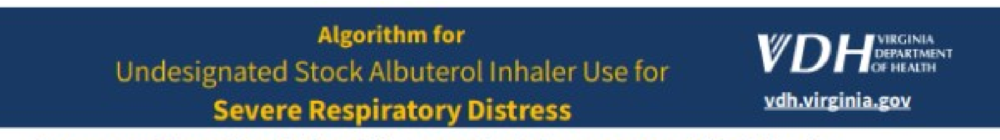


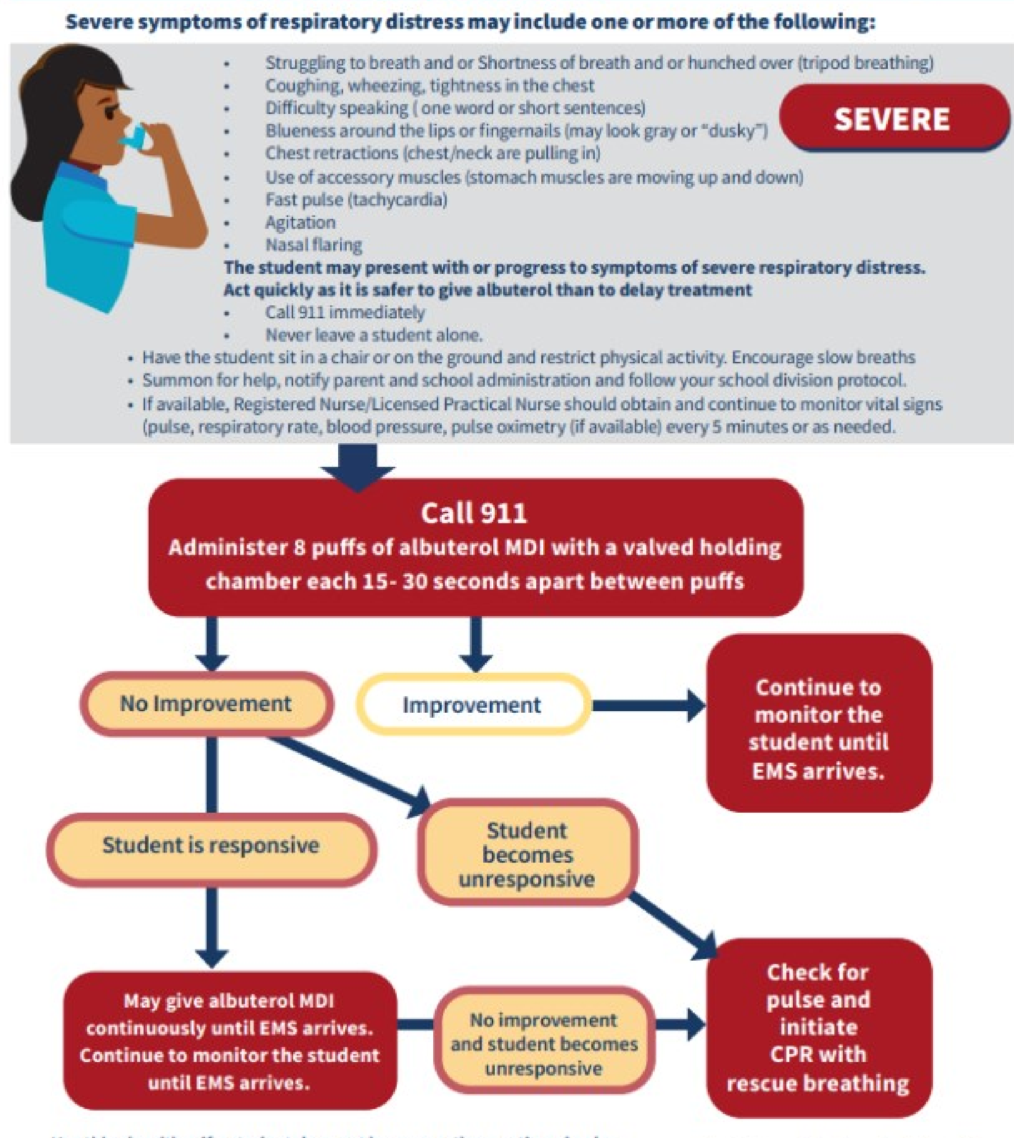


*** 2020-2022 Data Collection: Only 55 of the 131 school divisions in Virginia reported data to VDOE**

The “Virginia School Health Guidelines” was revised to reflect the workgroup’s recommendations. Even though the percent of children with and without special healthcare needs, ages 0-17, who have a medical home (NPM 11) increased by 7.90% from the previous school year, according to the VDOE 2021-2022 school year data, this collaboration addressed gaps in access to healthcare many of our children with and without special healthcare needs experience and expanded access to life saving emergency medication.







SCHOOL NURSE STAFFING LEGISLATIVE-MANDATED WORK GROUP

School nurse staffing in the 131 school divisions remains relatively unknown because public schools are not required to report data to VDOE. Since 2019, only 55 school divisions have consistently reported staffing data. The 2021-2022 data demonstrates, Registered Nurses (RN) providing direct services decreased 1.10% from 2020-2021. The reason for this decrease in RN staffing is unknown.

*** 2020-2022 Data Collection: Only 55 of the 131 school divisions in Virginia reported data to VDOE**

Action taken to improve the MCH workforce by the 2021 Virginia General Assembly:
The 2021 Virginia General Assembly, in budget Item 137 (Paragraph T) of the 2021 Appropriation Act (i.e., Chapter 552):
T. The Superintendent of Public Instruction shall convene a workgroup to make recommendations on the desired qualifications and training for school personnel providing health services in schools. The workgroup shall include at least: (if) three local school division representatives, including one superintendent; (ii) two members of a local school board; (iii) school personnel
providing health services, including contracted personnel from a local health department, personnel with varying levels of nursing credentials, and personnel without nursing credentials. and (iv) two members of the Board of Education. The recommendations shall be submitted to the General Assembly no later than October 1, 2021. Such recommendations shall detail any necessary legislative or budgetary changes to implement the recommendations.

SHNC participated in this workgroup of community stakeholders charged with making recommendations on the qualification and training for school health personnel providing health services in Virginia schools. The recommendations include:

1. Direct the Board of Education to establish a definition of "school nurse" and
*"*unlicensed *assistive personnel" that includes education, licensure, and/or certification requirements.*

2. Ensure that every Virginia elementary and secondary school is served by a full-time Registered Nurse (RN) as their school nurse.

3. Allow currently employed LPNs serving as school nurses to maintain employment as a school nurse with a five-year "grace period" to pursue/complete licensure requirements to become an RN.

4. School divisions should allocate LPNs and/ or UAP to provide supplemental health services to large schools (over 750-1000 students) and schools with high populations of students with special health care needs.

5. Strengthen the comprehensive availability of school health services information by requiring the annual collection of school health data from all Virginia school divisions.

SHNC and the School Health Specialist, with VDOE, collaborate to provide professional development opportunities and training for school nurses to improve critical workforce development. The school nurse workforce is supported by providing education, training, guidance, technical assistance, and resources to private schools, and public school divisions

across the Commonwealth. Monthly meetings with school nurses and quarterly meetings with school nurse coordinators via zoom and in-person are well-attended (average 200 participants). These meetings provide updates, guidance, and opportunities for school nurses to collaborate on school health issues.

SUMMER INSTITUTE FOR SCHOOL NURSING

The Summer Institute for School Nursing (SISN) offers networking opportunities, education, training, and professional development for Virginia's school nurses. SISN 2022 had 176 participants and awarded 2,552 contact hours. All 176 school nurses received a Mental Health First Aid Certification. The Mental Health First Aid certification course materials were supplied by the Virginia Nurses Association, further promoting, and strengthening of optimal mental health and well-being through partnerships and programs (SPM 6).

Overall, conference participants were satisfied with the program. On a scale of 1(very dissatisfied) to 5 (very satisfied), 54.6% of the participants rated the overall program a five and 33.9% rated the overall program a four.

SHNC will continue to break down barriers, use quantitative and qualitative data collection, advocate for school nurses and school health programs that address internal and external challenges. SHNC will use feedback from school nurses and community stakeholders to enhances school health programs.

CDC PUBLIC HEALTH WORKFORCE GRANT

The Virginia Department of Health (VDH) was awarded $50,920,959 under the CDC Public Health Workforce Grant. Twenty five percent ($12,730,240) has been designated for school-based initiatives to support school health staff. This grant program, implemented by VDOE, available to all 131 public school divisions, is called the School Based Health Workforce. As of May 2022, 94, of the 131, school divisions applied for grant funding and were awarded a total of $6,217,313.07 on September 2. 2022. VDOE identified two priority areas:

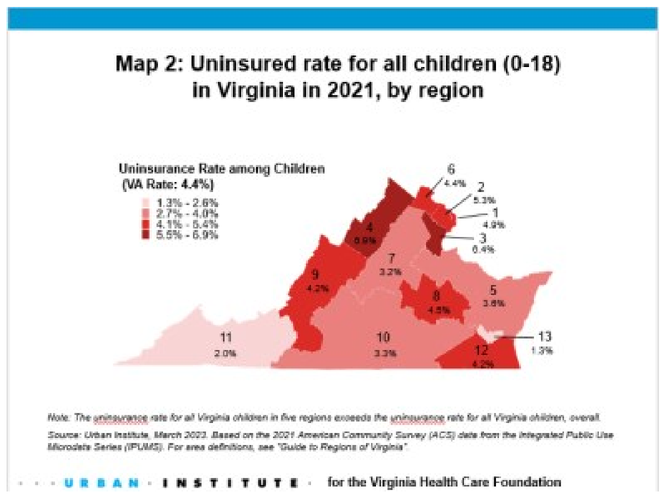
Recruiting and Retention: Grant funding can be applied to activities that support the recruiting and retention of school nurses. This can also include activities that support the working style of current Registered Nurses (RNs). The VDOE-approved activities include:
Software/electronic medical records (EMR) enhancements and/or purchases as necessary
Enhancements can also include upgrades to equipment or hardware (e.g., audiometers)
Recruiting and hiring
Wellness expenses for school nurses
Professional development.

Educational Development: Currently, not every school in Virginia has a Registered Nurse. To assist in increasing the number of RNs in schools and the number of skilled school health personnel, the School Based Health Workforce Grant can be used to fund programs that support school nurses with further education. The VDOE approved activities include:
Training for Mental Health
Scholarships
National Certification expenses for bachelor prepared RN's
Reimbursement for nursing academic classes
Per-diems (following General Services Administration (GSA) guidelines) for lodging, meals, and incidentals related to the above activities

Strategy 2: Maintain data capacity for school health immunization data

The SHNC, in partnership with the Virginia Department of Education (VDOE), community stakeholders and school nurses from across the Commonwealth, address family needs such as food security, dental care, behavioral health, and overall safety. Building capacity and establishing partnerships increases and ensures our most vulnerable students remain healthy,

safe and read to learn.



The COVID-19 Pandemic decreased access to routine healthcare, including dental care, increased conditional enrollment rates of our students, and created challenges to access the required TB screening for school enrollment. The SHNC supports Virginia families by establishing internal and external partnerships for community outreach with multiple organizations coming together to address lack of access to healthcare, barriers and immunization gaps created secondarily due to the COVID-19 pandemic. Virginia's immunization rates are still not at pre-pandemic levels. According to the Code of Virginia § 22.1-271.2, private and public school divisions are required to report their student immunization status at the beginning (October $15^{th)}$ of the current school year. This report is known as the Student Immunization Status Report (SIS) and includes the number of kindergarten, seventh grade, and twelfth grade students admitted to school with documentary proof of immunizations, the number of students who have been admitted with a medical or religious exemption and the number of students who have been conditionally admitted to a school.

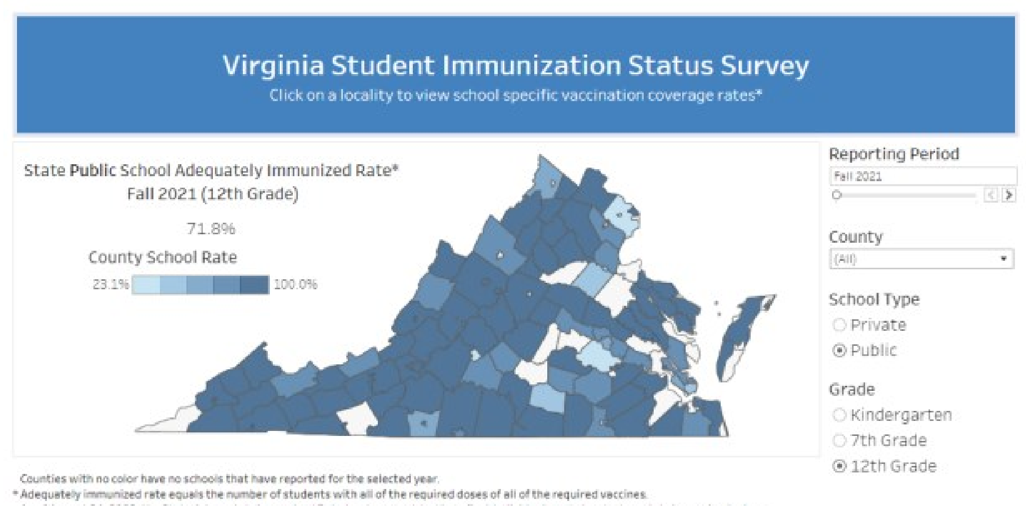
According to the SIS report, immunization rates have increased slightly from 2021 to 2022. Many local health departments employ Immunization Action Planners (IAP). IAPs are task with coordinating and supporting vaccination efforts by partnering with school nurses to prioritize vaccine access and provide opportunities for children to receive required vaccines for school enrollment. Many of our school based vaccination clinics target rising 7th and 12th grade students because these students are less likely to see a healthcare provider on a regular basis and are required to have at least one dose of HPV, Tdap, meningococcal conjugate vaccines for school enrollment per the Code of Virginia § 32.1-46 - Immunization of Children Against Certain Diseases. Seasonal influenza and COVID vaccines are not required for school enrollment but are recommended and offered at the same time during many of these vaccine events.

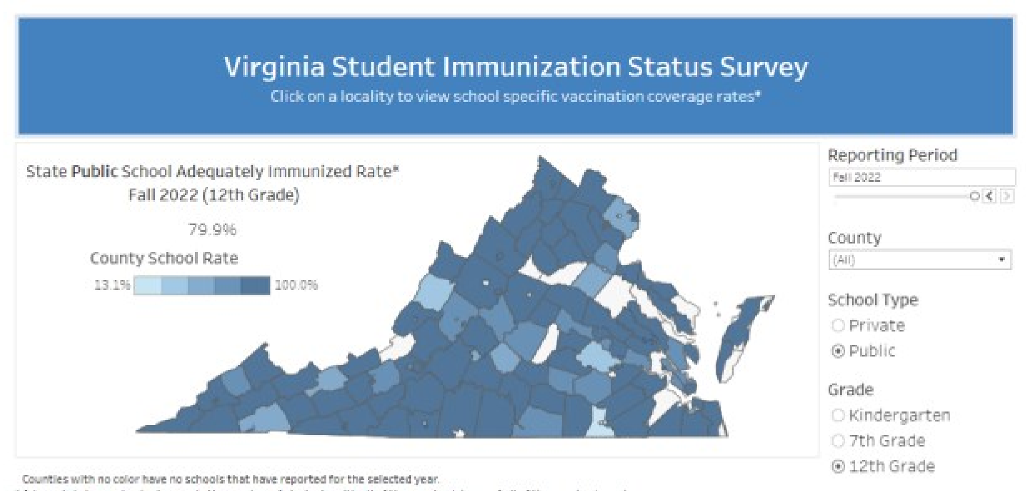
These school-based clinics have provided families with vaccination opportunities and increased the:

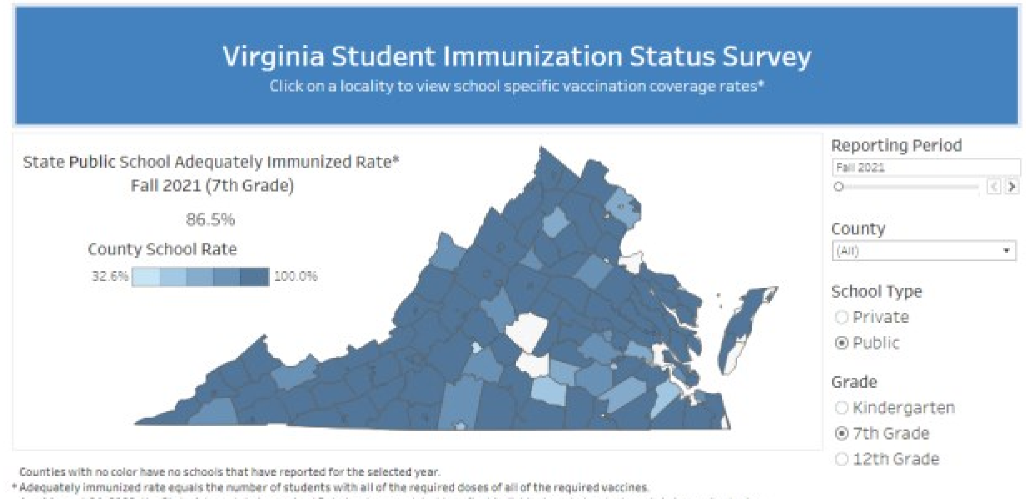
- Percent of children, ages 6mo-17 years who are vaccinated annually against seasonal influenza (NOM 22.2)
- Percent of adolescents, ages 13-17, who have received at least one dose of the HPV vaccine (NOM 22.3)
- Percent of adolescents, ages 13-17, who have received at least one dose of the Tdap vaccine (NOM 22.4)
- Percent of adolescents, ages 13-17, who have received at least one dose of the meningococcal conjugate vaccine (NOM 22.5)

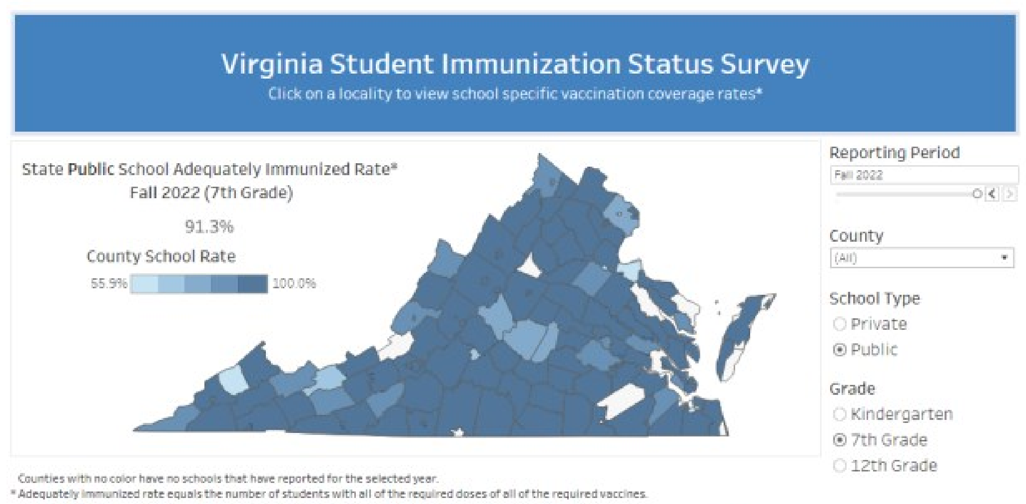
At the state level, communication strategies for school immunization requirements have proven to be successful in reaching Virginia families and consist of engaging with Superintendents through the partnership with the Virginia Department of Education (VDOE), training of school nurses, establishing data exchange between the Virginia Immunization Information System (VIIS) and school electronic health records, updating frequently VDH's websites (Division of Immunization, School

Health and Healthy Back to School) and the development of immunization resources including an annual HPV information letter to parents of rising 7th graders/families, infographics, tool kits and playbooks. All together our communication strategies, successful partnerships, and increased access to vaccines have improved Virginia's adequately immunized vaccination rates. In 2022, 7th grade student adequately immunized vaccination rates increased by 4.8% and 12th grade student adequately immunized vaccination rates increased by 8.1% from the previous year vaccines have improved Virginia's adequately immunized vaccination rates. In 2022, 7th grade student adequately immunized vaccination rates increased by 4.8% and 12th grade student adequately immunized vaccination rates increased by 8.1% from the previous year.









Strategic communication efforts targeting families continue to be a collaborative effort between VDH Division of Immunization, SHNC, VDH Office of Epidemiology, VDOE, and the Virginia Chapter of the American Academy of Pediatrics (VA AAP). The Healthy Back to School campaign and website provides families with short videos encouraging well child visits, a Back-to-School Checklist for parents to prepare their child for the upcoming school year and immunization resources including an immunization event locator.
SHNC has developed strong partnerships, over the past three years, with VDOE, local health departments, school divisions, VHIT, and Virginia Health Catalyst. These partnerships have provided families, school nurses and school health staff with resources and opportunities to promote health, increase access to healthcare and improve a child’s academic success. Two recent collaborations are highlighted below:

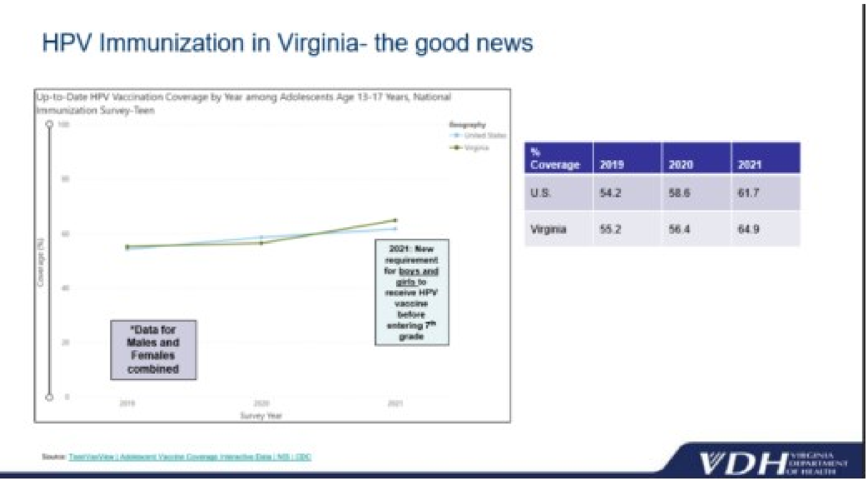
The development and implementation of the 2023-2027 VHIT Action Plan for Virginia. The Action Plan consists of four priorities areas to increase HPV vaccination rates:

- Decrease community disparities in HPV vaccination.
- Improve delivery of evidence-based strategies in providing HPV vaccine.
- Increase HPV data quality and sharing.
- Increase awareness of the burden of HPV-related cancers in men and women.

Capacity building and quality improvement to support school based initiatives are underway with the implementation of evidence-based interventions to improve HPV immunization rates in Virginia. VDH's annual HPV letter is distributed to school nurse coordinators, through VDOE channels, and disseminated to families/parents of rising 7th graders. The letter, along with educational resources (infographic below), is available in English and Spanish and provides families with information on the Code requirements for school entry and education on the benefits of adolescents receiving the HPV vaccine.

School divisions are encouraged to partner with local health departments, hospital community outreach programs, and pharmacies to provide opportunities for students to receive their required 7th grade dose of HPV for school enrollment and catch-up vaccines for students requiring additional doses of the HPV series before the start of the new school year.

HPV rates have increased by 3.1% from 2021 to 2022. The VHIT Action Plan outlines steps to increase the percent of adolescents, ages 13-17, who have received at least one dose of the HPV vaccine (NOM 22.3).



% Coverage	2019	2020	2021
U.S.	54.2	58.6	61.7
Virginia	55.2	56.4	64.9

The Healthy Back to School website information can be found below:

Communication: Families

Healthy Back to School Website

Jan 1, 2022 - Oct 28, 2022

Avg. Session Duration and Pages / Session

Avg. Session Duration · Pages / Session

New Users and Users

New Users · Users

Is your child back-to-school ready?

Visit a doctor.
See a dentist.
Get immunizations.

VDH VIRGINIA DEPARTMENT OF HEALTH

VDH: Back to School Immunization Resources - Website

Immunization Clinics Local Health Department

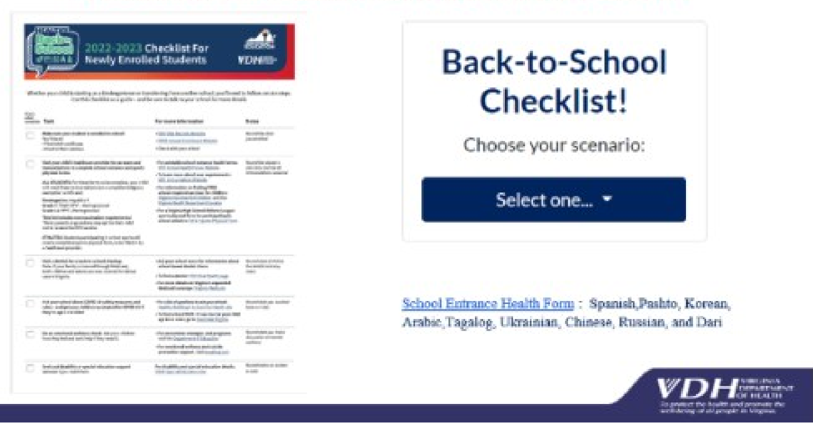
FIND ONE NOW!

Do you want a copy of your immunization record?

COVID-19 Vaccination Record

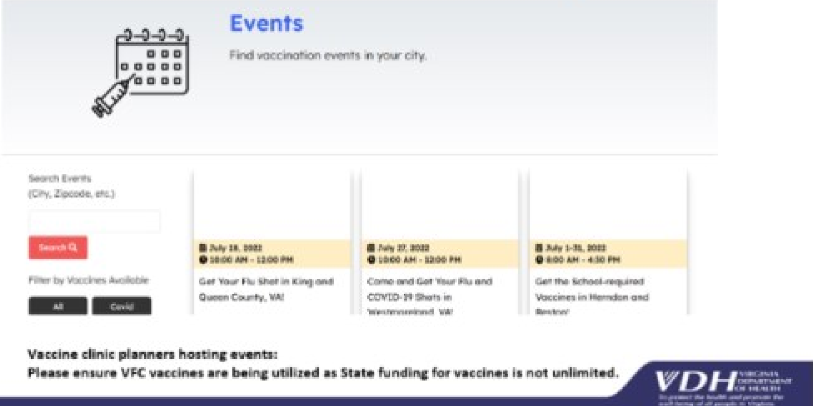
Full Immunization Record

VDH: Back to School Immunization Resources - Website



School Entrance Health Form : Spanish,Pashto, Korean, Arabic,Tagalog, Ukrainian, Chinese, Russian, and Dari

VDH VIRGINIA DEPARTMENT OF HEALTH



A programmatic success was the launch of a pilot program, in the spring of 2022, designed to increase MenACWY vaccination rates. The overall goal of the pilot program was to increase the percent of adolescents, ages 13-17, who have received at least one dose of the meningococcal conjugate vaccine (NONOM 22.5). The SHNC, in collaboration, with Harrisonburg City Public Schools (HCPS) and Central Shenandoah Health District partnered to expand access to healthcare and promote health by providing a school based MenACWY immunization clinic. This school-based vaccine clinic provided an opportunity for rising seniors to receive the one dose of MenACWY required for school enrollment. The clinic was scheduled for two hours during the school day, before summer break, around the Virginia Department of Education (VDOE) testing windows, exams, school sporting events and prom. Since this school located vaccination clinic was held during school hours, no transportation was needed for students, parents did not need to miss work and school officials were able to stand in loco parentis. This program was extremely successful, 38% of the targeted student population received the one dose of the meningococcal conjugate vaccine required for school enrollment. HCPS was selected to pilot this immunization program because of their robust school health program led by highly qualified registered nurses. 11.2% of HCPS (KG-12 grade) students identify as immigrants (born outside the U.S., with fewer than three years in U.S. schools), many families lack transportation and access to vaccine opportunities. The purpose of this pilot program was to address the social determinants of health and established a framework to make school age vaccinations more accessible to all families by coordinating immunization efforts through strong school, local health department, community partnerships, and to strengthen access to vaccinations and health promotion.

The pilot program objectives were achieved:

- A framework was created for meeting the health needs of the community that is sustainable and easily replicated.
- Access to immunization health services was streamlined.
- The number of adequately immunized students enrolled in HCPS increased.

Routine Vaccination Update - Virginia vs U.S.

Virginia maintains vaccination rates at or above national levels and exemption rates lower than national levels (MMWR).

Exemptions remain low in Virginia.

Virginia Success Stories/Activities

- VDH re-established a statewide immunization coalition - ImmunizeVA
- VDH is proactive partnering with stakeholders to provide education, resources, and guidance (in multiple languages).
- VDH produces annual information to parents of rising 7th graders regarding the importance of routine vaccination including prevention of cancer with the HPV vaccine.
- Launch of Back to School Website and Communications Campaign

2020-21 MMWR Statistics
Virginia vs U.S.

120.00%
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%

93.90% 95.80% | 93.60% 97.70% | 93.60% 94.10% | 2.20% 1.50%

2 doses of MMR | 5 doses of DTaP | 2 doses of Varicella | Any Exemption

U.S. Estimates | Virginia

HCPS Rising 12th Graders - Pilot Program

300
250
200
150
100
50
0

Pre Event | Post Event

Adequately Immunized | Not Adequately Immunized | Exemptions

Student Immunization Survey - Exemption Rates

1.80%
1.60%
1.40%
1.20%
1.00%
0.80%
0.60%
0.40%
0.20%
0.00%

SY2019-20 Medical Exemption Rate | SY2021-22 Medical Exemption Rate | SY2019-20 Religious Exemption Rate | SY2021-22 Religious Exemption Rate

Kindergarten | 7th Grade

10

https://www.cdc.gov/mmwr/volumes/71/wr/mm7116a1.htm

https://www.vdh.virginia.gov/immunization/datamanagement/sisreports/

The success of this pilot program has led to the development of a MenACWY playbook, providing Virginia's school divisions with step-by-step guidance and best practices for school-based immunization clinic:

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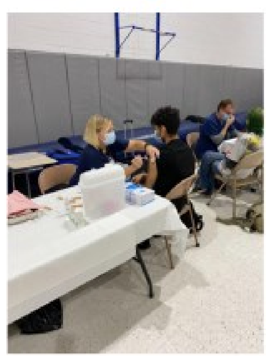
Pilot Program Partnership



Harrisonburg City School
Central Shenandoah Health District

MenACWY Immunization Clinic held 5/13/22

38% of students vaccinated

- Targeting rising seniors = 412
- Consents sent home to families = 272
  - 116 consents returned
- 106 students vaccinated in 2 hours
  - Students absent on clinic day = 10
  - Religious Exemptions =10

https://www.vdh.virginia.gov/content/uploads/sites/58/2022/11/MenACWY-Final-Playbook8-18-2022.pdf

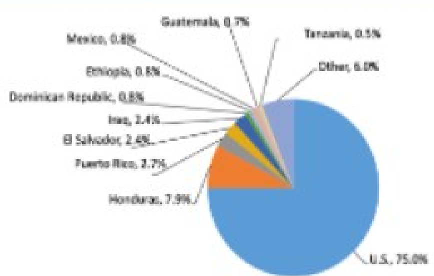
EQUITY CENTERING:

School-based health programs support equitable access and improve health outcomes by addressing the social determinants of health and reducing barriers to children receiving care.

Many students are missing school-required immunizations for multiple reasons, including transportation, cost of services, insurance status, scheduling conflicts and are unable to acquire access to routine healthcare resulting in the student receiving a conditional enrollment. Harrisonburg City Public Schools (HCPS) partnered with SHNC and VDH Central Shenandoah Health Department to address barriers and provide immunization opportunities for students during school hours. As seen in the chart below, 11.2% of HCPS (KG-12th grade) students identify as immigrants (born outside the U.S., with fewer than three years in U.S. schools), there are high numbers of students whose primary language is not English and 100% of students are eligible for free lunch. Many HCPS families lack transportation and access to vaccine opportunities. HCPS 2021 uninsured rate among children is 5.5%-6.9%. The data strongly suggest the correlation between poverty, as a determinant of health, and equitable healthcare. HCPS and Central Shenandoah Health Department's school-based vaccination pilot program addressed the social determinants of health and established a framework to make school age vaccinations more accessible to all families by coordinating immunization efforts through strong school, local health department and community partnerships. HCPS is scheduled to open a school-based health center in spring 2023.

Harrisonburg City Public Schools

KG-12th Grade Students – Birth Country



- 72 different birth countries currently represented
- The majority of HCPS students are born in the U.S.
- Some of the "Other" birth countries with notable student populations include: Syria, Eritrea, Congo, Nepal, Ukraine, Jordan, Rwanda, Cuba, Egypt, Uganda, Sudan, Venezuela & Vietnam.
- 11.2% of current HCPS KG-12th grade students are identified as Immigrants (born outside the U.S., with fewer than three years in U.S. schools)
- School based health center - *Opening 2023*

The SHNC collaborated with Harrisonburg City Public Schools, and the Central Shenandoah health department to address the social determinants of health by:

- Removing barriers to “catch-up vaccines” required for school enrollment
- Providing the necessary “catch-up vaccines” to allow children to remain in school
- Decreasing conditional enrollment by providing opportunities for children to receive “catch-up” vaccines.

Jeffress Trust Awards Program in Research Advancing Health Equity Partnership - Collaborative Establishment Awards (6/30/2022 - 6/30/2024) Dr. Erin Maughan, with George Mason School of Nursing (GMU) was awarded the Research Advancing Health Equity Grant for $149,868.57. The Virginia Association of School Nurses (VASN), Virginia Department of Education (VDOE), Virginia Department of Health (VDH), community stakeholders, and regional contacts from across the Commonwealth support this partnership building grant. This partnership, known as Virginia School Health & Equity Research Consortium (VSHERC), includes the formation of an advisory group and plans provide training/professional development opportunities for school nurses, along with a Child Summit. The objective of VSHERC’s is to increase the percentage of students in Virginia schools with a school health program that facilitates child health and does not contribute to child health inequities.

The 2021-2022 partnership with the Virginia Health Catalyst targeted preventative dental services for children living in Southwest Virginia, who had less access and fewer services. Public schools partnered with 7 dental clinic teams: Bland Ministry Center & Dental Clinic (Bland, VA), Community Health Center of the New River Valley (Christiansburg, VA), CVHS: Petersburg Health Center (Petersburg, VA), CVHS: Hopewell/Prince George Health Center (Prince George, VA), Eastern Shore Rural Health System (Onancock, VA) Johnson Health Center (Lynchburg, VA), Piedmont Regional Dental Clinic (Orange, VA) to provide students in Southwest Virginia an opportunity to receive school based dental care during the school day.

Grade & Trend

Virginia earned a B for this indicator. Over half (59%) of Virginia's children aged 3-20 in Medicaid/FAMIS received a preventive dental service, which is 15% higher than the national benchmark. The most recent data for this analysis is from the state fiscal year 2019. The graph at the right details the children aged 3-20 in Medicaid/FAMIS who received a preventive dental visit in SFY 2016-2019.

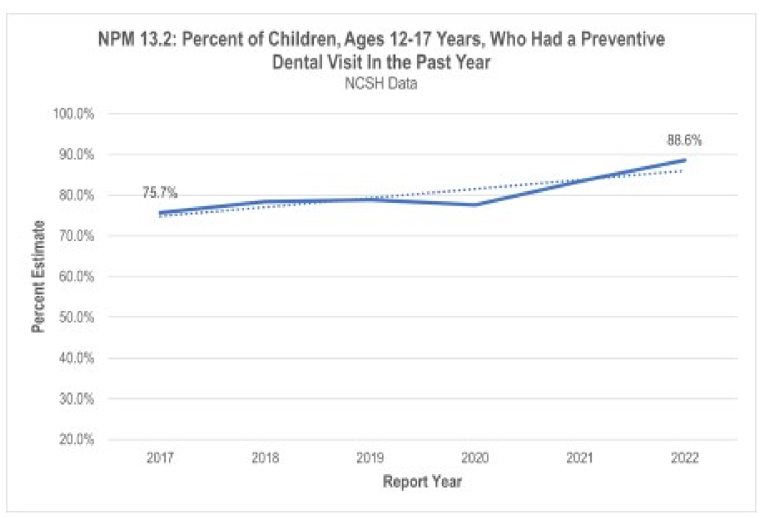
2016 Report Card	2022 Report Card	Trend
53% (C)	59% (B)	Cannot be compared*

*These rates cannot be directly compared. The 2016 *Report Card* measured the rates for children aged 1-20, but the 2022 *Report Card* workgroup revised it to 3-20 to remove the overlap with the previous indicator.

Focus on Equity

Adolescents aged 19-20 (24%) had the lowest rates of preventive dental services, followed by those aged 15-18 (52%). Children living in Eastern or Southwest Virginia (54%) and Black/African American children (55%) also reported fewer dental services than other groups.

Oral Health	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

SHNC collaborated with VDOE, Virginia Health Catalyst, Delta Dental, school divisions and school nurses to provide school based dental care programs to students. School-based dental health programs address the social determinants of health, promote health, support equitable access to dental care and improved health outcomes by connecting school nurses with dental clinic staff to provide children and families with school-based dental services. During the 2021-2022 school year, Virginia's school divisions partnered with Bland Ministry Center & Dental Clinic (Bland, VA), Community Health Center of the New River Valley (Christiansburg, VA), CVHS: Petersburg Health Center (Petersburg, VA), CVHS: Hopewell/Prince George Health Center (Prince George, VA), Eastern Shore Rural Health System (Onancock, VA) Johnson Health Center (Lynchburg, VA), Piedmont Regional Dental Clinic (Orange, VA) to provide students an opportunity to receive school based dental care during the school day. 25 schools across Virginia, increased the percentage of children, ages 1-17, who had preventive dental visits in the past year (NPM 13.2), decreased the percent of children, ages 0-17, who were unable to obtain needed healthcare in the past year (NOM25) and provided dental care and referrals to the children, ages 1-17, who have decayed teeth or cavities in the past year (NOM 14).

The partnership between school divisions and the Virginia Health Catalyst has provided almost 8,000 additional students access to dental care. School nurses work directly ith dental service providers to bring school-based dental care to their students. Dental clinics are scheduled during the school day and therefore remove the barriers of transportation and parent workday disruptions. As of September 2022, Virginia's oral Health Report Card received a score of C+. The SChool Health Nurse Consultant has continued to work closely with school nurses and the Virginia Health Catalyst team to develop and implement strategies to increase the percentage of children, ages 1-17, who had a preventive dental visit in the past year (NPM 13.2) with thegoal of increasing access to dental care for all Virginia's children and improving the 2023 Virginia Oral Health Report Care score.

Virginia Health Catalyst
www.vahealthcatalyst.org

2021-2022 School-Based Oral Health Program

Summary Report

OVERVIEW

Dental safety net clinic teams and local school nurses participated in an 18-month learning collaborative to learn how to implement new school-based oral health programs (SBOHPs) in their areas. SBOHPs remove barriers to accessing dental care for students and connect students to local clinics to establish a dental home.

OUTCOMES

- Almost **8,000 additional students in 25 schools** across Virginia have access to oral health care in their school
- In the 2022-2023 school year, the seven participating dental clinic teams will implement **18 new SBOHPs**
- Partnerships between school and clinic teams offer communities opportunities to **connect to health care providers and dental homes**
- Dental clinic teams and school staff are equipped to **improve processes using quality improvement** strategies and tools
- State agencies and local partners exemplified **effective collaboration** to improve the health of Virginians

Between January-June 2022, teams reported:

- **715** Students received dental services
- **1,652** Consent forms collected
- **21%** Consent form return rate
- **1,068** Diagnostic services provided
- **1,005** Preventive services provided*
- **635** Fluoride varnish applications
- **430** Dental sealants applied
- **14** Restorative services provided

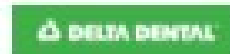
*Includes fluoride varnish and dental sealants

CLINIC TEAMS

1. **Bland Ministry Center & Dental Clinic**, Bland, VA
2. **Community Health Center of the New River Valley**, Christiansburg, VA
3. **CVHS: Petersburg Health Center**, Petersburg, VA
4. **CVHS: Hopewell/Prince George Health Center**, Prince George, VA
5. **Eastern Shore Rural Health System**, Onancock, VA
6. **Johnson Health Center**, Lynchburg, VA
7. **Piedmont Regional Dental Clinic**, Orange, VA

This project was funded in part by the Virginia Department of Health's CDC DP18-1810 Oral Health Surveillance Grant, and by contributions from the Delta Dental of Virginia Foundation.

VDH VIRGINIA DEPARTMENT OF HEALTH



ADOLESCENT HEALTH DOMAIN
FY24 APPLICATION YEAR

PRIORITY 1	Reproductive justice and support: Promote equitable access to choice-centered reproduction-related services.
OBJECTIVE	Recue the rate of mistimed pregnancies from 25.3% (PRAMS 2018)_ t0 21.8%
OUTCOME MEASURE	SPM4: Pregnancy Intention: Mistimed or unwanted pregnancy (wanted to become pregnant late or never)

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.

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 1,110 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: Increase the LHD capacity to assure access to and engage in reproductive care that is tailored to the adolescent population

During January 2023, all 35 LHDs were asked to complete a survey regarding adolescent health. The survey examined the resources available to the adolescent population in each health district including school-based health services and contraceptive and reproductive health services, staff training needs, especially regarding policies around mandated reporting, confidentiality and privacy, and regarding special topics such as “healthy relationships”, “sexuality and gender”, and “puberty and adolescent brain development”. Additionally, questions regarding referrals and referral tracking processes were asked. Twelve districts indicated an interest in participating in a work group to strengthen LHD work with and for their adolescent population. For FY24, those 12 districts will form a work group, led by the Adolescent Health Coordinator, addressing needs and areas of opportunity identified by the survey.

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	October 2023 – September 2024	James Madison University; 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.

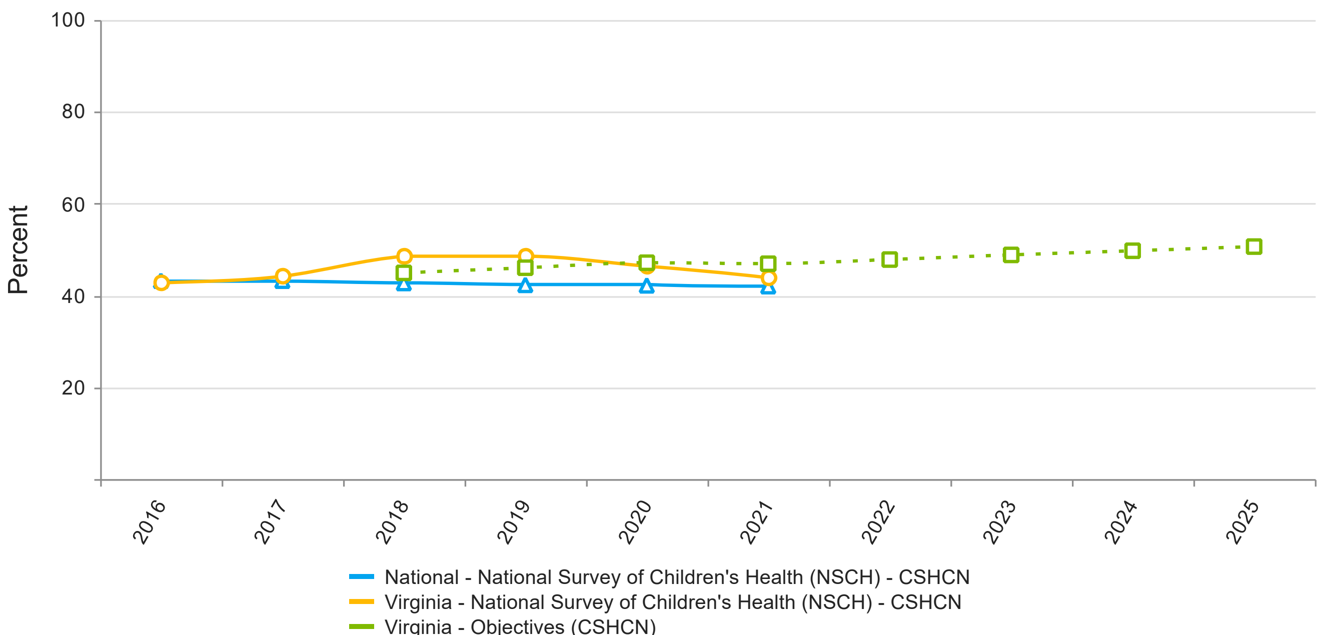
PRIORITY 4	Oral Health
OBJECTIVE	By June 30, 2025, increase the percentage of children, ages 12-17, who had a preventive dental visit in the past year from 88.2% (NSCH 201) to 93.5%
PERFORMANCE MEASURE	NPM 13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.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

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					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	44.9	46	47.1	46.9	47.8
Annual Indicator	44.2	48.4	48.6	46.4	43.9
Numerator	172,978	188,625	174,804	155,562	150,246
Denominator	391,467	389,683	360,019	335,140	342,489
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	100	250	400	40	45
Annual Indicator	0	0	37	49	11
Numerator					
Denominator					
Data Source	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

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

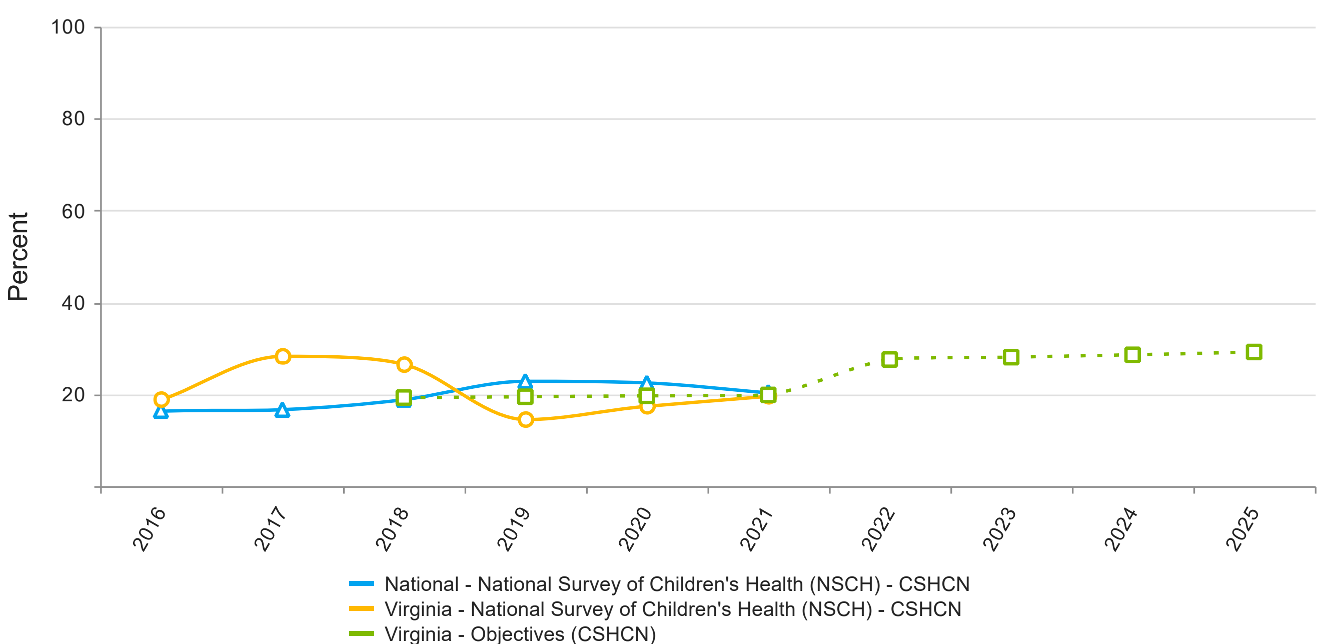
ESM 11.2 - Percentage of children served by the VA CYSHCN Program who report having a medical home

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	91.5	93	94.5	96	97.5
Annual Indicator	96.8	99	96	95.4	94.4
Numerator	4,239	4,788	5,490	3,348	4,148
Denominator	4,377	4,835	5,719	3,508	4,393
Data Source	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	19.3	19.5	19.7	19.9	27.6
Annual Indicator	28.1	26.5	14.5	17.4	19.5
Numerator	48,657	47,355	22,590	23,724	26,913
Denominator	172,958	179,018	155,964	136,302	138,287
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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					
	2018	2019	2020	2021	2022
Annual Objective	100	250	400	40	45
Annual Indicator	0	0	45	49	11
Numerator					
Denominator					
Data Source	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Provisional	Final	Final	Final	Final

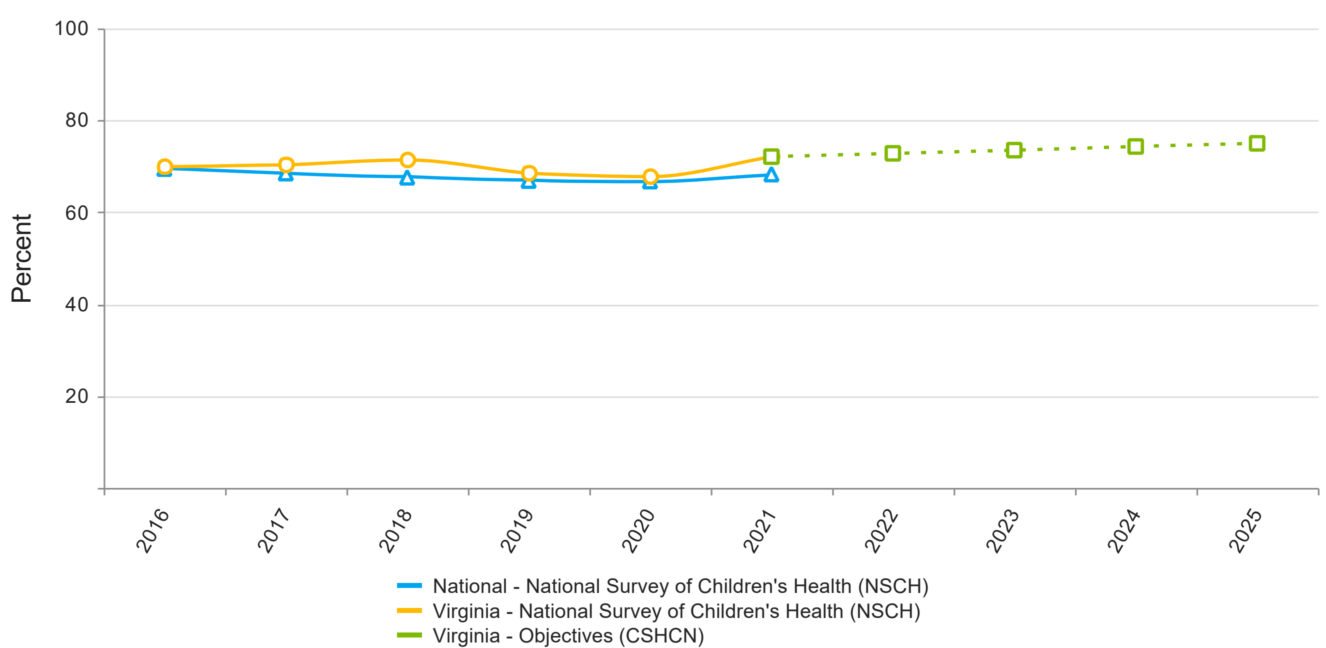
Annual Objectives			
	2023	2024	2025
Annual Objective	50.0	55.0	60.0

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	2022
Annual Objective			75	77
Annual Indicator		68.2	68.2	42
Numerator		90	90	55
Denominator		132	132	131
Data Source		VDH and VDOE School Health Nurse Documentation	VDH and VDOE School Health Nurse Documentation	VDH and VDOE School Health Nurse Documentation
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	79.0	81.0	100.0



NPM 15 - Children with Special Health Care Needs

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH)				
	2019	**2020**	**2021**	**2022**
Annual Objective			72	72.7
Annual Indicator	71.2	68.5	67.7	71.9
Numerator	1,323,014	1,274,181	1,257,254	1,324,660
Denominator	1,857,510	1,859,679	1,856,744	1,843,322
Data Source	NSCH	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021

State Provided Data				
	2019	2020	2021	2022
Annual Objective			72	72.7
Annual Indicator	71.3	66.9	62.9	66.4
Numerator				
Denominator				
Data Source	NSCH	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	73.4	74.2	74.9

Evidence-Based or –Informed Strategy Measures

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

Baseline data was not available/provided.

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	2022
Annual Objective			100	100
Annual Indicator		100	100	100
Numerator		4	5	4
Denominator		4	5	4
Data Source		CYSHCN Program Documentation	CYSHCN Program Documentation	CYSHCN Program Documentation
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Final	Final

Annual Objectives

	2023	2024	2025
Annual Objective	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)

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) - COMPLETED

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
FY22 ANNUAL REPORT

CSHCN PROGRAM DESIGN AND OVERVIEW

The VDH, Children with Special Health Care Needs (CSHCN) program is based on the Maternal and Child Health Bureau's vision for this population and closely aligns with the overall system outcomes for CSHCN (as described in the national standards). The program's goals also align with the newly implemented Blueprint for Change. 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 are 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. CYSHCN staff executed the first contracts in July of 2022. 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 In FY22, the CSHCN program served approximately 7,198 families. This represents an increase in service level from FY21 (6412). The rebound from COVID is encouraging but the program has a goal of eventually returning to pre-COVID levels of service (7,498). Please note the chart below showing service trends since the year before the pandemic.

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 accessing care. Such services include but are not limited to:

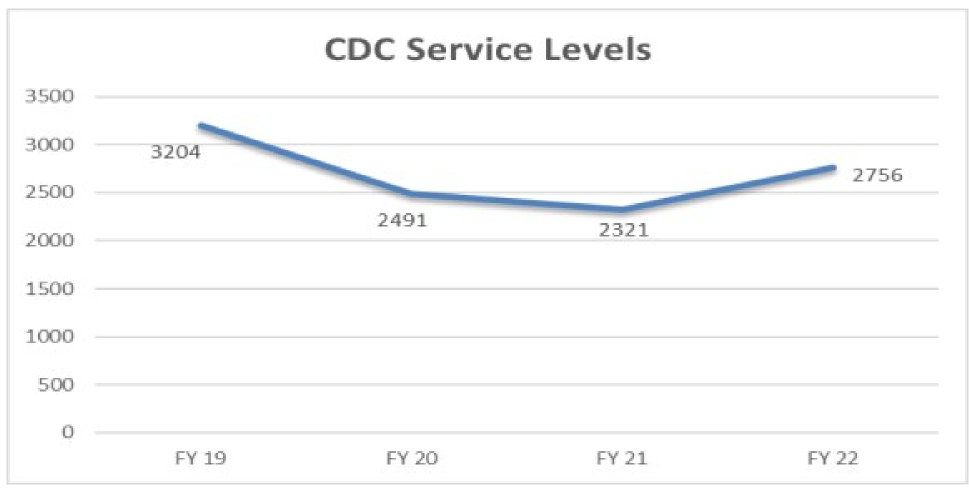
- Medical insurance benefit evaluation and referral (including Medicaid);
- Linkage to a primary care provider/medical home;
- Referrals to necessary resources and specialty services;
- Family-to-family support via parent coordinators;
- Support from the Virginia Department of Education's (DOE's) state 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 FY22, the CCC program served 2,805 families. The represents an increase from FY 21 (2,740 families).

Child Development Clinics (CDCs)

The CDC program serves families with children who are suspected of having behavioral and/or developmental disorders

(e.g., autism, ADD/ADHD, learning disabilities, anxiety, PTSD, and 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 FY22, the CDC program served 2,756 families resulting in 6,208 diagnoses and 6,529 referrals for services. This represents a significant increase from FY 21 (2,321 families served, resulting in 5,340 diagnoses and 5,484 referrals for additional services) but falls short of pre-COVID numbers of 3,204 (FY19) total families served. The CSHCN director has set a goal for the Child Development Clinic program to return to pre-COVID service levels. Progress has been made, but the task is exceedingly difficult due to partner's struggles in hiring staff. Please note the following service level chart from FY 19-FY 22.



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 FY22, the VBDP served 449 people.

Virginia Sickle Cell Awareness Program (VASCAP)

VASCAP provides access to 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. The network is fully functional as of 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. In FY22, the clinics served 1188 individuals.

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. By the end of FY 21, the documents were drafted to solicit requests for proposals. In FY 22, the proposals were reviewed, and vendors selected. Four vendors were selected that were located in major medical centers. FY 23 is the first year will provide comprehensive medical and support services for adults under VASCAP.
(https://law.lis.virginia.gov/admincode/title12/agency5/chapter191/section340/)

STATE ACTION PLAN UPDATES

Strong Systems of Care	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***
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, Cindy deSa
Hold quarterly meetings with UVA to encourage promotion of the resource. Discussions will include a stronger partnership with the AAP and other organizations and broader sharing of the resource at forums such as the AMCHP National Conference	Quarterly	Marcus Allen, Jennifer MacDonald
Continue to communicate with partners to promote the modules	Ongoing	Marcus Allen & UVA
Gather any evaluation data or feedback from UVA about the modules	by 6/30/22	VDH & UVA
Tracking of people who complete the modules	by 6/30/22	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. Staff renewed the University of Virginia (UVA) contract to continue this work. During FY 22, 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 22, UVA reported an enrollment of 0 people for the *Medical Home for Youth and Family* module and 11 people for the *Medical Home for Healthcare Providers* module. VDH has several modules managed by UVA that are related to our maternal and child health work, so the Title V/MCH director took over the management of the contract.

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 Allen, Shamaree Cromartie
Partner with family-identified medical home to coordinate entry into specialty care for newborns with a positive hemoglobinopathy screening.	Ongoing	Shamaree Cromartie
All CYSHCN programs will continue to promote medical home and help families find one, if needed	Ongoing	Marcus Allen, Shamaree Cromartie
Seek an update from the national AAP to see if they are still interested in promoting the fact sheet for pediatricians on the National Survey of Children's Health. The document focuses on medical home and the plan was to promote the fact sheet here in Virginia.	by 6/30/22	Marcus Allen & State/National AAP
CYSHCN leadership will continue to work with state Medicaid on any issues that may be a barrier to care for the children we serve	Ongoing	Marcus Allen, 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. If they do not have one, centers are expected to connect families to a medical home. 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 medical home generates the referral. Children who do not have a medical home are connected to one. During FY 22, the program rebounded from a significant drop in service levels due to COVID. Assessments of children increased by more than 400 families (compared to the previous year), but the total evaluations completed were still about 450 short of pre-COVID levels. The CYSHCN director received support from partners regarding his goal of returning to pre-COVID service levels. However, workforce issues continue to plague the program. One center hired a new developmental pediatrician but also lost its psychologist. Several other centers had vacancies during FY 22 that still need to be filled (developmental pediatrician, psychologist, social worker). Centers continue to think outside the box regarding staffing issues. For example, one center is exploring replacing one of its developmental pediatricians with a nurse practitioner. Partners also participated in regular meetings with the University of Virginia, Department of Developmental Pediatrics, to openly discuss issues with waiting lists and provider shortages. Last, the CYSHCN director continued to provide technical assistance, including site visits at centers to troubleshoot issues.

The CYSHCN program was not able to promote the medical home fact sheet. However, discussions were held with UVA regarding displaying a poster (to promote the medical home/transition modules to providers and other maternal and child health programs) at the annual Association of Maternal and Child Health Conference, in May of 2023. UVA agreed to pursue

this opportunity. VDH continues to work with Medicaid regarding issues that impact our clients and the population, in general. One specific ongoing problem in our state is obtaining low-protein food for children (Medicaid recipients) with PKU and other similar conditions. VDH accepted responsibility for reaching out to Medicaid (Virginia Department of Medical Assistance Services) to report the issues that exist on behalf of one of our partners. Moreover, regular ongoing meetings have been set to continue to focus on this issue for families.

The VBDP and Pediatric Comprehensive Sickle Cell Centers continued to partner with medical homes to coordinate care in partnership with families. The centers also continue to provide comprehensive clinics every month at the main locations and, for some, satellite locations.

Strong Systems of Care	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***
PERFORMANCE MEASURE	NPM 12 - Percent of children with and without special health care needs who received services to prepare for the transition to adult healthcare
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 module for health care providers and families to educate them on the importance of healthcare transition (including those with special health care needs)

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 22, 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 include medical home, breastfeeding, newborn screening blood spot, critical congenital heart disease and Early Hearing Detection and Intervention. During state fiscal year 22, UVA reported an enrollment of 3 people for the *Healthcare Transition for Youth and Family* module and 11 people for the *Healthcare Transition for Healthcare Providers* module.

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 Allen
Partner with the Comprehensive Sickle Cell Centers to ensure all transition-age patients complete the American Society of Hematology transition readiness assessment tool or a similar tool/process.	Ongoing	Shamaree Cromartie
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 Cromartie
Encourage all CYSHCN programs to promote the transition and medical home community/family modules and provider modules	Ongoing	Marcus Allen, Shamaree Cromartie, 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 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 SCP clinics use the American Society of Hematology (ASH) SCD Transition Readiness Assessment Tool. All centers are encouraged to partner with an adult sickle cell provider or primary care provider who understands SCD to assist in transitioning transition age clients. This will become easier now with the creation of the Adult Sickle Cell Clinic Network.

After several years of planning and lots of hard work, the CYSHCN program's Blood Disorders Coordinator was able to execute four contracts with adult providers in the state of Virginia to offer clinical services to adults living with sickle cell disease. This was all made possible by grassroots efforts on the ground, Virginia's former governor making improving care for adults with sickle cell disease a state priority and VDHs work to draft changes to the Code of Virginia. The first full year of implementation will be in FY23 and VDH looks forward to helping to assure that the population of people living with sickle cell disease in the Commonwealth receive the care they need.

Strategy 3: Utilize youth advisors 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
Work with youth advisors and family delegate to create a survey implementation plan	December 2021	Youth Advisors, family delegate, Meagan Robinson
Implement Survey	June 2022	Meagan Robinson, Marcus Allen, Family Delegate
Analyze data from survey and begin discussions regarding strategies to improve youth transition	August 2022	Meagan Robinson, Epi team, Cindy deSa

During FY 22, the CYSHCN program (in partnership with the Division of Population Health Data) obtained feedback from the MCH youth advisors and family delegates regarding the transition survey (initial draft based on the work of *Got Transition).* After modifications were made, the survey was launched using REDCap. Response to the survey was very slow at first, even though there was a small incentive. To address this problem, staff contacted student at the University of Virginia for help. The student shared the survey with a listserv of other students and it helped the agency to reach 152 people (parents and young adults combined). In the following year, VDH plans to post the survey results online, share them with partners and explore strategies to improve transition outcomes. Specifically, VDH will contact UVA to share data related to their students. The percentage of students who reported depression and anxiety was of concern.

Finances as a Root Cause	PRIORITY 3 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, including identifying potential Medicaid-eligible families, assisting with applying, and providing ongoing education and support to access covered services.	Ongoing	Marcus Allen, Shamaree Cromartie
Work towards increased support from health systems to pay for care coordination services through the CCC program	Ongoing	Marcus Allen
Administer a Care Connection for Children pool of funds for payment of direct medical care services for the uninsured and underinsured clients.	Ongoing	Marcus Allen
Administer a bleeding disorders pool of funds for payment of direct medical care services for the uninsured and underinsured clients.	Ongoing	Shamaree Cromartie
Manage an insurance case management contract (PSI) to help assure people with bleeding disorders have ongoing access to insurance.	Ongoing	Shamaree Cromartie
Continue to encourage social work support at the VBDP and SCP centers across the state	Ongoing	Shamaree Cromartie
Hold several brainstorming meetings with DMAS staff regarding strengthening regional partnerships for care coordination for Medicaid recipients. During FY21, VDH/DMAS led a statewide meeting to describe our care coordination work and to encourage continued partnerships. We will help to facilitate these partnerships in FY22.	By September 2022	Marcus Allen, DMAS staff (Virginia Medicaid agency)
The Virginia Bleeding Disorders program will complete a needs assessment in partnership with Virginia Commonwealth University (VCU) to evaluate the extent to which the program serves its target population and is maximizing the funding based on changes in healthcare and treatment options.	By June 2022	Shamaree Cromartie and VCU
The CYSHCN director will fully implement new CCC and CDC work plan templates. The new work plans include a focus on health equity	By October 2021	Marcus Allen, CCC/CDC Teams
VDH will explore a regional meeting in the SWVA area to discuss developmental/behavioral follow-up services issues. The proposed meeting would focus on potential solutions to the problem. This is a holdover from FY21. COVID made it impossible to hold this meeting.	By September 2022	Marcus Allen , SWVA CDC

The CYSHCN programs continued 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 CYHCN served are insured and the CDC program reports that 97.6% 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 meets both family and client medical needs. One of the VBDP's most important partners in this process is Accessia Health. Accessia Health provides 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 people of all ages with hemophilia. Since the implementation of Medicaid expansion, the CYSHCN program has already had a number of clients with hemophilia transition to Medicaid.
VDH continued to manage a Pool of Funds (POF) for the CCC and VBDP. The POF is the payer of last resort, and helps families purchase needed medications when no other viable options are present, including insurance. The Hearing Aid Loan Bank is located at one of the regional CCC centers and continues to provide gap-filling services to families of children with hearing loss.

VDH continued to work with DMAS regarding regional partnerships with their Managed Care Organizations (MCOs). The statewide meeting held in FY21 was an opportunity for DMAS care coordinators and CCC care coordinators to get reacquainted with one another. Regions strengthened their partnerships and continued to work with each other to help families. The biggest strength of this partnership is the CCC care coordinators knowledge of their health systems and services available and the MCOs knowledge of Medicaid coverage. The needs of the families served by the CYSHCN program are very complex, and staff on each side can share responsibility in solving complex issues. As mentioned earlier in this report, VDH partnered with Medicaid and a MCO in one particular region that was struggling to obtain low- protein food for Medicaid recipients. The partnership led to the problem being solved (for now) but it is a moving target. VDH and DMAS staff realize that this specific issue may continue to be a problem, so update meetings will be facilitated by DMAS and VDH CSHCN once/quarter, from now on, or until staff feel confident that the meetings are no longer needed. VDHs Women, Infants and Children (WIC) program was invited to attend, as well, by CSHCN staff because they struggle to get access to low protein food too. The issues generally involve being able to find durable medical equipment providers who are willing to provide the needed nutrition. The current approach of the 3 programs has been to troubleshoot issues collectively to make sure families have what they need, even if that means temporarily "bridging" children to ensure their nutritional demands are met.

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 Allen
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 Allen, Shamaree Cromartie
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	Marcus Allen, Shamaree Cromartie
Empower and equip populations impacted by sickle cell and bleeding disorders to manage the 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 CCC centers to employ parent coordinators as staff. Maintaining such staff has been difficult because statewide personnel costs have increased drastically. Most of the employed parent coordinators 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 also actively engaged families. The CDCs continued to provide assessments of children suspected of having developmental and/or behavioral 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 making at all levels. For the VBDP's needs assessment, they reviewed the National Patient Satisfactions Surveys that were conducted from 2014-2021. In each of the surveys, greater than 93% stated that they were always or usually satisfied with care. When asked on the needs assessment survey, patients and families said they were moderately to very satisfied with HTC care coordination. Families are constantly educated on in-home therapy management in order to infuse at home.

The SCP centers offered genetic counseling to aid in future reproductive decision making. The social worker and transition coordinator at one SCP center conducted assessments and coordinated needs with each patient during comprehensive sickle cell clinics and during outpatient services as needed. They also partnered with behavioral health at the hospital to ensure appropriate mental health services.   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*.

Community, Youth, Family Leadership	PRIORITY 4 Community, Family, & Youth Leadership: Provide a dedicated space, technical assistance, and financial resources to advance community leadership in state and local maternal and child health initiatives
PERFORMANCE MEASURE	SPM 5 – Cross-cutting (family leadership): Percentage of VDH CYSHCN programs that annually demonstrate active incorporation of family engagement (Care Connection for Children, Child Development Centers, Bleeding Disorders Program, Sickle Cell Program)
OBJECTIVE	Support and document annual family engagement in 100% of CYSHCN programs (Care Connection for Children, Child Development Centers, Bleeding Disorders Program, Sickle Cell Program)

Strategy 1: 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 Allen, Shamaree Cromartie
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 Allen
Collaborate with CCC Directors to encourage staff to become and maintain certifications as case managers	Ongoing	Marcus Allen
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 Allen, Shamaree Cromartie
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 Allen, CDC centers
CYSHCN program will continue to promote telehealth and support the CDC centers as they provide services remotely. Regular calls will be held statewide with centers to encourage teamwork to overcome barriers to telehealth and 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 Cromartie, 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 statewide. 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 can 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 due to COVID, increasing center personnel costs and workforce issues. Telehealth and other methods of communication were heavily used. The CDC program continued to complete some developmental/behavioral assessments via telemedicine. In SWVA Virginia, the CYSHCN program partnered with UVA to operate clinics out of a local health department. Families receive some neurology, orthopedic, and neurodevelopmental services via telemedicine to accompany in-person visits and care

coordination services. UVA is more than 3 hours away from the region, so this partnership helps to assure that the children who live there get the services they deserve. The neurology clinic serves both children and adults. This is significant because youth have somewhere to transition to for care. The work is hard and requires VDH and UVA to work very closely together to share resources and to cover when staff are out on vacation or ill. However, VDH is very proud of this critical relationship as the work contributes to the vision of the Blueprint for Change (quality of life and well-being, access to services and health equity). The picture below represents the team of UVA and VDH staff who make this work possible. The center director, CSHCN director and UVA neurology leadership meet regularly and all three are committed to keeping this valuable partnership going. We are also thankful for the support from the local health district:

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

In FY21, the VBDP began a needs assessment of the program. The goal of the needs assessment was to conduct a comprehensive assessment of the program to evaluate the extent to which the program serves its target population and the impact of significant changes in bleeding disorders care and in the funding for health care. The needs assessment continued into FY 22. In order to identify the unmet patient/family needs and changes in services needed, the program conducted four focus groups and surveyed hemophilia treatment center (HTC) providers and patients/families. The survey was distributed to 21 providers at four Virginia hemophilia treatment centers (HTCs) and to 18 providers in five non-Virginia HTCs in adjacent states. Some of the key findings from the HTCs' survey were: certain groups are underserved (non-English speaking patients, patients with immigration status issues, patients with low socioeconomic status, and women), distance to care and unmet needs related to mental health, pain management and substance abuse disorder services.

Some of the key findings from the patient/family surveys were needing more help in coordinating school and daycare issues, including emergency and health plans as well as special education plans and post high school planning and needing more nutrition services at the comprehensive visits. Some of the key findings from the focus group were needing more education and awareness for the community, providing mobile centers to provide care periodically in areas without a treatment center, and women being misdiagnosed, undiagnosed, or not taken seriously by health professionals.

Based on the survey findings and literature review, the program made several recommendations. The recommendations were:

- Expand access to VBDP for patients with inherited bleeding disorders other than factor deficiencies.
- Support strategies to reduce distance as a barrier to care.

- Reduce insurance barriers
- Provide support to patients during dramatic changes in bleeding disorders treatment
- Increase access to services for mental health, substance abuse, pain management, genetics counseling, nutrition services, dental care. Assist parents of young children in coordinating daycare and school issues.

Based on the needs assessment results, the Project Manager identified four priority committees based on the unmet needs. Each Virginia HTC was to pick a committee and work to address the unmet need. The four committees were:

- Females with Bleeding Disorders Committee
- Overcoming Distance or Travel Barriers Committee
- Transition to ATHN Clinical Manager Reporting Committee
- Expansion of Services in NOVA Committee

The HTCs will work to address the committee goals in FY23.

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

VCU Adult Sickle Cell Program, Richmond, VA: https://www.vcuhealth.org/services/sickle-cell-program/about-us

UVA Adult Sickle Cell Program, Charlottesville, VA: https://uvahealth.com/services/blood-disorders/sickle-cell-disease

Inova Adult Sickle Cell Program, Fairfax, VA: https://www.inova.org/locations/inova-hematology-oncology

Carilion Adult Sickle Cell Program, Roanoke, VA: https://www.carilionclinic.org/sicklecell#about

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 can 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 the 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 the transition survey that the agency implemented 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 engage families who care for children with special needs enthusiastically.

MCH WORKFORCE CAPACITY

The CYSHCN program in Virginia is extensive. Nine staff members report to the CYSHCN Program Director but 7 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, and blood disorders coordinator). The program director asked leadership for help, and they responded. During FY 24, funding has been set aside for the CYSHCN program to hire another central office staff person. The person will manage the child development work to include all the contracts and will serve as VDH administrator for the bleeding disorders program. This will give the program director more time to focus on managing the CCC program, staff and future population health aims. It will give the current blood disorders coordinator more time to nurture the new adult sickle cell program and to focus more on the pediatric sickle cell clinics and the critical newborn screening follow-up she provides for all hemoglobinopathies.

Workforce issues continue to exist at the CCC and CDC centers. Positions are increasingly difficult to fill and salaries have grown significantly, especially in the CCC program. VDH provides technical assistance to help partners make critical decisions and continues to encourage the CCC program to ask their health systems for more support. The argument is that care coordination services keep children healthier, reducing the financial burden on each health system because CCC staff help ensure that needs are met. The CDC program has had difficulty finding and hiring developmental pediatricians, social workers, psychologists, and other staff for some time now. VDH continues to hold regular meetings with partners across the state to try and figure out the best solution to this problem.

EMERGING ISSUES

The CYSHCN program continues to focus on equity and data. The CCC and CDC workplans include language regarding the importance of equity and outreach to diverse communities. In Virginia, equity is not just about race. The CYSHCN program wants all people to be a priority. In addition to the language, in work plans, regarding reaching out to minority populations, we also continue to support the infrastructure in southwest Virginia enthusiastically. As described earlier in this document, VDH partners with UVA to maintain certain clinic services. We are also changing some of our report templates to be gender friendly. Our goal is for every single human being to feel welcome anywhere in the state where Title V/MCH funding helps to support services and population health work for CYSHCN and their families.

In addition to the above, the blood disorders coordinator has done a fantastic job building the adult sickle cell network. Data has shown for years that people with sickle cell disease are often not believed when they present with unbearable pain and have been labeled as drug seekers. The CYSHCN program finds this unacceptable. We are proud of the grassroots efforts that helped secure general funds for an adult sickle cell program and the bipartisan support the general assembly provided. Staff will continue to try to fill a gap in the Hampton Roads area and support our partners as they strengthen their relationships with the clinicians, in their regions.

Last, the CYSHCN program continues to make data a priority. Without data, it is difficult to make decisions and to strategize. The program is fortunate to have support from epidemiologists in the Division of Population Health Data. The

staff are very skilled and dedicated to public health. They have published Sickle Cell Newborn Screening data on our website and Child Development Clinic data. This makes our information available to the public to help people make decisions in their regions and helps program leadership identify gaps and improve. Please visit the following two links to view our data:

https://www.vdh.virginia.gov/sickle-cell-programs/sickle-cell-data-collection-program/sickle-cell-data-collection-scdc-newborn-screening-data/

https://www.vdh.virginia.gov/child-development-services/child-development-clinic-data/

In the future, we plan to add data about our bleeding disorders program and CCC program.

PROGRAM LOGOS AND BRANDING

The Care Connection for Children logo has been with the program for over 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 the 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.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS DOMAIN
FY24 APPLICATION YEAR

Blueprint for Change

The Virginia Department of Health (VDH), Children with Special Health Care Needs (CSHCN) program has spent time thinking about the Maternal and Child Health Bureau's (MCHB) new Blueprint for Change, or Blueprint. As described by MCHB, the Blueprint is, "A national framework for a system of services for children and youth with special health care needs (CYSHCN) where they enjoy a full life and thrive in their community from childhood through adulthood". The Blueprint focuses on **quality of life and well-being, access to services, financing of services and health equity (https://mchb.hrsa.gov/programs-impact/focus-areas/children-youth-special-health-care-needs-cyshcn/blueprint-change)**. Virginia's team thinks that the Blueprint complements the overall system outcomes for CSHCN, as listed below:

1. Family Professional Partnerships;
2. Medical Home;
3. Insurance and Financing;
4. Early and Continuous Screening and Referral;
5. Easy to Use Services and Supports;
6. Transition to Adulthood.

The VDH program has been based on the latter for years and the CSHCN unit will continue to carve out much of its work, using the overall system outcomes, as a framework. The program's belief is that the Blueprint is a 30k foot view of the work and the overall system outcomes represent a 10k foot view. In other words, the outcomes can and should be used to help guide VDH in making the Blueprint a reality (in Virginia). Staff will continue to focus on its core CSHCN programs but realizes there needs to be more focus on certain core population health based aims that also help to move the vision of the Blueprint forward.

Recently, the CSHCN team, epidemiology staff, family delegate and youth advisors designed a transition survey (based on the work of *Got Transition* and with their recommendation). The survey was implemented in FY23 and VDH received more than 150 responses from people/families with special health care needs and those without. During FY 24, the CSHCN program decided to make transition its "Blueprint" population health project for the year. Please note the strategy and activities below.

Strategy: Utilize Division of Population Health Data epidemiologists to analyze transition survey data, convene state group of experts to approve report, publish report and plan activities for improvement.

Activity	Expected Completion Date	Responsible Staff
Complete analysis of transition survey results and produce report (epidemiologists)	11/1/23	Parker Brodsky and Dr. Dane De Silva
Present report to CSHCN staff, family delegate, Title V/MCH Director, Adolescent Health Coordinator and approve	12/1/23	CSHCN team, Parker Brodsky, Dr. Dane De Silva, Dana Yarbrough, Cindy deSa, Rachel Brown
Publish report on VDH website	1/15/24	Parker Brodsky and Dr. Dane De Silva and Communications Team/Web Team
Share report with clinical partners and others and request sharing with their colleagues	1/15/24	Marcus Allen and Shamaree Cromartie, Dana Yarbrough, Rachel Brown
CSHCN staff, family delegate, Title V/MCH director, epidemiologists, adolescent health coordinator to brainstorm on actions that can be taken to address findings from survey and plan activities. Once hired, advice will also be sought from the Adolescent Health Program's Youth Advisors. VDH may involve a UVA student who helped to promote the survey, if her schedule allows	6/30/24	CSHCN team, Parker Brodsky, Dr. Dane De Silva, Dana Yarbrough, Cindy deSa, Rachel Brown, Youth Advisors

The goal is to have activities to implement in FY 25 and the activities will be in the FY 25 application. There may even be the possibility of using the survey as part of VDHs MCH Needs Assessment, if the Title V/MCH director thinks this would be helpful and align with her plan. Preliminary results have already been reviewed and mental health concerns were identified, among college age students, who responded. This is not surprising but it is concerning and will certainly be something that VDH will seek to increase awareness of, regarding transition aged youth and encourage action that helps to assure that young people in our state have access to the resources they need.

The narrative below represents our general program related strategies and activities that align with the core outcomes. The alignment with the core outcomes, in general, means that the activities and strategies also align with the Blueprint and can contribute to overall improvements in well-being, access to services, financing of services and health equity.

Strong Systems of Care	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***
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	7/1/24	Cindy deSa
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	Cindy deSa, Marcus Allen will attend
Continue to communicate with partners to promote the modules	Ongoing	Marcus Allen and UVA
Gather any evaluation data or feedback from UVA about the modules	by 6/30/24	VDH & UVA
Tracking of people who complete the modules	by 6/30/24	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. UVA has been working on increasing awareness of this resource nationally. Recently, they were accepted by AMCHP to display a poster at the 2023 national conference. Staff are also having conversations with *Got Transition* regarding a broader partnership, to update the transition 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 Allen, Shamaree Cromartie
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 Cromartie, Marcus Allen, other staff making referrals
All CYSHCN programs will continue to promote medical home and help families find one if needed.	Ongoing	Marcus Allen, Shamaree Cromartie
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 Allen, DMAS, MCOs, CDCs, CCCs
VDH will continue to further develop and strengthen the Adult Sickle Cell program to help assure youth transitioning to adult care have adult services that they need	Ongoing	Shamaree Cromartie

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 and/or behavioral conditions. Upon diagnosis, the centers will share results with families and providers (as approved by parents) and will connect diagnosed CSHCN 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. The Adult Sickle Cell Program will be required to work closely with the pediatric partner in their region to help assure youth transitioning to adulthood have access to sickle cell disease specialty care. VDH will continue to try to identify an adult champion for sickle cell disease in the eastern region. The eastern region has a large pediatric sickle cell population, but the options to transition to an adult provider are few.

Strong Systems of Care	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***
PERFORMANCE MEASURE	NPM 12 - Percent of children with and without special health care needs who received services to prepare for the transition to adult healthcare
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	7/1/24	Cindy deSa
Hold quarterly meetings with UVA to encourage promotion of the resource. Discussions will include a stronger partnership with *Got Transition* and other organizations and broader sharing of the resource at forums such as the AMCHP National Conference	Quarterly	Cindy deSa, Marcus Allen will attend
Continue to communicate with partners to promote the modules	Ongoing	Marcus Allen and UVA
Gather any evaluation data or feedback from UVA about the modules	by 6/30/24	VDH & UVA
Tracking of people who complete the modules	by 6/30/24	VDH & UVA

See narrative above for the medical home modules.

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 Allen
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 Cromartie
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 Cromartie
Encourage all CYSHCN programs to promote the transition and medical home community/family modules and provider modules	Ongoing	Marcus Allen, Shamaree Cromartie, UVA development team
Identify an adult champion for sickle cell disease in the eastern region.	July 2024	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 CSHCN 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. VDH will continue to try to identify an adult champion for sickle cell disease in the eastern region. The eastern region has a large pediatric sickle cell population, but the options to transition to an adult provider are few.

Finances as a Root Cause	PRIORITY 3 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 CSHCN 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 Allen, Shamaree Cromartie
Work towards increased support from health systems to pay for care coordination services through the CCC program	Ongoing	Marcus Allen
Administer a Care Connection for Children pool of funds for payment of direct medical care services for the uninsured and underinsured clients.	Ongoing	Marcus Allen
Administer a bleeding disorders pool of funds for payment of direct medical care services for the uninsured and underinsured clients.	Ongoing	Shamaree Cromartie
Manage an insurance case management contract to help assure people with bleeding disorders have ongoing access to insurance.	Ongoing	Shamaree Cromartie
Continue to encourage social work support at the VBDP and SCP centers across the state	Ongoing	Shamaree Cromartie
Continue to engage DMAS regarding issues clients experience getting durable medical equipment or access to need medications/therapies	Ongoing	Marcus Allen, DMAS staff (Virginia's Medicaid agency), partners
The Virginia Bleeding Disorders program will use the needs assessment completed by VCU to inform program changes as capacity and funding allow	By June 2024	Shamaree Cromartie and VCU
The CSHCN director will continue to promote health equity as required in the CCC and CDC work plans. VDH epidemiologists will partner with the CSHCN program to publish data for the CCC program	By June 24	Marcus Allen, CCC/CDC, epi partners
VDH CSHCN 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 97.6% 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.

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 FY24.

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 Allen
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 Allen, Shamaree Cromartie
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 Cromartie, 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 Cromartie
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. This year, the CCC program will implement its parent survey. The last one was done in 2018. Data gathered helps to inform program changes and serves as a barometer to help manage client satisfaction.

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. The VBDP will continue to educate families on home therapy management for those who infuse at home. The SCP centers will continue to offer genetic counseling to aid in future reproductive decision making. The regional centers will provide events for families or send families to other programs, including social gatherings and overnight camps 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).

Community, Youth, Family Leadership	PRIORITY 4 Community, Faily, & Youth Leadership: Provide a dedicated space, technical assistance, and financial resources to advance community leadership in state and local maternal and child health initiatives
PERFORMANCE MEASURE	SPM 5 – Cross-cutting (family leadership): Percentage of VDH CYSHCN programs that annually demonstrate active incorporation of family engagement (Care Connection for Children, Child Development Centers, Bleeding Disorders Program, Sickle Cell Program)
OBJECTIVE	Support and document annual family engagement in 100% of CYSHCN programs (Care Connection for Children, Child Development Centers, Bleeding Disorders Program, Sickle Cell Program)

Strategy 1: 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 Allen, Shamaree Cromartie

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 Allen
Collaborate with CCC Directors to encourage staff to become and maintain certifications as case managers	Ongoing	Marcus Allen
Convene center director/consultant meetings to provide technical assistance and troubleshoot issues. Staff will make annual site visits and/or offer technical assistance via phone or email as time permits	Ongoing	Marcus Allen, Shamaree Cromartie
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 Allen, CDC centers
CSHCN 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.	Ongoing	CDC Centers
The VBDP committees will identify goals and outcome measures to achieve throughout the year. There were four priority committees identified throughout the process: Females with Bleeding Disorders, Overcoming Distance or Travel Barriers, Transition to American Thrombosis & Hemostasis Network (ATHN) Clinical Manager Reporting, and Expansion of Services in Northern Virginia (NOVA).	Ongoing	Shamaree Cromartie VBDP
Southwest Virginia CCC will continue to support onsite telehealth services for families in partnership with UVA.	Ongoing	SWVA CCC staff and UVA
The CCC Program will distribute its parent survey across the state and analyze the data	Summer-Fall of 2023	Dane De Silva, CSHCN staff, Virginia Commonwealth University-Survey and Evaluation Research Laboratory, CCC centers, parents
CCC Program will update its assessment tool in the CCC-SUN database and make it	Summer-Fall of 2023=template	Ryan Malpaya (Public Health Intern), CCC

functional with the database .	draft completion Summer 2024=database integration	staff, Marcus Allen, Shamaree Cromartie, VDH Information Technology Staff

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.

The VBDP will continue to use the needs assessment conducted in FY 22 to guide their efforts to improve care for the bleeding disorders population. The committees will: work to increase awareness and expand access to VBDP for women with bleeding disorders, create strategies to reduce distance as a barrier to care, transition to use of ATHN Clinical Manager to better represent the patients served by HTCs, and explore contracting with Georgetown HTC to serve Virginia adult population not receiving VBDP services in NOVA.

For many years, the CCC program has contracted with the Virginia Commonwealth University (VCU)-Survey and Evaluation Research Laboratory to survey parents. Survey questions ask them about their satisfaction with the support they receive. The questions relate to the core outcomes for children with special health care needs, such as medical home, transition, support understanding insurance, help accessing care, etc. This year, our Public Health Epidemiologist Supervisor will be managing the contract with VCU. The implementation usually takes several months to complete and VCU leads the analysis of the data. Once done, the data will be presented to partners. It will be used to help make program improvements and we will be able to compare the newly collected data with previous years.

The CCC program has an outdated assessment tool that is part of its care coordination database (CCC-SUN). Recently, VDH was fortunate enough to receive help from an intern. Through collaboration with program directors, care coordinators, and other essential personnel, he will update the assessment tool to ensure families of CYSHCN receive optimal services via a well-functioning system. Updates in the assessment tool include removing repetitious questions and implementing new challenge categories such as "Health-Related Social Needs." Suggestions/Inputs gathered from other care connection teams will be integrated into the updated assessment tool. VDH information technology will condense the new data into CCC Sun. This is a very complex project that we hope to be able to complete in FY24 but it may extend into FY25.

The CDC program has rebounded some from COVID but service levels continue to be less than what they were in 2019, before COVID. The CSHCN director continues to consult with center partners and holds regular leadership meetings. Workforce struggles plague the program, however, center partners are resilient and continue to search very hard for qualified staff. During FY 24, partners will continue to explore other options for dealing with workforce struggles. A couple of centers have had developmental pediatrician positions open for years. Some have hired nurse practitioners to help with the workload. This is not an option for two centers in a remote area of the state. They employ psychologists who complete the assessments and diagnose children. During FY 24, the network will collectively consider whether or not the hiring of more psychologists statewide, who are interested in this work, is feasible (although the filling of these positions is often difficult too).

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	2022
Annual Objective			100	100
Annual Indicator	100	100	100	100
Numerator		436	301	286
Denominator		436	301	286
Data Source	VDH Newborn Screening Program, VDH EHDI	VDH Newborn Screening Program, VDH EHDI	VDH Newborn Screening Program, VDH EHDI	VDH Newborn Screening Program, VDH EHDI
Data Source Year	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final

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

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			Yes	Yes
Annual Indicator		No	Yes	Yes
Numerator				
Denominator				
Data Source		OFHS MCH Program Documentation	OFHS MCH Program Documentation	OFHS MCH Program Documentation
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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

Create a workgroup across OFHS to revise the 2021 Maternal Health Strategic Plan

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 FY22 ANNUAL REPORT

DOMAIN CONTRIBUTORS

Adolescent Health Program– Division of Child and Family Health - Repro Health Unit
Newborn Screening Program - Division of Child and Family Health
Local Health Districts

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.

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

STATE ACTION PLAN UPDATES

Community, Youth, Family Leadership	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.

Racism as a Root Cause	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.

There are currently five MCH Team members who participate in the cohort alongside Urban Baby Beginnings – OFHS Director, Title V Director, Resource Mothers/State Doula Certification Coordinator, MCIEHV Director, and the Maternal Mortality Programs Manager alongside the Executive Director of Urban Baby Beginnings.

The monthly learning and practice cohort meetings and Mural Board activities stepped each team through a decision making process designed to direct each team towards a strategic area on which to focus for the remainder of the cohort. Virginia's team chose: *Restructure Title V funding requirements to support community-based organizations and interdisciplinary perinatal providers with an anti-racist, equity-centered, reproductive justice framework.* Through this strategy, Virginia's team further 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.

The major focus on this workgroup will be to discover and implement collaborative approaches to develop, strengthen, and support the doula workforce in Virginia, including: Increasing opportunities for the individual doula seeking training, certification, and Medicaid reimbursement for services; strengthening doula collaboratives wishing to expand their services across Virginia's pregnant and birthing population who receive Medicaid – including coordination with local health districts; and enhancing and empowering the statewide doula community-at-large through community-driven creation of statewide governing organization.

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

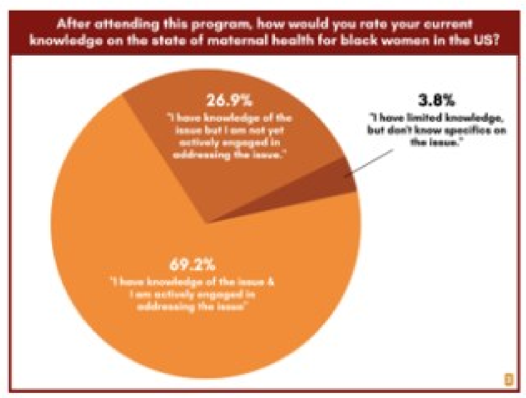
The Blue Ridge Health District and Birth Sisters of Charlottesville, a doula collective supporting BIPOC mothers, is one of eight teams selected national for the CityMatCH Alignment for Action Learning Collaborative (AAC), a two-year initiative, which began in March 2021, and will continue through March 2023. 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 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.

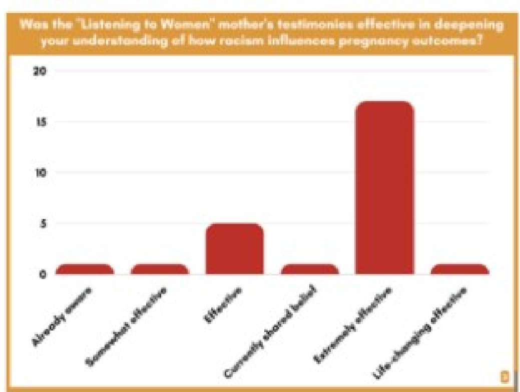
This Team meets weekly, and receives monthly TA support from CityMatCH. The Team plans to work across three domains:

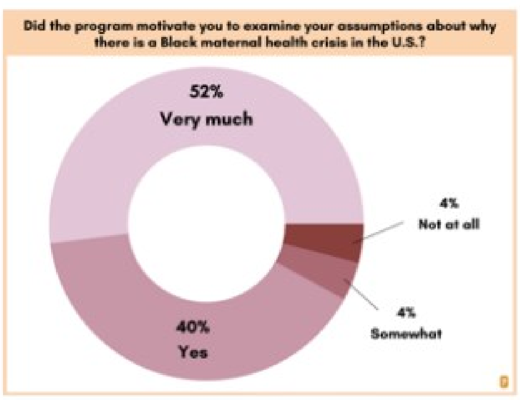
- Create a method by which the black woman's birthing experience is shared back to the medical community to evoke process/systems change
- Explore methods by which Black medical providers, including nurses, midwives, pediatricians and OB/GYN providers, who train at University of Virginia will remain and serve the Black birthing community or methods by which new Black providers can be recruited and retained
- Serve as a clearinghouse for information and awareness regarding black maternal mortality

From the onset of the Learning Collaborative Team, one strategy centered around planning, preparing, and launching a virtual event called "Listening to the Living: Centering Black Women's Birth Experiences". In celebration of Black Maternal Health Week, the event was held on April 12, 2022. The 2-1/2 hour agenda featured Dr. Arthur James, a National Leader in birth equity, as the Keynote Speaker. Patrice Wright, a Sociology PhD Candidate at University of Virginia, shared her research findings regarding race, culture, and inequality in reproductive health. A panel of Charlottesville care providers, including the Executive Director of Birth Sisters of Charlottesville. The most significant piece to this event, however, were the shared stories from three Black Women, all residents of Charlottesville, who were willing to share their birth story. The event ended with a call to action by the Executive Director of Birth Sisters of Charlottesville.

The event was intended to focus on the Charlottesville/Blue Ridge Health District maternity care community – however, registration was opened to VDH teams across all 35 health districts. There were a total of 185 registrants with 119 attendants, 110 of whom stayed for the entirety of the 2-1/2 hour virtual event. A total of 28 people completed the post-event survey, with a number of tangible take-aways, satisfying the Team's overall goal of drawing consensus and evoking action regarding the poor birth outcomes for Black Women.







A recording of the event remains available at www.listeningtotheliving.org. The recording has been shared widely across the Charlottesville maternity care community, and across Virginia's MCH community through collaborative networks including the local health districts and through the Virginia Neonatal Perinatal Collaborative. The recording continues to be shared and watched.

Continued work by the Learning Collaborative Team, includes the ongoing development of a black birth plan, networking and building stronger foundations and influence in the Charlottesville maternity care community, and exploring ways to bring Black maternity care providers into the community.

Strategy 3: Local Health District (LHD) Strategy: Increase opportunities for workforce development for LHDs to align with MCH leadership competencies

Beginning Fall FY23, the Local Health Districts were given the opportunity to participate in the MCHsmart asynchronous learning environment available through the MCH Navigator, housed within The National Center for Education in Maternal and Child Health (NCEMCH). MCHsmart contains 12 modules, one for each MCH leadership competency, with a pre- and post-test regarding each module. Twelve of the 35 districts selected this activity for their MCH Teams to focus on during FY23. An initial TA call was held with the districts and leadership from NCEMCH, and participants were given a special passcode to use at registration, so that Virginia participant information could be aggregated. The districts will have continued access to engage with the learning environment and complete the modules during FY23.

MCH Data Capacity	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

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 program also provides staff support to the Virginia Rare Disease Council (RDC). 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). The NBSP is currently establishing a long-term follow-up program for monitoring newborn bloodspot screening disorder outcomes.

Virginia currently screens for 35 of the 37 targeted disorders on the national recommended universal screening program (RUSP) as well as 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. Virginia initiated screening for Spinal Muscular Atrophy (SMA) and X-linked Adrenoleukodystrophy in March 2022. The CCHD program focus is on quality assurance and passive surveillance. All infants identified with a confirmed newborn screening disorder, including positive CCHD newborn screens, are referred to CYSHCN care coordination services. Infants identified with hearing loss through the EHDI program are automatically referred to Early Intervention for care coordination services. The VNSP maintains a 100% referral rate for care coordination services, unless a healthcare provider notes that a referral is not indicated, or the infant has already been referred for services.

In 2021, Virginia had a total of 96,072 births. A total of 93,894 (97.7%) of infants born were screened for hearing, with 92,298 infants passing overall. Of the infants who received a hearing screen, 5,223 passed with risk and 3,325 infants did not pass the initial hearing screening. Of the infants who did not pass the initial hearing screening, 137 were diagnosed with permanent hearing loss, of which 137 (100%) of these infants were referred to Part C Early Intervention services. A total of 94,711 (98.5%) of infants born received a bloodspot newborn screen. Of the infants that received a bloodspot newborn screen, 13,814 (14.6%) had an out-of-range result (abnormal) requiring follow-up services or diagnostic testing. Of these infants, 1,602 (1.69%) had a critical (presumptive positive) targeted newborn bloodspot screening disorder result with 148 confirmed diagnosed cases referred for care coordination. A total of 62,403 (70%) of all infants born were reported to have a CCHD screen. A total of 29,369 (30%) infants did not have record of screening reported, and 4,586 (15.6%) infants of these were not screened due to prenatal diagnosis, parent refusal, NICU admission, or other reasons. Of these infants screened, 76 (0.12%) had a reported failed screen with one confirmed case. Challenges in staffing for all programs resulted in delays in follow-up reporting and case closures.

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, healthcare providers, and hospitals report confirmed cases into the Virginia Congenital Anomalies Reporting and Education System (VaCARES) until two years of age. 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. The BDS program successfully engaged a CCHD NBS Program/Rare Disease Council (RDC) Coordinator in October 2022. This has expanded the CCHD NBS program has expanded its capacity to initiate, document, and track referrals to Care Connection for Children.

Future plans include enhancing the active surveillance of the BDS program to provide quality assurance to hospitals. By ensuring compliance of reporting, the program will have a better understanding of the impact of birth defects on Virginia's population.

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, continued to serve 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. The product has been piloted and the Virginia NYMAC team is currently assessing feedback for continued development and improvements. NYMAC presented to the RDC in September 2022 about the needs of individuals affected by rare diseases as they relate to genetic services in Virginia. These types of partnerships will assist the RDC with advising the Governor and the General Assembly about potential policy improvements.

Upstream/ Crosssector Strategic Planning	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 Rare Disease Council includes representation from, and engages with, individuals diagnosed with rare diseases, caregivers, patient organization representatives, healthcare providers, researchers, insurance and biotechnology companies, and other community partners to identify health inequities for individuals affected by rare diseases in order to advise the Governor and the General Assembly about potential policy improvements. 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.

In order to thoroughly address Diversity Equity and Inclusion (DEI) in EHDI systems, it was essential to consult with experts within this field of work. In partnership with Virginia Commonwealth University (VCU), Partnership for People with Disabilities, VA EHDI worked with the Virginia Center for Inclusive Communities (VCIC) to establish the first series of diversity, equity and inclusion training for stakeholders within the EHDI system. From January to May of 2022, VA EHDI and CFI hosted a webinar series in two cohorts: Your Role in Workplace, Diversity, Equity & Inclusion. These included the following webinars: Foundations
of Diversity and Inclusion and Inclusion/ Unconscious Bias 101, Unconscious Bias 201, Cycle of Prejudice, Microaggressions, Exploring Race and Racial Equity, and Exploring Socioeconomic Status. Due to resounding positive feedback, in the October to December 2022, VA EHDI hosted the Diversity, Equity and Inclusion Lunch and Learn Workshop series, which included the following sessions: Intersectionality, Fostering LFBTQ+ Inclusion, Microaggressions, Building Facilitation Skill for Dialogue, Creating Upstander/Active Bystander Cultures, Creating a Sense of Belonging.

Additionally, prenatal and postnatal education are important aspects of increasing awareness of hearing screening prior to birth and to allow families to be prepared with next steps if their child fails the initial hearing screening. In 2019, the Virginia EHDI team launched a pilot program with Home Visiting agencies in Northern Virginia to provide education for prenatal mothers regarding newborn hearing screening. Survey results highlighted that many families were not aware that their child would be getting a hearing screening after birth. This pilot highlighted the need for continued prenatal education and identified a gap in existing prenatal education regarding newborn screening programs. In Early 2020, the VA EHDI program

created a diversity and inclusion DEI plan that outlined improvements to the program which support intentional changes to ensure inclusion and diversity in all areas of the program.

One major change included the development of a plan is to collaborate with the Blood Spot Screening program in Virginia to increase prenatal outreach regarding the newborn screening programs. The NBSP collaborated with VA EHDI in FY22-23 on a Prenatal Outreach initiative to consolidate and disseminate educational materials and community resources to expecting parents and prenatal health care providers. The aim of this collaboration was to increase understanding of newborn screening in addition to improving health literacy relating to the newborn period for both infants and their caregivers. The VNBSP is currently collaborating with the Department of Consolidated Laboratory Services (DCLS) on a Primary Care Provider Outreach initiative to improve timeless of newborn bloodspot screening follow-up. The aim of this collaboration is to provide training and education to primary care providers offering pediatric services to encourage collections of repeat newborn bloodspot screens in office, rather than outpatient laboratory settings. This initiative will also focus on improving communication between the programs and healthcare providers in support of the overarching mission of the VNBSP. This collaboration is ongoing with plans for future joint outreach.

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

EHDI Staff continue their work with VCU's Center for Family Involvement to provide family to family support. They also 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 2022, VA EHDI started planning the first Statewide VA EHDI conference to be held in January 2023.
The Virginia Early Hearing Detection and Intervention (VA EHDI) program continues efforts to create technological and system enhancements to educate families, providers, and stakeholders and decrease loss to follow-up and lost to documentation within the EHDI system. Additionally, VA EHDI continues to evaluate the Virginia Infant Screening & Infant Tracking System (VISITS), which is the EHDI Information System (EHDI-IS), for accuracy and efficacy. Implementation of new program elements, such as the automated follow-up efforts via VISITS and an enhanced follow up plan, have helped to ensure improved and timely communication efforts with stakeholders and families. The enhancements in VISITS include updates to the texting platform, implementation of an Interactive Voice Response system for incoming calls, and continued updates to the VA EHDI website. These advancements aid in decreasing loss to follow-up, as well as meeting the Centers for Disease Control (CDC) 1-3-6 guidelines.
In 2023, the focus of the SLC will be data driven decision making and establishing workgroups focused on relevant programmatic updates such as the development of ENT Guidelines, Data Driven Decisions, and Quality Improvement (QI) activities. The SLC was tentatively scheduled for virtual meetings in May and November 2022; however, due to lack of responses and concerns about low participation, the SLC meeting has been postponed to February 2023 for an in-person meeting. The tentative agenda for this meeting will include the following: programmatic updates and enhancements, review and discussion of data, and workgroup sessions related to the development of the ENT guidelines and QI activities.

VIRGINIA
Newborn
BLOODSPOT
Screening
PROGRAM

EHDI
VIRGINIA

CROSS-CUTTING/SYSTEMS BUILDING DOMAIN
FY24 APPLICATION YEAR

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

Building on the work done by the Summer 2022 National MCH Workforce Development Center Interns, the Title V Leadership Team, including our Family Delegate, will finalize this strategy in FY24, utilizing this measure to inform family engagement across the 2025 Needs Assessment process.

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

The Learning and Practice Cohort through AMCHP ended in January 2023; however, Virginia's TV Team and Urban Baby Beginnings continue to meet monthly. Activities for FY24 will include continued exploration and development of workforce development opportunities that will grow, strengthen, and sustain Virginia's doula community.

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

The CityMatCH Learning Collaborative ended in March 2023; however, the three primary groups of this Collaborative continue to meet monthly and advance the original goals of evoking systems change across the perinatal community in Charlottesville, VA regarding care provision to BIPOC birthing people.

Strategy 3: Local Health Districts (LHD) Strategy: Increase opportunities for workforce development for local health districts to align with MCH leadership competencies

The LHD work plans for FY24 will include the opportunity for continued participation in the MCH Smart asynchronous learning community through National Center for Education in Maternal and Child Health - MCH Navigator. For those district teams that completed the learning modules during FY23, continued utilization of MCH Smart will be encouraged throughout FY24 as part of new staff onboarding and orientation, and opportunities for team building exercises.

Strategy 4: Create a workgroup across OFHS to revise the 2021 Maternal Health Strategic Plan

In April 2021, the Governor's Office released a Maternal Health Strategic Plan, with the aim of eliminating the racial disparity in maternal mortality in Virginia by 2025. The plan outlines six specific strategies and twenty recommendations for achieving this goal. Several of the strategies and recommendations align with the work being done through OFHS, in partnership with sister agencies, and local, district, and state stakeholders. Revision of this strategic plan during FY24 will further align efforts to address racism and inform future year strategies and activities.

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. Solicitation of public input is an ongoing process, as summarized below.

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.

Stakeholder Comment and Input: REDCap 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. Historically, this survey was distributed after the state's annual federal grant review and before the federal deadline for edits to the state's Title V submission.

To better meet recommended guidelines to solicit feedback during the development of the Application/Annual Report, this year, Title V staff made the FY24 State Action Plan available for formal comment and feedback by Sister Agencies, Local Health District MCH staff, and central office MCH staff and stakeholders via a REDCap survey before report transmittal.

The survey was administered as follows:

- A REDCap survey was developed including a link to the draft FY24 State Action Plan. Stakeholders and staff were asked to review the draft and then complete the survey with a 14-day deadline.
- To recruit respondents, the survey details were emailed directly from the MCH Epidemiologist to a wide range of central staff, Local Health Districts, and state agencies. State agencies and partners included:
    - Department of Social Services
    - Department of Behavioral Health and Developmental Services
    - Department of Medical Assistance Services
    - Virginia Neonatal Perinatal Collaborative
    - Division of Community Nutrition, VDH
- 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.

Overall, 42 individuals responded to the survey and represented primarily local or state health department employees (85.7%), and included parents of a child/adolescent, community members, and health care providers. Nearly three quarters of all participants (74.4%) were 35 years of age or older and all identified as female. Additionally, 4.8% identified as Hispanic (All Races), 19% identified as Non-Hispanic Black, and 69% identified as Non-Hispanic White. Respondents indicated their primary residence or work location were within the Central and Southwest regions of the state.

When asked about familiarity about Title V:

- 100% (N = 38) of respondents were moderately or extremely familiar with the purpose of the Title V Block Grant
- 100% (N = 38) of respondents were moderately or extremely familiar with the programs and services available through the Title V Block Grant
- 100% (N = 38) of respondents were moderately or extremely familiar with Virginia's MCH priority needs
- 81.6% (N = 31) of respondents were moderately or extremely familiar with Virginia's MCH national and state performance measures
- 92.1% (N = 35) of respondents were moderately or extremely familiar with current strategies and activities to address Virginia's MCH priority needs

No additional comments about the individual priorities within each population domain was received. However, one respondent indicated strong agreement that priorities within each domain were important issues to be addressed.

Direct Submission of Comments or Inquiries

A copy of the current application and contact information for the Title V Director are made publicly available on the VDH Title V website to facilitate submission of any additional public comments or inquiries throughout the year.

III.G. Technical Assistance

Virginia’s Title V Program will seek Technical Assistance for FY24 from the National MCH Workforce Development Center. The TA application to the Single State Intensive TA will focus on reviewing Title V and other federal funding allocations across all MCH programs, to ensure that all parts of the system are functioning more efficiently, effectively, and that Virginia is leveraging available resources to the maximum ability, with the goal of increasing the reach and impact of MCH with existing/ available funds.

There will be specific attention to the way that Title V funds are distributed and utilized in the 35 local health districts.

Stronger financial reporting tools will be designed during this process as well.

The TA Work Group will include Title V Leadership Team, which includes: MCH/Title V Director, CYSCHN Director, DCFH Director, OFHS Director, and Title V’s Fiscal Grant Manager.

The Work Group will aim for budget transformation to align with the next five year work plan, beginning FY26.

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 - VA LHD Activity Bundles for FY22.pdf

Supporting Document #02 - VA_Sup Doc 1 - Maternal Health Strategic Plan_FY22.pdf

Supporting Document #03 - Youth Transition Survey.pdf

Supporting Document #04 - MCH Key Partners List.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - 2023 Virginia Title V Organization Chart and programs chart.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Virginia

	FY 24 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 12,692,968	
A. Preventive and Primary Care for Children	$ 5,128,714	(40.4%)
B. Children with Special Health Care Needs	$ 4,223,332	(33.2%)
C. Title V Administrative Costs	$ 975,905	(7.7%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 10,327,951	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 9,520,837	
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)	$ 2,250,433	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 13,473,960	
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)	$ 26,166,928	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 16,104,022	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 42,270,950	

OTHER FEDERAL FUNDS	FY 24 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 160,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 1,376,062
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 7,622,952
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 332,487
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	$ 1,144,121
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 5,015,050
Department of Health and Human Services (DHHS) > Other > Virginia Mental Health Access Program (VMAP)	$ 453,350

	FY 22 Annual Report Budgeted		FY 22 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 12,457,398 (FY 22 Federal Award: $ 12,682,968)		$ 12,457,398	
A. Preventive and Primary Care for Children	$ 3,795,675	(30.5%)	$ 5,033,530	(40.4%)
B. Children with Special Health Care Needs	$ 5,130,124	(41.2%)	$ 4,144,950	(33.2%)
C. Title V Administrative Costs	$ 1,227,859	(9.9%)	$ 957,793	(7.7%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 10,153,658		$ 10,136,273	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 6,092,387		$ 9,344,139	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 1,702,690		$ 1,702,690	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 1,547,972		$ 2,250,433	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 9,343,049		$ 13,297,262	
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		$ 25,754,660	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 17,859,944		$ 14,896,683	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 39,660,391		$ 40,651,343	

OTHER FEDERAL FUNDS	FY 22 Annual Report Budgeted	FY 22 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	$ 773,249	$ 879,857
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 7,622,952	$ 7,377,935
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 235,000	$ 219,054
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 160,000	$ 150,953
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 2,522,297	$ 0
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Comprehensive Cancer Control Program (NCCCP)	$ 366,200	$ 0
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 4,660,000	$ 4,568,385
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Sexual Risk Avoidane Education	$ 1,324,796	$ 1,169,001
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sickel Cell Data Collection Program (SCDC)	$ 195,450	$ 0
Department of Health and Human Services (DHHS) > Other > Pediatric Mental Health Care Access		$ 431,289
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative		$ 100,209

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:	**2022**
	Column Name:	**Annual Report Expended**

Field Note:
Care for Children costs came in at below the budgeted estimate due to a realignment of domains in order to more adequately address the needs of Adolescents needing MCH services.

2.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**

Field Note:
CYSHCN costs came in at above the budgeted estimate due to a realignment of domains in order to more adequately address the needs of Adolescents needing MCH services.

3.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**

Field Note:
Admin costs were reduced from the 1,227,859 budgeted in the FY21 application to $957,793 as they were found to be in program costs for FY22.

4.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**

Field Note:
State Match funds increased to include more match funds (entire 75% match of $9,344,139) in addition to other funds (Newborn Screening of $1,702,690) and Program income (Child Development Assessment Clinic Assessments of $2,250,433), which also increase from $1,707,091.

5.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**

Field Note:
This self-reported figure is based on billings for assessments in the Child Development Clinics. Last year, this figure was $1,707,091. Both the number of assessments and the cost increased from FY21. This money is put back into the program to sustain it as this is a public private partnership and the clinics must contribute to this effort.

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 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 611,358	$ 600,011
2. Infants < 1 year	$ 1,373,154	$ 1,347,670
3. Children 1 through 21 Years	$ 5,128,714	$ 5,033,530
4. CSHCN	$ 4,223,332	$ 4,144,950
5. All Others	$ 380,505	$ 373,444
Federal Total of Individuals Served	$ 11,717,063	$ 11,499,605

IB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 460,767	$ 452,216
2. Infants < 1 year	$ 460,767	$ 452,216
3. Children 1 through 21 Years	$ 1,842,238	$ 1,808,048
4. CSHCN	$ 6,259,325	$ 6,143,157
5. All Others	$ 460,767	$ 452,216
Non-Federal Total of Individuals Served	$ 9,483,864	$ 9,307,853
Federal State MCH Block Grant Partnership Total	$ 21,200,927	$ 20,807,458

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2024**
	Column Name:	**Application Budgeted**
	Field Note: Reduced by $1.00 (rounding) to match award.	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: Rounded down to match award.	

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 24 Application Budgeted	FY 22 Annual Report Expended
1. Direct Services	$ 115,640	$ 113,493
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 13,644	$ 13,391
B. Preventive and Primary Care Services for Children	$ 101,207	$ 99,328
C. Services for CSHCN	$ 789	$ 774
2. Enabling Services	$ 6,358,313	$ 6,240,309
3. Public Health Services and Systems	$ 6,219,015	$ 6,103,596
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		$ 31,490
Physician/Office Services		$ 1,492
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 71,833
Laboratory Services		$ 8,678
Direct Services Line 4 Expended Total		$ 113,493
Federal Total	$ 12,692,968	$ 12,457,398

IIB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Direct Services	$ 9,023,097	$ 9,279
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 921,534	$ 4,640
B. Preventive and Primary Care Services for Children	$ 1,842,238	$ 4,639
C. Services for CSHCN	$ 6,259,325	$ 0
2. Enabling Services	$ 4,747,663	$ 4,667,429
3. Public Health Services and Systems	$ 4,747,664	$ 4,667,430
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		$ 5,220
Physician/Office Services		$ 4,059
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 9,279
Non-Federal Total	$ 18,518,424	$ 9,344,138

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIA. Federal MCH Block Grant, 4. Physician/Office Services**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**

Field Note:
Rounded down to equal total direct services.

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

State: Virginia

Total Births by Occurrence: 96,072 **Data Source Year: 2021**

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	94,711 (98.6%)	3,274	286	286 (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 I (MPS I)	Primary Congenital Hypothyroidism	Propionic Acidemia
S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	ß-Ketothiolase Deficiency
Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency		

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

There is no formal long-term monitoring or follow-up process that occurs with infants diagnosed through the Virginia Newborn Screening Program (VNSP); however, the VNSP does have a process in place to refer screen positive infants to Care Connection for Children (CCC) of the VDH Children with Special Health Care Needs Program. The CCC is a statewide network of Centers of Excellence for Children with Special Health Care Needs (CSHCN) that facilitates access to comprehensive medical, support, and case management services for all CSHCN served under VDH programs. The program is currently establishing a long-term follow-up program for dried blood-spot disorder outcomes.

Form Notes for Form 4:

Note for 2022 reporting year:
Data reported from most recent validated data year 2021; 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 Receiving At Least One Screen**
	Fiscal Year:	**2022**
	Column Name:	**Core RUSP Conditions**

Field Note:
For Critical Congenital Heart Disease: 29369 infants did not have record of screening reported, and 4586 infants were not screened due to prenatal diagnosis, parent refusal, NICU admission, or other reasons. Defined as total number of infants born in 2021 with Pulse Oximetry results reported into VISITS of (Negative (Pass) or Positive (Fail)). Other responses include Not Screened (along with reason for not screened) and Missing (no screen result reported).

Spinal Muscular Atrophy (SMA) and X-linked Adrenoleukodystrophy (X-ALD) were both added to the panel on March 16, 2022. Virginia is in early stages of forming workgroups to review implementation of Guanidinoacetate Methyltransferase (GAMT) deficiency and Mucopolysaccharidosis Type 2 to the panel.

2.	**Field Name:**	**Core RUSP Conditions - Total Number of Out-of-Range Results**
	Fiscal Year:	**2022**
	Column Name:	**Core RUSP Conditions**

Field Note:
For Critical Congenital Heart Disease only: Defined as total number of infants born in 2021 with a Positive (Fail) Pulse Oximetry Screening result reported into VISITS.

3.	**Field Name:**	**Core RUSP Conditions - Total Number Confirmed Cases**
	Fiscal Year:	**2022**
	Column Name:	**Core RUSP Conditions**

Field Note:
For Critical Congenital Heart Disease only: Defined as total number of infants born in 2021 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 that started with last year's report. Using the prior definition, there were 117 infants with a confirmed CCHD diagnosis (note: 2021 follow-up continues until infants reach 2 years of age). One infant had reported pulse oximetry values in the pass range with a reported "positive/fail" result; another infant had reported pulse oximetry values in the retest range with a reported "negative/pass" result: these infants are not included in the counts for this column.

4.	**Field Name:**	**Core RUSP Conditions - Total Number Referred For Treatment**
	Fiscal Year:	**2022**
	Column Name:	**Core RUSP Conditions**

Field Note:
For Critical Congenital Heart Disease only: Defined as the total number of confirmed CCHD cases (as defined by (C)) who were referred to CCC as a result of CCHD follow-up. This reflects a change in case definition that started with last year's report. Using the prior definition, there were 67 infants referred to CCC as a result of CCHD follow-up (note: 2021 follow-up continues until infants reach 2 years of age).

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 2022

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	7,522	31.4	0.0	63.3	5.0	0.3
2. Infants < 1 Year of Age	2,870	31.4	0.0	63.3	5.0	0.3
3. Children 1 through 21 Years of Age	21,703	25.0	0.0	69.0	6.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	7,152	34.0	0.0	65.0	1.0	0.0
4. Others	9,466	10.0	0.0	81.0	9.0	0.0
Total	41,561					

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	95,825	No	95,647	100.0	95,647	7,522
2. Infants < 1 Year of Age	96,062	No	96,072	98.6	94,727	2,870
3. Children 1 through 21 Years of Age	2,254,555	Yes	2,254,555	100.0	2,254,555	21,703
3a. Children with Special Health Care Needs 0 through 21 years of age^	434,199	Yes	434,199	100.0	434,199	7,152
4. Others	6,295,251	Yes	6,295,251	30.5	1,920,052	9,466

^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:	**2022**
	Field Note: Data note for reporting year [2022]: Resource Mothers Program Data (REDCap entries from community health workers); WebVision – Report #081 from the Data Warehouse using the date range Oct 1, [2021] to Sep 30, [2022]; Number reported Title V funded BabyCare (Prenatals) services from LHDs (WebVision – Report #009 using the date range Oct 1, [2021] to Sep 30, [2022]); Number reported includes pregnant and postpartum women receiving safe sleep kits/counseling/education/maternity/referral services from LHDs - obtained from LHD reports.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2022**
	Field Note: Data note for reporting year [2022]: 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 (CY2021, 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, [2021] to Sep 30, [2022]); Number reported includes infants receiving safety seats/immunizations/case management services from LHDs - obtained from LHD reports.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2022**
	Field Note: Data note for reporting year [2022]: WebVision – Report #081 from the Data Warehouse using the date range Oct 1, [2021] to Sep 30, [2022]; 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.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2022**
	Field Note: Data note for reporting year [2022]: 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.	
5.	**Field Name:**	**Others**

	Fiscal Year:	**2022**
	Field Note: Data note for reporting year [2022]: WebVision – Report #081 from the Data Warehouse using the date range Oct 1, [2021] to Sep 30, [2022]; 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); Pregnancy loss services program data (number receiving services); Number of doulas certified during reporting period; Number reported includes others receiving counseling/education services from LHDs - obtained from LHD reports.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2022**
	Field Note: Data note for reporting year 2022: 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 (including water fluoridation project) and educational activities.	
2.	**Field Name:**	**Pregnant Women Denominator**
	Fiscal Year:	**2022**
	Field Note: Data note for reporting year 2022: Denominator obtained from Virginia Vital Statistics data (2021) for resident births.	
3.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2022**
	Field Note: Data note for reporting year 2022: Number reflects infants who received at least one newborn screening test. Percentage is rounded based on Form 4. Title V provides 100% salary support for Mat/Inf Consultant, EHDI program manager staff and Birth Defects surveillance coordinator; provides support for VACARES; support to perinatal collaboratives.	
4.	**Field Name:**	**Infants Less Than One Year Denominator**
	Fiscal Year:	**2022**
	Field Note: Data note for reporting year 2022: Denominator obtained from Virginia Vital Statistics data (2021) for occurrent births.	
5.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2022**

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.

6.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2022**

Field Note:
Data note for reporting year 2022: 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.

7.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2022**

Field Note:
Data note for reporting year 2022: 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). Counts for this population will continue to be improved for accuracy.

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Virginia

Annual Report Year 2022

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	99,581	53,986	21,147	15,551	154	7,626	116	0	1,001
Title V Served	95,647	52,586	19,686	15,019	150	7,248	106	0	852
Eligible for Title XIX	30,109	11,400	10,792	6,583	52	1,036	25	0	221
2. Total Infants in State	96,072	52,158	20,327	15,151	149	7,303	111	0	873
Title V Served	94,711	51,419	20,039	14,936	147	7,200	109	0	861
Eligible for Title XIX	30,031	11,377	10,752	6,570	52	1,034	25	0	221

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: Note for reporting year 2022: Data reported are most recent validated year (2021) of Virginia Vital Events Statistics	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: Data note for reporting year 2022: Data obtained from Virginia Vital Statistics data (2021) for resident births by race/ethnicity.	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: Note for reporting year 2022: Data reported are most recent validated year (2021) of Virginia Vital Events Statistics.	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: Note for reporting year 2022: Data reported are most recent validated year (2021) of Virginia Vital Events Statistics	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: Data note for reporting year 2022: Number by race/ethnicity reflects percentage of infants screened by newborn screening program (98.6%).	

6.	Field Name:	2. Eligible for Title XIX
	Fiscal Year:	**2022**
	Column Name:	**Total**

Field Note:
Note for reporting year 2022: Data reported are most recent validated year (2021) 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	2024 Application Year	2022 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"	Cynthia deSa	Cynthia deSa
4. Contact Person's Telephone Number	(804) 864-7674	(804) 864-7674
5. Number of Calls Received on the State MCH "Hotline"		23,395

B. Other Appropriate Methods	2024 Application Year	2022 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/#:~:text=The%20Title%20V%20Maternal%20and,needs)%2C%20and%20their%20families.	https://www.vdh.virginia.gov/vdhlivewell/maternal-and-child-health-services-title-v-block-grant/#:~:text=The%20Title%20V%20Maternal%20and,needs)%2C%20and%20their%20families.
4. Number of Hits to the State Title V Program Website		1,434
5. State Title V Social Media Websites	VDH Facebook, Twitter, Instagram, Livestories	VDH Facebook, Instagram, Twitter, Livestories
6. Number of Hits to the State Title V Program Social Media Websites		19,603

Form Notes for Form 7:

Annual Reporting Year 2022, Section A5 – reported calls to 211 (retrieved from: https://va.211counts.org/). The number of calls reported is the sum of the following MCH-related needs:

Child care/parenting = 887
Special population services = 3,471
Food = 8,033
Health insurance = 1,058
Shelters = 9,946

Annual Reporting Year 2022, Section B3 – Breakdown of VDH TV-funded program websites (retrieved from: VDH Analytics). The number of unique hits reported is the sum of the following pages:

Title V MCH = 379
Adolescent Health = 258
VDH LiveWell = 1,749
Care Connection for Children (CYSHCN) = 2,069
Child Development Clinics (CYSHCN) = 784
CYSHCN Dashboard = 176
Sickle Cell = 623
Sickle Cell Dashboard = 180
Safe Sleep = 1,187
Family Planning = 4,487
Doula State Certification = 2,947
MIECHV = 774
Pregnancy Loss Project = 60
Healthy Start = 583
Resource Mothers = 34
Oral Health = 1
MMRT Surveillance = 340
Pregnancy Associated Mortality Surveillance = 861
MMRT Reports = 962
Child Fatality = 609

Annual Reporting Year 2022, Section B6 – Breakdown of social media metrics 10/1/2021 – 9/30/2022. The number reported is the sum of MCH-related posts across all three social media sites.

Facebook = 634 MCH-related posts (other notes: 14,776,032 impressions)
Twitter = 663 MCH-related posts (other notes: 2,118,745 impressions)
Instagram = 137 MCH-related posts (other notes: 29,857 impressions)

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 Leader (Optional)	
Name	Dana Yarbrough, MS, MA
Title	Director, Center for Family Involvement
Address 1	Virginia Commonwealth University
Address 2	700 E. Franklin Street
City/State/Zip	Richmond / VA / 23219
Telephone	(804) 828-0352
Extension	
Email	dvyarbrough@vcu.ed

4. State Youth Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Virginia

Application Year 2024

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
2021	80.3 %	0.1 %	75,886	94,467
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 % ϟ	0.1 % ϟ	72,042 ϟ	90,155 ϟ
2014	80.9 % ϟ	0.1 % ϟ	60,618 ϟ	74,896 ϟ
2013	77.5 % ϟ	0.2 % ϟ	57,327 ϟ	73,938 ϟ

Legends:

Indicator has a numerator <10 and is not reportable

ϟ 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
2020	73.8	2.9	645	87,420
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
2017_2021	26.8	2.3	131	488,237
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
2021	8.3 %	0.1 %	7,979	95,776
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
2021	9.9 %	0.1 %	9,480	95,794
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
2021	27.8 %	0.1 %	26,640	95,794
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
2021/Q1-2021/Q4	1.0 %			
2020/Q4-2021/Q3	1.0 %			
2020/Q3-2021/Q1	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 %			

Year	Annual Indicator	Standard Error	Numerator	Denominator
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
2020	5.0	0.2	471	94,948
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
2020	5.8	0.3	546	94,749
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
2020	3.8	0.2	362	94,749
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
2020	1.9	0.1	184	94,749
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
2020	183.6	13.9	174	94,749
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
2020	102.4	10.4	97	94,749
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
2021	6.2 %	1.2 %	5,485	89,133
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
2020	5.9	0.3	514	87,203
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
2020_2021	10.7 %	1.2 %	187,762	1,746,842
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
2021	16.2	1.3	149	918,601
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
2021	36.9	1.8	406	1,101,167
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
2019_2021	9.9	0.8	162	1,641,051
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
2019_2021	11.7	0.8	192	1,641,051
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
2020_2021	18.5 %	1.3 %	342,489	1,851,878
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
2020_2021	15.6 %	2.8 %	53,284	342,489
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
2020_2021	3.5 %	0.7 %	54,098	1,552,184
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
2020_2021	12.0 %	1.2 %	186,184	1,551,673
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
2020_2021	54.1 %	4.9 %	122,152	225,874
2019_2020	46.7 %	5.0 %	95,754	205,072
2018_2019	49.4 % ϟ	5.3 % ϟ	98,029 ϟ	198,549 ϟ
2017_2018	49.7 % ϟ	5.8 % ϟ	94,052 ϟ	189,236 ϟ
2016_2017	56.4 %	5.1 %	108,269	192,099
2016	61.7 % ϟ	5.6 % ϟ	132,277 ϟ	214,368 ϟ

Legends:

Indicator has an unweighted denominator <30 and is not reportable

ϟ 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
2020_2021	90.8 %	1.1 %	1,680,808	1,851,660
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
2020	15.7 %	0.2 %	4,404	28,038
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 <20 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
2021	16.4 %	1.2 %	57,694	352,110
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
2020_2021	17.6 %	2.2 %	146,086	831,320
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
2021	4.3 %	0.2 %	80,589	1,880,782
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
2018	71.9 %	3.6 %	73,000	101,000
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 % ϟ	5.2 % ϟ	70,000 ϟ	106,000 ϟ

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

ϟ 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
2021_2022	63.6 %	1.2 %	1,107,508	1,742,162
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
2021	77.3 %	3.1 %	412,933	534,113
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
2021	88.3 %	2.5 %	471,731	534,113
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
2021	88.0 %	2.5 %	470,248	534,113
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
2021	11.7	0.2	3,198	273,055
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
2021	11.4 %	1.8 %	9,996	87,998
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
2020_2021	4.0 %	0.8 %	74,180	1,845,614
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 % ϟ	0.6 % ϟ	30,045 ϟ	1,857,731 ϟ

Legends:

⚑ Indicator has an unweighted denominator <30 and is not reportable

ϟ 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**	**2022**
Annual Objective			84.6	85.4
Annual Indicator	82.9	91.7	87.5	83.3
Numerator	73,338	84,128	78,142	65,318
Denominator	88,459	91,769	89,302	78,385
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2016	2017	2018	2019

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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**	**2022**
Annual Objective			27.5	28
Annual Indicator	26.4	30.4	27.5	25.8
Numerator	22,710	27,265	23,681	19,388
Denominator	85,942	89,656	85,967	75,148
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2016	2017	2018	2019

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	27.1	27.9	28.3	29.5	29.9
Annual Indicator	29.1	31.4	29.9	31.3	34.4
Numerator	59,469	54,036	67,406	73,254	74,637
Denominator	204,083	171,987	225,762	234,340	216,844
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	94.9	92.8	90.7	88.7	86.7
Annual Indicator	95.4	98.6	88.4	95.1	79.1
Numerator	982	1,013	906	970	808
Denominator	1,029,557	1,026,897	1,025,381	1,020,363	1,021,604
Data Source	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD
Data Source Year	2016	2017	2018	2019	2020

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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)					
	2018	2019	2020	2021	2022
Annual Objective	162.9	156.8	151	145.3	139.9
Annual Indicator	196.3	184.5	168.1	173.7	180.2
Numerator	2,087	1,964	1,800	1,854	1,927
Denominator	1,062,972	1,064,407	1,070,646	1,067,063	1,069,640
Data Source	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2016	2017	2018	2019	2020

Annual Objectives			
	2023	2024	2025
Annual Objective	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					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	44.9	46	47.1	46.9	47.8
Annual Indicator	44.2	48.4	48.6	46.4	43.9
Numerator	172,978	188,625	174,804	155,562	150,246
Denominator	391,467	389,683	360,019	335,140	342,489
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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					
	2018	2019	2020	2021	2022
Annual Objective	19.3	19.5	19.7	19.9	27.6
Annual Indicator	28.1	26.5	14.5	17.4	19.5
Numerator	48,657	47,355	22,590	23,724	26,913
Denominator	172,958	179,018	155,964	136,302	138,287
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	2024	2025
Annual Objective	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**	**2022**
Annual Objective			16.7	16.8
Annual Indicator	11.6	16.5	16.6	13.0
Numerator	56,684	71,210	75,517	64,432
Denominator	489,697	431,868	455,838	493,986
Data Source	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-NONCSHCN
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	49.7	50.8	50.4	50.9	51.4
Annual Indicator	44.7	49.9	48.4	46.7	46.3
Numerator	42,882	46,558	43,840	41,629	41,487
Denominator	95,839	93,304	90,596	89,193	89,630
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2016	2018	2019	2020	2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	93.2	94.3	89.1	90	81.3
Annual Indicator	83.1	82.4	80.5	77.1	74.2
Numerator	1,448,110	1,463,318	1,432,504	1,360,700	1,295,174
Denominator	1,741,839	1,775,616	1,778,464	1,763,868	1,744,544
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	79.7	80.7	79.7	80.5	81.3
Annual Indicator	78.4	78.9	77.6	74	80.4
Numerator					
Denominator					
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021
Provisional or Final ?	Final	Final	Final	Final	Final

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

Field Level Notes for Form 10 NPMs:

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 (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.

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 (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.

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 (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.

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 (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.

5.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Note for reporting year 2022: the data source is the latest available data year (2020_2021) 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.

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					
	2018	2019	2020	2021	2022
Annual Objective	93.2	94.3	89.1	90	90.8
Annual Indicator	90.5	88.2	86.6	83.4	81.8
Numerator					
Denominator					
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	91.7	92.6	93.5

Field Level Notes for Form 10 NPMs:

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 (2016_2017) from the National Survey of Children's Health. Data is reported from age break-out for children age 12-17 years.

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 (2017_2018) from the National Survey of Children's Health. Data is reported from age break-out for children age 12-17 years.

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 (2018_2019) from the National Survey of Children's Health. Data is reported from age break-out for children age 12-17 years.

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 (2019_2020) from the National Survey of Children's Health. Data is reported from age break-out for children age 12-17 years.

5.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Note for reporting year 2022: the data source is the latest available data year (2020_2021) 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**	**2022**
Annual Objective			72	72.7
Annual Indicator	71.2	68.5	67.7	71.9
Numerator	1,323,014	1,274,181	1,257,254	1,324,660
Denominator	1,857,510	1,859,679	1,856,744	1,843,322
Data Source	NSCH	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021

State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			72	72.7
Annual Indicator	71.3	66.9	62.9	66.4
Numerator				
Denominator				
Data Source	NSCH	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Note for reporting year 2021: the data source is the latest available data year (2020_2021) from the National Survey of Children's Health. Data are reported from SHCN status break-out for CYSHCN.	
5.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: % increase needed to meet Goal of 5% increase based on 2017_2018 state baseline data.	

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	2022
Annual Objective			100	100
Annual Indicator	100	100	100	100
Numerator		436	301	286
Denominator		436	301	286
Data Source	VDH Newborn Screening Program, VDH EHDI	VDH Newborn Screening Program, VDH EHDI	VDH Newborn Screening Program, VDH EHDI	VDH Newborn Screening Program, VDH EHDI
Data Source Year	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives

	2023	2024	2025
Annual Objective	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.

3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Note for Reporting Year 2022: 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	2022
Annual Objective			Yes	Yes	Yes
Annual Indicator		Yes	Yes	Yes	Yes
Numerator					
Denominator					
Data Source		VDH Adolescent Health Program	VDH Adolescent Health Program	VDH Adolescent Health Program	VDH Adolescent Health Program
Data Source Year		2019	2020	2021	2022
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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.

4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Note for reporting year 2022: VDH established a structure to ensure youth voice is included in the Adolescent Health Program as well as across the department. Youth Advisors are paid, part-time employees who serve as subject matter experts and provide feedback on a variety of initiatives. They are also tasked to lead the statewide Youth Advisory Council, which convenes a group of young people from throughout the commonwealth to discuss youth health and other matters of importance that they identify. The first Youth Advisory Council completed their term in May 2022. The members identified topics to focus on and selected mental health as a top priority. The group worked together to create an infographic and QR code with resources for youth, in addition to resources for parents of young people dealing with mental health issues. A new Youth Advisor was hired in May 2023.

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	2022
Annual Objective			Yes	Yes
Annual Indicator		No	Yes	Yes
Numerator				
Denominator				
Data Source		OFHS MCH Program Documentation	OFHS MCH Program Documentation	OFHS MCH Program Documentation
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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.

3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Note for 2022 reporting year: VDH MCH began the following activities during program period 10/1/2021-09/30/2022:

CityMatCH Alignment for Action Learning Collaborative (AAC): The purpose of this project is to better align state- and local-level MCH work. Blue Ridge Health District (BRHD) and Birth Sisters of Charlottesville, community-based doula collective supporting people of color, were selected to participate in this learning collaborative. Virginia's Title V leadership is providing consultation to assist BRHD 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. To meet one of the goals of the learning collaborative, Title V leadership and BRHD supported the Birth Sisters of Charlottesville to hold "Listening to the Living", an online learning event that centered black women's birth experiences to address racial disparities. This work was presented at CityMatCH in 2022.

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, Hispanic, Indigenous, Asian, Pacific Islander, and other racialized communities.

National Maternal Child Health Workforce Development Center cohort: VDH's Title V staff is participating in the National MCH Workforce Development Center cohort to initiate a robust strategic process to strengthen maternal mental health in conjunction with the Reproductive Health and Injury/Violence Prevention teams. This cohort is an opportunity to breakdown silos to develop and implement better policies, programs, and practices across shared spaces.

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

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			23.8	23.3
Annual Indicator	25.3	27.1	25.1	19.8
Numerator				
Denominator				
Data Source	VA PRAMS	VA PRAMS	VA PRAMS	VA PRAMS
Data Source Year	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Note for 2022 reporting year: 2021 VA PRAMS data; Survey Question: Thinking back to just before you got pregnant with your new baby, how did you feel about becoming pregnant?; Answer options included in analysis: "I wanted to be pregnant later" and "I didn’t want to be pregnant then or at any time in the future"; Division of Population Health Data, Office of Family Health Services.

SPM 5 - Cross-Cutting (Family Leadership): Percentage of VDH CYSHCN programs 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	2022
Annual Objective			100	100
Annual Indicator		100	100	100
Numerator		4	5	4
Denominator		4	5	4
Data Source		CYSHCN Program Documentation	CYSHCN Program Documentation	CYSHCN Program Documentation
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Final	Final

Annual Objectives

	2023	2024	2025
Annual Objective	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.

3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Note for 2022 Report 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 Virginia Bleeding Disorders Program (VBDP) and the Sickle Cell Program (SCP) continued to have a number of programs/events to support families in decision making at all levels. For the VBDP's needs assessment, they reviewed the National Patient Satisfactions Surveys that were conducted from 2014-2021. In each of the surveys, greater than 93% stated that they were always or usually satisfied with care. When asked on the needs assessment survey, patients and families said they were moderately to very satisfied with HTC care coordination. Families are constantly educated on home therapy management in order to infuse at home.

The SCP centers offered genetic counseling to aid in future reproductive decision making. The social worker and transition coordinator at one SCP center conducted assessments and coordinated needs with each patient during comprehensive sickle cell clinics and during outpatient services as needed. They also partnered with behavioral health at the hospital to ensure appropriate mental health services. 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.

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

Measure Status:	Active

State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	42.9	71.4
Numerator	15	25
Denominator	35	35
Data Source	OFHS MCH Program Documentation	OFHS MCH Program Documentation
Data Source Year	2021	2022
Provisional or Final ?	Final	Final

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.

2. **Field Name:** **2022**

   Column Name: **State Provided Data**

   Field Note:
   Note for 2022 reporting year: In FFY22, 25 local health districts selected maternal mental health as an activity.

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	2022
Annual Objective			1.8	2.1	1.9
Annual Indicator	2.2	2	2.3	2.2	2.2
Numerator	9.6	9.7	10.6	10.7	10.1
Denominator	4.4	4.9	4.7	4.8	4.6
Data Source	VDH Division of Health Statistics	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	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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. The black/white infant mortality disparity ratio is calculated as (black infant mortality rate per 1,000 live births)/(white infant mortality rate per 1,000 live births).

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. The black/white infant mortality disparity ratio is calculated as (black infant mortality rate per 1,000 live births)/(white infant mortality rate per 1,000 live births).

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. The black/white infant mortality disparity ratio is calculated as (black infant mortality rate per 1,000 live births)/(white infant mortality rate per 1,000 live births).

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. The black/white infant mortality disparity ratio is calculated as (black infant mortality rate per 1,000 live births)/(white infant mortality rate per 1,000 live births).

5.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Note for reporting year 2022: the data source is the latest available data year (2021) from the VDH Division of Health Statistics. The black/white infant mortality disparity ratio is calculated as (black infant mortality rate per 1,000 live births)/(white infant mortality rate per 1,000 live births).

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

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective			2.8	2.4	2.1
Annual Indicator	1.9	2.2	2.7	2.1	2.2
Numerator	52.6	32.4	38.2	49.1	55
Denominator	27.7	14.5	14.1	23.7	24.6
Data Source	National Vital Statistics System	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	2018-2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Note for reporting year 2022: 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, 2018-2021. Data reflect four years because race categories are reported as single race (starting in 2018), where previously they were reported as bridged race.

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	2022
Annual Objective			Yes	Yes
Annual Indicator			No	No
Numerator				
Denominator				
Data Source			OFHS MCH Program Documentation	OFHS MCH Program Documentation
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives

	2023	2024	2025
Annual Objective	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.

2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Note for reporting year 2022: Due to a vacancy for the Maternal-Infant Health Consultant position until August 2022, this objective was unable to be accomplished this year. However, a survey was sent to Local Health Districts to inform work related to breastfeeding.

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

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	15	20	25	35	50
Annual Indicator	30	30	30	50	100
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	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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.

6.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:

Data note for reporting year 2022: There is confusion by state funded childcare programs about using an evidence based developmental screening tool (for example, ASQ3/ASQSE2) or the VQB5 that will be required for 3-5-year-old programs through the VDOE. With the DOE PDG grant, a requirement is for childcare programs receiving PDG funds to use the DOE tool called VQB5. This is intended as part of school entry and is used for 3-5-year-olds. Implementation of this project will continue with exploration of strategies for increasing public awareness about developmental milestones and screening in FY23 through greater utilization of the LTSAE materials, which provide a comprehensive approach to messaging. Exploration of approaches taken by other states that have resulted in increased parental uptake of the ASQ screening tool is also recommended.

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

Measure Status:	**Inactive - Completed**		
State Provided Data			
	2020	**2021**	**2022**
Annual Objective			16
Annual Indicator	14	16	16
Numerator			
Denominator			
Data Source	VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program	VDH - Injury and Violence Prevention Program
Data Source Year	2020	2021	2021
Provisional or Final ?	Final	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 ESM replaces the 2016-2020 ESM "Proportion of maternity centers with prenatal courses including Virginia's injury prevention curriculum"	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Retiring this measure as the goal was met last year.	

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

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective		2,549	2,549	2,549	2,549
Annual Indicator	2,596	1,560	1,738	426	104
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	VDH - Injury and Violence Prevention Program
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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.

4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Note for 2022 reporting year: Efforts continued to be 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 and essential tasks. 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 7.1.3 - Percentage of stakeholders that disseminated Virginia's injury prevention curriculum with fidelity

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives		
	2024	2025
Annual Objective	100.0	100.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Note for 2022 reporting year: This is a new measure for FFY23

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

Measure Status:	Active

State Provided Data

	2018	2019	2020	2021	2022
Annual Objective		10	20	250	300
Annual Indicator	102	195	237	501	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	VDH - Injury and Violence Prevention Program
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives

	2023	2024	2025
Annual Objective	350.0	400.0	450.0

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					
	2018	2019	2020	2021	2022
Annual Objective	100	250	400	40	45
Annual Indicator	0	0	37	49	11
Numerator					
Denominator					
Data Source	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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

6.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Notes for 2022 reporting year: VDH has asked UVA to increase outreach to providers for the medical home modules. UVA was accepted to attend AMCHP 2023 and had a poster there to promote the work.

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

Measure Status:	Active

State Provided Data

	2018	2019	2020	2021	2022
Annual Objective	91.5	93	94.5	96	97.5
Annual Indicator	96.8	99	96	95.4	94.4
Numerator	4,239	4,788	5,490	3,348	4,148
Denominator	4,377	4,835	5,719	3,508	4,393
Data Source	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives

	2023	2024	2025
Annual Objective	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.

6.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Notes for 2022 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 come up with a number for the numerator.

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

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	100	250	400	40	45
Annual Indicator	0	0	45	49	11
Numerator					
Denominator					
Data Source	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program	VDH CYSHCN Program
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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

6.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Notes for 2022 reporting year: VDH has asked UVA to increase outreach to providers for the transition modules. UVA was accepted to attend AMCHP 2023 and had a poster there to promote the work.

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	2022
Annual Objective			75	77
Annual Indicator		68.2	68.2	42
Numerator		90	90	55
Denominator		132	132	131
Data Source		VDH and VDOE School Health Nurse Documentation	VDH and VDOE School Health Nurse Documentation	VDH and VDOE School Health Nurse Documentation
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Final	Final

Annual Objectives

	2023	2024	2025
Annual Objective	79.0	81.0	100.0

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.

3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
VDOE has mandated school health data collection for the 2022-2023 school year. Training has been provided to public school nurses and school health staff. Public schools must collect and submit data to VDOE by June 30, 2023.

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

	2018	2019	2020	2021	2022
Annual Objective		6	6	6	6
Annual Indicator	3	4	8	7	6
Numerator					
Denominator					
Data Source	VDH Oral Health Program documentation	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	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives

	2023	2024	2025
Annual Objective	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.

5.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Note for 2021 reporting year: There were 6 Regional Oral Health Collaborative Projects that implemented work plans and/or education to increase dental visits among pregnant women in FY22--three projects in Richmond, one in Hampton Roads, and two in 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					
	2018	2019	2020	2021	2022
Annual Objective		6	6	6	6
Annual Indicator	3	4	8	9	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	VDH Oral Health Program documentation
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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.

5.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Note for Reporting Year 2022: There There were 9 Regional Oral Health Collaborative Projects that implemented work plans and/or education to increase dental visits among children and adolescents in FY22--one project in Richmond, three in Southwest VA, one school-based oral health program in Northern VA, one school-based oral health program in Harrisonburg, Smart Beginnings partnership in Petersburg and two state-wide projects with fluoride varnish.

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

Baseline data was not available/provided.

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

2. **Field Name:** **2022**

   Column Name: **State Provided Data**

   Field Note:
   Notes for reporting year 2022: As this is a new measure, baseline data were not able to be obtained for FY22. A new reporting structure was created in REDCap to track data related to this measure, starting FY23.

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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percentage of infants with confirmed newborn screening disorders who enter care coordination</td></tr>
<tr><td>Definition:</td><td><table><tr><td>Unit Type:</td><td>Percentage</td></tr><tr><td>Unit Number:</td><td>100</td></tr><tr><td>Numerator:</td><td>Number of infants with a confirmed newborn screening disorders who are referred to care coordination</td></tr><tr><td>Denominator:</td><td>Total number of infants with a confirmed newborn screening disorder</td></tr></table></td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: NBS, EHDI Program, VISITS, VaCARES; Data lag is 2 years</td></tr>
<tr><td>Significance:</td><td>Early identification of developmental disorders is critical to the well-being of children and their families. The Virginia MCH priority for early and continual screening supports optimal physical, mental health and social emotional development for all children.</td></tr>
</table>

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, Perinatal/Infant 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:	Inactive - Completed
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 7.1.3 - Percentage of stakeholders that disseminated Virginia's injury prevention curriculum with fidelity
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
ESM Subgroup(s):	Children 0 through 9
Goal:	To increase percentage of dissemination of Virginia’s injury prevention curriculum among stakeholders that received the curriculum.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of stakeholders that disseminated the curriculum with fidelity. **Denominator:** Total number of stakeholders that received the curriculum.
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; evaluation tool in REDCap.
Evidence-based/informed strategy:	Increase knowledge of best practices. Educational curricula is one evidence-based prevention strategy, and an approach to injury prevention is focusing on the "Three E's: Education, Enforcement, and Engineering/Environment" (MCH Evidence). Education and training can help inform priority populations about potential risks, safety options, and safe behaviors (e.g., home visiting/local health departments teaching expectant parents how to properly use a child safety seat). Dissemination of the curriculum with fidelity will ensure that the education is being followed appropriately and using evidence-based methods.
Significance:	This ESM is related to the previously retired ESM 7.1.1, which was identified through the Title V needs assessment, Virginia’s Plan for Well-Being 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 7.2.1 - Number of gatekeepers trained in the prevention of suicide among youth
NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Measure Status:	Active
Goal:	Reduce non-fatal injury related hospitalizations for children ages 0 through 9 and adolescents ages 10 through 19.
Definition:	**Unit Type:** Count **Unit Number:** 100,000 **Numerator:** Number of gatekeepers trained in the prevention of suicide among youth **Denominator:**
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Prevention and Health Promotion (DPHP); DPHP will track the number of participants from quarterly reports of program stakeholders
Significance:	Unintentional injury is the leading cause of child and adolescent mortality, from age 1 through 19. Homicide and suicide, violent or intentional injury, are the second and third leading causes of death for adolescents ages 15 through 19. Gatekeeper training is designed to help professionals interacting with youth and adolescents identify and refer students at risk for suicide.

ESM 11.1 - Number of providers in Virginia who have completed the medical home training module
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Increase the number of typical and children with special health care needs who can identify a primary care provider as a medical home
Definition:	**Unit Type:** Count **Unit Number:** 100,000 **Numerator:** Number of providers in Virginia who have completed the medical home training module **Denominator:**
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Child and Family Health
Significance:	This ESM was identified through the Title V needs assessment, Virginia's Well-being Plan, and Healthy People 2020 (MICH-30).

ESM 11.2 - Percentage of children served by the VA CYSHCN Program who report having a medical home
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Increase the number of typical and children with special health care needs who can identify a primary care provider as a medical home
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children served by the VA CYSHCN Program who report having a medical home **Denominator:** Total number of children served by the VA CYSHCN Program
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Services, Division of Child and Family Health, CYSHCN Program; includes the CCC-SUN database and figures reported directly by contractors/program partners for the state fiscal year.
Significance:	The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. Providing comprehensive care to children in a medical home is the standard of pediatric practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. The Maternal and Child Health Bureau uses the AAP definition of medical home.

ESM 12.1 - Number of providers in Virginia who have completed the transition training module.
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Measure Status:	Active
Goal:	Increase the number of children ages 10-24 engaged in transition services to adult health care
Definition:	**Unit Type:** Count **Unit Number:** 100,000 **Numerator:** Number of providers in Virginia who have completed the transition training module **Denominator:**
Data Sources and Data Issues:	Virginia Department of Health, Office of Family Health Services, Division of Child and Family Health
Significance:	This ESM was identified through the Title V needs assessment, Virginia's Well-being Plan, and Healthy People 2020 (DH-5).

ESM 12.2 - Percentage of Virginia school divisions reporting into the VDOE school health data system
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Measure Status:	Active
Goal:	Maintain and expand MCH data capacity regarding school health
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Virginia school divisions reporting into the VDOE school health data system **Denominator:** Number of Virginia school divisions
Data Sources and Data Issues:	VDH and VDOE School Health Nurse Documentation (numerator); VDOE Statistics and Reports, Enrollment & Demographic tables, Local and Regional Schools and Centers (denominator) (http://www.doe.virginia.gov/statistics_reports/enrollment/index.shtml)
Significance:	School nurses recognize the importance of each student having a medical home and healthcare transition services, as supported by the American Academy of Pediatrics, American Academy of Family Physicians and American College of Physicians. Poor health has the potential to impact negatively the youth and young adults' academic and vocational outcomes. Health and health care are cited as two of the major barriers to making successful transitions. The VDH School Health Nurse Consultant partnership with the VDOE School Nurse Consultant is critical to understanding scope of needs and services regarding school health in Virginia.

ESM 13.1.1 - Number of Regional Oral Health Collaborative Projects that implemented work plans to increase dental visits among pregnant women
NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

Measure Status:	Active
ESM Subgroup(s):	Pregnant Women
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
Evidence-based/informed strategy:	There were 6 Regional Oral Health Collaborative Projects that implemented work plans and/or education to increase dental visits among pregnant women in FY22-three projects in Richmond, one in Hampton Roads, and two in Southwest VA.
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 15.3 - 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

Measure Status:	Active
Goal:	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.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of uninsured children served by the CDCs who are referred to Medicaid and/or other financial resources **Denominator:** Number of uninsured children served by the CDCs
Data Sources and Data Issues:	VDH CYSHCN Program Documents
Evidence-based/informed strategy:	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.
Significance:	The VDH Title V MCH needs assessment identified that health insurance for health care services for CYSHCN is both an asset and a frustration for families. The assessment also demonstrated that parents struggle to understand their insurance and what it provides. Examples of barriers mentioned included: filling out required paperwork; understanding information about insurance/confusion; being able to access certain medications; language issues; not having insurance at all; and MCO/benefit changes mid-year that at times may disrupt services provided.

Form 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 2022

	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:

None