



**Maternal and Child Health Services
Title V Block Grant**

**State Narrative for
Virginia**

**Application for 2013
Annual Report for 2011**



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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Copies of signed assurances and certifications for Virginia are maintained on file in the Office of Family Health Services, Virginia Department of Health. Copies are available by contacting the Title V Director, Office of Family Health Services, 109 Governor Street, 7th Floor, Richmond, VA 23219 or by phone at (804) 864-7650.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

In Virginia, opportunity for public input into the MCH planning process is ongoing, utilizing the variety of stakeholders and linkages described elsewhere in the application. In FY 2010 Virginia focused specific efforts on obtaining public input for the five-year needs assessment and the FY 2011 Title V application. These efforts included a PowerPoint presentation describing Title V and the MCH services that Virginia provides that was developed and placed on the OFHS website (www.vahealth.org), a survey of district health departments, key stakeholder interviews, and focus groups. Marjory Ruderman from Johns Hopkins University facilitated a priority-setting meeting that included input from external partners as well as the OFHS staff.

During the current year routine mechanisms continued in place to obtain input and feedback on specific MCH programs. The Office of Family Health Services utilizes advisory groups and task forces that regularly provide input into specific MCH programs. Public notification and the draft MCH Block Grant application were made available on the OFHS website along with the 2011 Needs Assessment. In addition, emails were sent to numerous stakeholders notifying them of the availability of the draft application. These stakeholders included the following:

Health District Directors, Nurse Managers, and Business Managers of Virginia's 35 local health districts

CSHCN Families

Care Connection for Children

Early Hearing Detection and Intervention Advisory Board

Family to Family Network of Virginia

Genetics Advisory Committee

Infant and Toddler Connection

Medical Home Plus

Virginia Association of Family Physicians

Virginia Association of Obstetricians and Gynecologists

Virginia Association of Women's Health, Obstetric, and Neonatal Nurses

Virginia Bleeding Disorders Program
Virginia Chapter of the AAP
Virginia Coordinated Chronic Disease Partners
Virginia Council of Nurse Practitioners
Virginia Dental Association
Virginia Department of Education
Virginia Department of Medical Assistance Services
Virginia Early Childhood Foundation
Virginia Health Care Foundation
Virginia Home Visiting Consortium Members
Virginia Injury Network
Virginia Nurses Association
VA-Lend (VA Leadership Education in Neuro-developmental Disabilities Program)

After transmittal to MCHB, the final application will be available on the OFHS website. The OFHS will continue to seek opportunities during FY 2013 to present information regarding Virginia's Title V funded programs at various meetings with interested parties and obtain stakeholder input.

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

/2013/ Since the last needs assessment, the biggest factors impacting the needs of the maternal and child health population in Virginia are related to changing demographics. Data from the 2010 U.S. Census show population growth across all racial and ethnic groups in the state. The most notable increase is from the Hispanic population, which increased by 92% from 2000 to 2010. In addition, since the economic downturn began, an additional 33,000 children in Virginia are now considered to be living in poverty an increase from 12.2% in 2006 to 14.6% in 2010. These factors are indicators that more Virginians will need services and support from Title V and there will be a need for more linguistically and culturally competent programs.

VDH continues to administer grants for several new and expanded programs including those for home visiting, abstinence, pregnancy assistance for college students, and first-time motherhood.

New years of data continue to be released from multiple sources (such as Vital Records, PRAMS, BRFSS). For the first time ever, Virginia achieved weighted data collection for the 2011 Virginia Youth Survey. These data are being analyzed and prepared for public release and will provide a new data source to measure trends in youth risk behaviors. Datasets such as the Pregnancy-Associated Mortality Surveillance System (PAMSS) and the Virginia inter-generational birth file have been developed to augment the state's capabilities to monitor relevant maternal and child health data and conduct analysis and surveillance. Virginia continues to routinely analyze these data and monitor trends.

An evaluation of Virginia's Pregnancy Risk Assessment Monitoring System (PRAMS) was completed in October 2011. The assessment was conducted by Gandarvaka Gray, from the Council on State and Territorial Epidemiologists (CSTE). The project was found to be functioning as planned and fulfilling the goal of providing high-quality data to inform maternal and child health programs and policy. The recommendation to provide more salient incentives has been followed up on, as well as establishing a contract with a professional survey research group to conduct telephone interviews. It is expected these changes will increase response rates.

Additional data updates and analysis continue to be routinely provided to the Health Commissioner's Infant Mortality Work Group. This information is used to evaluate the status of initiatives and to develop future priorities and initiatives.

Data gathering and analyses have begun for the upcoming Title X needs assessment. A social work intern from Virginia Commonwealth University, Stephanie Hochhalter, has been working on this project expected to be completed in 2012 which will provide updated data and indicators of need regarding reproductive health and help inform the Title V program regarding trends in service utilization and gaps in services.

An annual meeting of MCH program staff was held to review the National and State Title V Performance Measures, the Health Status Indicators and the Health Systems Capacity Indicators. The review was followed by a discussion of issues and potential responses.

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III. State Overview

A. Overview

Geographic Description

The Commonwealth of Virginia is a mid-Atlantic state, bordered by Washington D.C., the nation's capitol, and Maryland to the north; the Atlantic Ocean to the east; and to the south North Carolina; and Tennessee, West Virginia and Kentucky to the west. Virginia encompasses 42,774 square miles (110,784 km²) making it the thirty-fifth largest state by area. The Virginia Department of Health has grouped its 134 localities (cities and counties) into 35 health districts and 5 health planning regions. The Northern Region, composed of Loudoun, Fairfax, Alexandria, Arlington and Prince William health districts located just south of Washington, D.C., is densely populated and includes six of the twenty highest income counties in the United States. However, with over 150 languages spoken in the region, and limited translation and interpretation services, communication can be problematic and interfere with access to health services. In addition, this region has severe daily traffic congestion. Conversely, the Southwest Region, made up of Loudoun, Cumberland Plateau, Mount Rogers, West Piedmont, New River, Alleghany and Roanoke health districts, bordered by West Virginia, Kentucky and Tennessee, 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. Ice and snow during the winter months can hamper travel. The East Central Region is composed of Southside, Piedmont, Crater, Chesterfield, Richmond, Henrico, Chickahominy, Three Rivers and Rappahannock health districts. West Central Region is made up of Pittsylvania/Danville, Central Virginia, Thomas Jefferson, Central Shenandoah, Rappahannock/Rapidan and Loudoun/Fairfax. These two regions have a mix of urban, suburban and rural areas. The urban areas are home to large state universities/ colleges and are business districts. The suburban areas are more residential than industrial. The rural areas are agricultural. The Eastern Region, composed of Western Tidewater, Chesapeake, Virginia Beach, Portsmouth, Norfolk, Hampton, Peninsula, and Eastern Shore 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 very sparsely populated and has high poverty. The Eastern region has the largest concentration of military bases and facilities of any metropolitan area in the world. The coastal region has many bridges and tunnels that create transportation barriers to services. The region also has daily severe traffic congestion. Occasionally, hurricanes and tropical storms affect the area and can bring flooding. More information regarding local health districts can be found at www.vdh.virginia.gov/lhd.

Demographic Description

Virginia's population is growing and changing. It reached 7.77 million in 2008, maintaining the Commonwealth's position as the 12th largest state population in the country with an annual growth rate of about 1.12 percent since 2000. In 2007, among people reporting one race alone, 70 percent were non-Hispanic White, 20 percent were non-Hispanic Black, and 5 percent were Asian. Compared to the nation, Virginia had a slightly higher proportion of Black or African American population. The proportion of Hispanics in Virginia (6.5%) was significantly lower than the national average (15.1%). Most of the minority populations in Virginia reside in the three major metropolitan areas of the state. Within Virginia, two metropolitan areas are clearly much more densely populated and developed than other areas of the state: The Northern region has the largest number of housing units and people per square mile, followed closely by Hampton Roads. In 2008, the Northern region had a housing density of 324.3 per square mile, while Hampton Roads was at 285.0 homes. The Southside region had the sparsest housing density at only 28.8 houses per square mile. Housing density is closely correlated with population density data. In this, too, the Northern and Hampton Roads regions have the highest population density rates, while the Southside region has the lowest in the state. In 2000, 73 percent of Virginia's population lived in urban areas, lower than the national average of 79 percent. California had the highest percent (94%) of people living in urban areas. The urban population rates for North

Carolina, Tennessee and Maryland were 60 percent, 64 percent and 86 percent respectively. Not surprisingly, urban populations within Virginia are largest in Hampton Roads, with 92 percent, and the Northern Region, with 91 percent. The Southwest and Southside regions had the largest rural populations, at 75 percent and 65 percent respectively.

Virginia's population has grown by more than 800,000 since the 2000 census -- a growth rate of 11.4 percent over nine years. The Commonwealth's 1.12 percent annual growth rate between 2000 and 2008 was 15th highest among states, and higher than the nation's rate of 94 percent. The 2009 provisional state population estimate is 7,882,590, which represents an increase of more than 87,000 since 2008. Virginia's metropolitan areas account for 93.5 percent of the population growth since 2000; as a result, by July 2009, more than 85.7 percent of Virginians lived in one of the state's metropolitan areas. Rural and small-town Virginia represents a diminishing share of the state's population. While some urban localities (such as Fairfax, Chesterfield and Chesapeake) have large increases in population, they may not register as among those with the fastest rate of growth, due to the size of their population. According to the University of Virginia's Weldon Cooper Center for Public Service, three critical trends will shape Virginia's population over the next few decades: selective decentralization, an aging population, and increasing racial and ethnic diversity. As noted earlier, people are moving away from the state's central cities and counties to the surrounding suburbs and exurbs, thus increasing selective decentralization. As a result, the number of metropolitan areas is expected to increase, and the boundaries of existing metro areas are expected to expand. Rural counties adjacent to metro areas are likely to experience significant population growth as space and affordable housing become harder to obtain in the urban core areas. Counties with significant quality-of-life advantages, those with access to urban amenities (either their own or nearby), and those with a diversified, service-based economy are particularly prone to rapid growth. The state's 11 metropolitan areas contained about 86 percent of the total population in 2007 and almost 69 percent of all Virginians lived in just three metropolitan areas: Northern Virginia, Richmond, and Virginia Beach. These three metropolitan areas accounted for more than 83 percent of state population growth from 2000 to 2007.

The population will continue to age. About 21.9 percent of all households in 2007 had one or more persons age 65 years and older and 39.4 percent of persons age 65 years and older had a disability. In Virginia today, older adults comprise 11 percent of people receiving Medicaid services yet drive nearly 25 percent of Virginia's total Medicaid spending and 50 percent of Medicaid spending on long-term care services. As the population grows and ages in the next 20 years, many more people will become dependent on Medicare and Medicaid for health insurance coverage.

The average age of the population will increase as the baby boom generation enters retirement age. The population of Virginians age 60 and over will grow from 14.7 percent of the total population in 1990 to almost 25 percent by 2025 when there will be more than 2 million Virginians in this age group. By 2030, nearly one in every five Virginians is projected to be 65 years or older. As the Baby Boomer generation ages, the gap between male and female life expectancy is expected to narrow as a result of health advances. Women of that generation are also better educated than in the past and will be less likely to live in poverty. Some 70 percent of Virginia's seniors today live in metro areas, especially Northern Virginia, Hampton Roads and Richmond. But the localities with the highest proportion of seniors tend to be rural localities, as young people have left or retirees have moved in. Aging boomers have fewer children to care for them as they become elderly parents and grandparents. Delayed fertility and increased longevity increases the likelihood of 'sandwich responsibilities for children of boomers- caring for their own children and their parents as well.

The number of Virginians age 85 and older will increase dramatically between 1990 and 2025 -- five times faster than the state's total population growth. This population will be predominantly female, as women have a longer life expectancy than men. As the baby boomers age, the percentage of older workers will increase as will the average age of the labor force. The senior

population will have vastly different levels of needs, abilities and resources. The oldest seniors are more likely to live in poverty, to be less-educated and to have more health problems. Elderly women significantly outnumber elderly men. Among those 85 and older, the ratio is more than two to one. Women are more likely to be widowed and to live alone and in poverty. While the senior population in Virginia is less diverse than the population overall, in the coming decades, the percent of older Virginians who are minorities will continue to grow.

In Virginia, 40 percent of grandparents are living with their own grandchildren and 6.2 percent of all children or 107,602 are being raised in a home where the grandparent is the head of household, often without a parent present at all. According to AARP, 59,464 grandparents report they are raising their grandchildren in Virginia. Of these, 40 percent are African American; 3 percent are Hispanic/Latino; 3 percent are Asian; and 52 percent are White. Grandparents raising grandchildren must establish legal custody in order to enroll grandchildren in school, access medical records and apply for benefits. The process of gaining legal custody or guardianship can be expensive, emotionally draining and confusing. These grandparents are 60 percent more likely to live in poverty than grandparents who are not responsible for children. The cost of caring for children can be overwhelming for those on a fixed income. Many grandparents make significant employment changes such as delaying retirement or quitting work sooner than planned in order to care for children.

The minority population (all who indicate they are Hispanic or a race other than white only) has grown since 1980. Approximately 48 percent of Virginia's population was born in another state or nation. New residents from other states tend to be younger, better educated and earn more than native Virginians. In 2007, there were more than 794,000 foreign-born Virginians, an increase from about 570,000 in 2000. Immigrants tended to be younger and divided between the less- and better-educated population segments. The mix of immigrants in Virginia included a higher percentage of Asians compared to the national average. Virginia's most racially and ethnically diverse communities are in Northern Virginia and the Tidewater area. In Tidewater, where the population is mostly comprised of non-Hispanic White and non-Hispanic Black, it is also home to one of the largest Asian populations in the state. While non-Hispanic Whites will continue to be the majority of Virginia's population in the next few decades, the proportion of Asians and Hispanics will grow.

Virginia's Hispanic population tripled between 1990 and 2006. Hispanics account for 6 percent of Virginia's population, compared to 15 percent nationwide. Participation in the labor force (defined as currently working or actively looking for work) characterizes 68 percent of Virginians age 16 and above, and 80 percent of Hispanic immigrants. Hispanic immigrants account for 3.4 percent of Virginia's labor force. Employed in a wide range of occupations, they are concentrated in a few occupational sectors that require little education. For example, Hispanic immigrants represent nearly 15 percent of workers in construction, farming, and buildings and grounds cleaning and maintenance. Food preparation and serving also employ large numbers of Hispanic immigrants. Additionally, more than 3 percent of Virginia's military employees are Hispanic immigrants.

The distribution of Virginia's Hispanic population is highly uneven, concentrated in the state's three major metropolitan areas, and selected rural areas. In Northern Virginia, Hispanics represent more than 15 percent of the populations of Manassas Park City, Manassas City, Prince William County, and Arlington County; Fairfax County, the largest county in Virginia, is home to more than one-quarter of all of Virginia's Hispanic residents. Additionally, a number of rural localities in Virginia show a significant increase in the number of Hispanics residents. Included among them is Galax City in Southwest Virginia, with 14 percent of its population being Hispanic. Forty percent of Hispanics in Virginia are immigrants, both documented and undocumented.

Hispanic immigrants are less educated, poorer, more likely to lack health insurance, and live in larger households than the overall population. Hispanics (both citizens and immigrants) received benefits and were over-represented in two social welfare programs (WIC and job training) and two public subsidy programs (rent subsidies and free-and-reduced-price school lunch). Of 17,000

job-training recipients, 7 percent were Hispanics. Hispanic households are also over-represented in uptake of rent subsidies and free and reduced priced lunch (accounting for 20 and 16 percent, respectively, of the total recipient households), but were significantly under-represented in the remaining three categories (public housing, food stamps, and energy subsidies). Hispanic immigrants and their children receive little welfare other than WIC and school lunch subsidies. Hispanic immigrants are less likely to have health insurance than the overall population. In 2006, 57 percent of Hispanic immigrants lacked health insurance, compared to 27 percent of Hispanic citizens, and 14 percent of all Virginians.

Economy

According to The Council for Virginia's Future, poverty has a significant impact on individuals and society at large. Children who live in poverty are likely to suffer from poor nutrition during infancy, experience increased emotional distress, and have an increased risk for academic failure and teenage pregnancy. Adult men and women who live in poverty are at high risk of poor health and violence. Poverty can also affect seniors' ability to care for themselves or to obtain prescription medication. Virginia had the 12th lowest poverty rate in the nation in 2008. 10.2 percent of Virginians fell below the federal poverty level, which in 2008 was \$10,991 for an individual. The national average was 13.2 percent in 2008. There was an increase in the percent in poverty, from 8.74 in 2002. In 2007, poverty most affected Black (18.2 percent) and Hispanic (13.3 percent) residents compared to White residents (7.7 percent).

In 2008 the Southside region had the highest percentage (18.5%) of individuals living below the poverty level of any region in the state, followed by the Southwest (18.1%) and Eastern (15.0%) regions. At the other end of the scale, the Northern region (5.4%) had the lowest percentage of individuals living below the poverty level, followed by the Central (10.7%) and Hampton Roads (11.0%) regions. Among Virginia's peers, Maryland had the lowest poverty rate at 8.1 percent, while North Carolina and Tennessee both had higher rates of poverty at 14.6 and 15.5 percent respectively.

The percentage of children in poverty increased from 12 percent in 2000 to 13 percent in 2007. The US rate of children living in poverty for 2007 and 2008 was 18%. More recently, in 2008, 14 percent of Virginia children were living in poverty, 6 percent were living in extreme poverty; 22 percent were below 150% poverty. Thirty percent of children living in poverty were Black/African American, 8 percent were non-Hispanic white, and 16 percent were Hispanic or Latino.

According to the Council for Virginia's Future, per capita personal income includes wages and salaries, transfer payments, dividends, interest, and rental income and is used as the broadest indicator of the magnitude of improvement in an economy. Rising income levels allow individuals to provide for their families, buy homes and improve the quality of their lives.

In 2008, Virginia ranked seventh among the states in per capita personal income, with \$44,224 per capita income (in 2008 dollars). Relative to its peers, Virginia's per capita income was lower than Maryland, (\$48,378) in 2008, but higher than North Carolina (\$35,344) and Tennessee (\$34,976). National per capita income stood at \$40,194. Within Virginia, the Northern region had the highest per capita personal income in 2007 at \$56,981 (in 2007 dollars), while the Central region had the second-highest (\$39,719). At the other end of the spectrum, the Southside and Southwest regions had the lowest per capita personal income at \$25,527 and \$26,264, respectively.

Between 2000 and 2008 Virginia's per capita income grew at a rate of 1.4 percent, compared to the national average of 0.7 percent over the same period. Within Virginia, Hampton Roads had the fastest growth rate at 2.2 percent between 2000 and 2007.

Median household income has increased from \$36,367 in 1995 to \$61,210 in 2008. The US median household income has increased from \$50,800 in 2004 to \$58,900. The median family (with child) income was \$69,400 in 2008, up from \$57,200 in 2004. The number of households

receiving Food Stamps has increased from 160,345 in 2002 to 253,273 in 2008. The TANF rates increased from 46 TANF recipients per 1,000 children in 1998 to 111 per 1,000 children in 2008.

Employment

According to Virginia Performs, employment growth is an indicator of expansion in the economy and represents an increase in the economic opportunities available to the citizens of a region or state. Employment growth is generally tracked as a percentage change from a previous year. Between 2000 and 2005, Virginia's employment grew at a faster rate than the national average but it lagged U.S. growth during 2006-2008. Virginia's 2007-08 employment growth rate of 1.04 percent exceeded Tennessee (0.71 percent) but was slightly slower than Maryland (1.12 percent) and North Carolina (1.06 percent). Regional employment growth data in 2007 indicate that the Northern region (2.71 percent) had the fastest growing rate in the state over the previous year. The Central region exhibited the second highest employment growth at 2.64 percent, while the West Central region registered 1.76 percent employment growth. Virginia's remaining regions all saw rates at or below 1.64 percent. In 2006-2008, for the employed population 16 years and older, the leading industries in Virginia were educational services, and health care, and social assistance (20 %), and professional, scientific, and management, and administrative and waste management services, (14 %). Among the most common occupations were: management, professional, and related occupations (40 %), sales and office occupations (24 %), service occupations (15 %) production, transportation, and material moving occupations (10 %) and construction, extraction, maintenance and repair occupations (10 %). Seventy-four percent of the people employed were private wage and salary workers; and 20 percent were federal, state, or local government workers.

Unemployment is a measure of how many people without jobs are actively seeking employment. According to Virginia Performs, since most people earn a living through a job, unemployment is also a measure of how the economy is doing in providing opportunities for Virginians to support themselves and their families. Unemployment not only hurts the personal finances of those without jobs, but also reduces their participation in the overall economy. The inability to find work is also associated with psychological stress, health problems, and stress on family relationships. Only people who have jobs or who are actively seeking one are part of the labor force; unemployed people who have stopped looking for a job are no longer counted as members of the labor force.

In 2008, Virginia, with a 4.0 percent unemployment rate, ranked ninth among the states. South Dakota had the lowest unemployment rate at 3.0 percent. Virginia's 2008 rate was lower than its peers, North Carolina (6.3%), Tennessee (6.4%) and Maryland (4.4%), and lower than the national rate of 5.8 percent. Across the state, the unemployment rate varied in 2008 from a high of 7.2 percent in the Southside region to a low of 3.0 percent in the Northern Region. The central tier of the state (Central and West Central regions) had rates between 4.2 percent and 4.3 percent. The Southwest region was second highest with 5.4 percent unemployment. In the last decade, the Southside and Southwest regions have routinely experienced higher rates of unemployment than other regions, largely due to the loss of manufacturing jobs and limited economic growth. More recently, the Virginia unemployment rate for December 2009 was 6.7 percent, an increase of 1.6 percent from December 2008 (5.1%). Virginia's rate is lower than the US rate of 9.7 percent.

Examination of Virginia's unemployment by industry reveals that certain fields, such as construction, administrative and waste services, accommodation and food services, manufacturing, and health care and social assistance, have relatively higher rates of unemployment. Financial services, government, transportation, and education and health care have relatively lower unemployment rates than other industries in the state. There were 330 mass layoff events in the state in 2009; representing a 184.5% increase from 2008. Total unemployment insurance claimants increased from 42,809 in 2005 to 104,212 in 2009. In 2007, 27 percent of children were living in families where no parent has a full-time, year-round employment and 3 percent were living in low-income households where no adults work. In 2008,

63 percent of teens ages 16 to 19 were unemployed.

Health

Virginia is 21st in health this year, unchanged from 2008. Strengths include a low prevalence of smoking at 16.4 percent of the population, a low violent crime rate at 256 offenses per 100,000 population, ready availability of primary care physicians with 125.0 primary care physicians per 100,000 population and few poor mental health days per month at 3.0 days in the previous 30 days. Virginia ranks higher for health determinants than for health outcomes, indicating that overall healthiness should improve over time. Challenges include high levels of air pollution at 12.1 micrograms of fine particulate per cubic meter, low immunization coverage with 73.2 percent of children ages 19 to 35 months receiving complete immunizations and high geographic disparity within the state at 14.9 percent. In the past year, the rate of preventable hospitalizations decreased from 70.2 to 64.8 discharges per 1,000 Medicare enrollees. In the past five years, the prevalence of smoking decreased from 22.0 percent to 16.4 percent of the population. In the past ten years, the rate of deaths from cardiovascular disease decreased from 361.4 to 282.1 deaths per 100,000 population. Since 1990, the prevalence of obesity increased from 9.9 percent to 25.5 percent of the population. In Virginia, obesity is more prevalent among non-Hispanic blacks at 34.3 percent than non-Hispanic whites at 24.0 percent. The WIC data on children shows the significant increasing trend in overweight and obesity. In 2001, 17.4% WIC children were overweight or obese as compared to 33.5% in 2009. This is just one specific population, but the data highlights the increasing overweight and obesity for all children. The prevalence of diabetes also varies by race and ethnicity in the state; 14.9 percent of non-Hispanic blacks have diabetes compared to 7.0 percent of non-Hispanic whites. In addition, mortality rates vary in Virginia, with 1,012.4 deaths per 100,000 population among blacks compared to whites, who experience 791.6 deaths per 100,000 population.

Some other health status indicators that highlight the challenges that Virginia faces include unintentional injuries, birth outcomes, and births to teens. Injuries took the lives of 3,929 Virginians in 2008, making this the third leading cause of death. Motor vehicle crashes accounted for approximately 1 out of every 5 of these fatalities. Although there is a continuing decline in child deaths, the leading cause of death for Virginia children is injury. Violent and abusive behavior has been increasingly recognized as an important public health issue. In 2008, 374 people were homicide victims in Virginia. Of the 374 homicides, the majority died by firearm. Approximately 18 percent of all the deaths in the 15 to 19 year-olds were classified as homicides in 2008. Homicide disproportionately affects young African American males. Fifty-nine youth ages 10-19 died from self-inflicted injuries in 2008.

The racial disparity in a number of health status indicators also presents significant challenges. For example, the infant death rate is often used as a state health status indicator. In 2008, the rate was 6.7 per 1,000 live births, down from 7.7 in 2007. However, there continues to be a large disparity between the rates for white non-Hispanic and for black non-Hispanic infants. In 2008, the infant death rate for white non-Hispanic infants was 5.1/1,000 as compared to 12.1/1,000 for black non-Hispanic infants. Low birth weight is an indicator of limited access to health care and a major predictor of infant mortality. In 2008, 8.3 percent of births were low birth weight infants. This represents a significant increasing trend since 1999. The rate of births to teens aged 15 through 17 years old has decreased from 24.9/1,000 in 1999 to 15.4/1,000 in 2008.

Health Insurance

Families USA estimates that more than 10 working-age Virginians die each week due to lack of health insurance (approximately 550 people in 2006). Between 2000 and 2006, the estimated number of adults between the ages of 25 and 64 in Virginia who died because they did not have health insurance was more than 3,200. According to Virginia Performs, estimates of uninsurance in Virginia over the past several years have ranged from 10 percent to 15 percent of the total population; the range is due to differences in survey methodology, changes in policies and demographics, and fluctuations in the economy. Based on U.S. Census Bureau estimates, the national average for uninsured people was 15.4 percent in 2008. In the same year, Virginia's rate

was 12.4 percent, ranking it 22nd among all states. According to the 2007 National Survey of Children's Health, about 93 percent of Virginia's children ages 0-17 were currently insured, higher than the US rate of 91 percent. About 12 percent of those surveyed reported lacking consistent insurance coverage in past year, lower than the US rate of 15 percent.

In comparison with its peers, Virginia had a lower percentage of uninsured individuals than North Carolina (15.4%) and Tennessee (15.1%) but a higher one than Maryland (12.1%). The Eastern (20.2 percent), Valley (16.9), Southwest (16.1), West Central and Northern (16.0), and Southside (15.7) regions exceeded this statewide average. The Hampton Roads region had the lowest rate at 13.7. The private sector, which insures about 68 percent of the population, provides insurance for families of workers and their dependents but does not cover the cost of long-term care. The public sector -- through Medicare at the federal level and Medicaid at the state level -- provides insurance for about 22 percent of the population, with services targeted to vulnerable persons including the poor, elderly and disabled. From FY 2007 to FY 2008, enrollment in Virginia's FAMIS/SCHIP program increased from 80,024 children to 85,977 children. Medicaid enrollment increased from 649,903 to 665,800 during the same period. The rate of Virginians dependent on Medicaid has increased from 7 to nearly 9 percent over the past five years. About 8 percent of the population covers medical insurance out of their own pockets. The remaining 12 percent of the population is uninsured. According to Virginia Health Care Foundations' Profile of the Uninsured, the vast majority of the uninsured (80%) live in households with at least one full-time (65%) or part-time (15%) worker. Forty-six percent of uninsured Virginians live in households with a worker employed by a small company (100 or fewer employees) or with a self-employed worker. In contrast, less than 8 percent of those in companies with 500 employees or more are uninsured. Only one in four uninsured Virginians (26.8%) lives in households that have an offer of employer-sponsored health insurance. The overwhelming majority of Virginians without insurance are U.S. citizens (81%). Fifty percent of uninsured Virginia adults are Caucasian/non-Hispanic, 20 percent are African-American, 20 percent are Hispanic, and 10 percent classify themselves as "other."

Housing

According to the 2000 Census, Virginia's home ownership rate was 68 percent, slightly higher than the US (66 %). The downturn in Virginia's economy has impacted home foreclosures. In April 2010, 1 in 467 Virginia housing units received a foreclosure filing notice. Fairfax and Prince William had the highest number of units receiving a notice in April. The population per household was 2.54 and 3.2 percent lived in crowded housing. Less than 1 percent of occupied units lacked complete plumbing or complete kitchen. A housing unit is considered crowded if there is more than 1 person per room. In 2008, 7 percent of Virginia's children lived in crowded housing; 13 percent of these children were in immigrant families. For the same year, the national rate of children living in crowded housing was 13 percent. In 2008, 66 percent of Virginia's children lived in low-income households where housing costs exceeded 30 percent of income; the same rate as in the US. Forty-nine percent were children in immigrant families, roughly the same percent (51%) as for the US. According to the 2007 National Survey of Children's Health, with respect to neighborhood amenities, 44.9 percent of Virginia children live in neighborhoods with a park, sidewalks, a library, and a community center compared to 48.2 percent of US children. Eleven percent of Virginia children live in neighborhoods with poorly kept or dilapidated housing, lower than the US rate of 14.6 percent. Eighty-three percent of children live in supportive neighborhoods, about the same as the national rate (85%). Almost ninety percent live in neighborhoods that are usually or always safe, higher than the US rate (86.1 %).

Education

According to Virginia Performs, the high school graduation rate is one measure of the success of a state's elementary and secondary educational system and the quality of its workforce. Completion of high school or its equivalent is increasingly the minimum level of education sought by employers; moreover, unemployment rates are lower and lifetime earnings are substantially higher for high school graduates than for high school dropouts. Graduation rates improved for each of Virginia's regions in 2008-2009 compared to 2007-2008 with the statewide average increasing from 82.2 percent to 83.2 percent. The Northern region (87.8%) has a rate that

exceeds the statewide average, while the Southwest (83%), Valley (82.9%), Southside and Central (82.3%), West Central (81.3%), Hampton Roads (80.6%), and Eastern region (78.1%) have graduation rates that are below the statewide average.

The student dropout rate has declined over time from 2.2 percent in 2002 to 1.9 percent in 2007. In 2008, 4 percent of teens were high school dropouts, down from 7 percent in 2004. In 2009, the dropout rate for Hispanic/Latino youth was 10 percent, for black non-Hispanic the rate was 3 percent and for white non-Hispanic the rate was 3 percent. The US rate for dropouts was 6 percent in 2008.

Virginia's educational attainment is slightly above the national average in terms of individuals with a high school education, but well above average for individuals with higher education. In 2008, Virginia ranked 30th in the nation for the highest percentage of its adult population (25 years or older) with at least a high school degree, but 6th for adults with at least a bachelor's degree.

In Virginia, 85.9 percent of adults had at least a high school degree in 2008, exceeding the national average of 85.0 percent. Neighboring states Tennessee (83.0%), North Carolina (83.6%), and Maryland (88.0%) also performed well, but Wyoming led the nation at 91.7 percent high school graduation. The percentage of Virginia's adult population with at least a bachelor's degree increased from 31.7 percent in 2002 to 33.7 percent in 2008, exceeding the national rate of 27.7 percent. Comparing rates of individuals with at least a bachelor's degree, Virginia is behind Maryland's rate of 35.2 percent, but above North Carolina (26.1%) and Tennessee (22.9%). Massachusetts led the states in 2008 with a rate of 38.1 percent of residents with a bachelor's degree or above. Educational attainment increased in every region across Virginia between 1990 and 2000. All regions increased both their high school- and college-educated population, with the Northern and Hampton Roads regions having the highest high school-educated population, and the Northern and Central regions having the highest college-educated populations.

Agency Accountability and Strategic Planning

House Bill 2097, passed by the 2003 General Assembly, requires that each state agency implement a state performance-based budgeting system. Since that time, an ad hoc advisory group of agency representatives designed the new planning and budgeting model that requires all state agencies to have strategic plans that are tied to their budget and use common language and format. The planning process was unveiled to agency heads by Governor Warner in December 2004. Since that time state agencies, including VDH, have developed their strategic plans and area service plans (operational plans) that are tied to the strategic plan and budgets. This significant change in state government planning and budgeting creates a greater transparency in government by making public how tax payer dollars are spent and the return on investment.

As a result, the VDH strategic plan identified 41 service areas and developed a service area plan for each. The following four service areas are related to state Title V activities:

Women's and Infants' Health

Injury and Violence Prevention

Child and Adolescent Health

Chronic Disease Prevention, Health Promotion and Oral Health

VDH monitors a series of agency performance measures that are tied to the service areas and are publicly reported on the Virginia Performs website <http://vaperforms.virginia.gov/>

The VDH Strategic Plan, including MCH related components, is available on the web at <http://www.vdh.virginia.gov/Administration/StrategicPlan/>.

State MCH Priorities

The Virginia Title V program staff collaborate with a number of agencies within the Virginia Secretariat of Health and Human Resources (SHHR) to identify and jointly address the needs of the MCH populations. Regular meetings with other agencies, cross-agency program development, workgroups and special taskforces assist in the identification of issues and the prioritization of Title V efforts. These agencies within the SHHR include the Department of Behavioral Health and Developmental Services, formerly the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Department of Social Services, the Department of Medical Assistance Services, the Department of Health Professions, and others. In addition, collaborative meetings with agencies outside the SHHR include the Department of Education, the Joint Commission on Health Care, the Commission on Youth and various legislative committees. Title V program staff also collaborate with and seek input from professional organizations, consumer representatives, advocacy groups and community providers as well as internally with offices within the VDH such as the Office of Minority Health and Public Health Policy, and the Division of STD/AIDS within the Office of Epidemiology.

For the FY 2011 needs assessment OFHS initiated special efforts to involve our external partners in setting the MCH priorities. The needs assessment process included the collection of qualitative data through focus groups, key stakeholder interviews and a survey of district health department nurse managers. In addition, Marjory Ruderman, a consultant affiliated with Johns Hopkins University, facilitated priority setting meetings of OFHS staff and external stakeholders. During the meetings the MCH priorities were developed based on the presentation of needs assessment data and the needs identified by participants along with some overarching principles to guide our approach to addressing the needs of Virginia's families over the next five years. These overarching principles include continuing to recognize and address health disparities and the social determinates of health, continuing to use a socio-ecological approach to health that addresses social and environmental determinants and promotes safe and healthy communities, increasing family involvement, increasing workforce capacity for medical, dental, mental health and nontraditional providers, making resources available for both providers and families, and continuing to focus program planning and strategy development on the life course perspective. These overarching principles will inform our work in addressing the MCH priorities.

The 2011 Title V needs assessment process served as an essential tool to reflect on system changes and examine the health status of Virginia's families. Although there have been improvements in some areas, there continue to be disparities based on race, income, age, insurance coverage and areas of the state. These variations continue to present challenges. During the next year, the Title V efforts will continue to focus on 1) reducing infant mortality; 2) reducing injuries, violence, and suicide among Title V populations; 3) increasing access to dental care and population-based prevention of dental disease across the lifespan; 4) decreasing childhood obesity; 5) decreasing childhood hunger; 6) improving access to health care services for CYSHCN; 7) promoting independence of young adults with special health care needs; and, 8) supporting optimal child development.

More detailed MCH-related health status indicators are reported in the FY 2011 Needs Assessment. Virginia's MCH priorities are listed in Section IV of this application. In addition, other emerging health trends, problems, gaps and barriers are also identified in the Needs Assessment.

B. Agency Capacity

The Office of Family Health Services (OFHS) within the Virginia Department of Health has responsibility for the development and implementation of the MCH Block Grant. The mission of Virginia's MCH efforts is to protect, promote and improve the health and well-being of women,

children and adolescents, including those with special health care needs. Major goals include improving pregnancy and birth outcomes, improving the health of children and adolescents, including those with special health care needs, assuring access to quality health care services, eliminating barriers and health disparities and strengthening the MCH infrastructure. The Office of Family Health Services is comprised of the divisions of Women's and Infants' Health, Child and Adolescent Health, Dental Health, Physical Activity, Nutrition and Food Programs, Chronic Disease Prevention and Control and Injury and Violence Prevention. The director of the OFHS is Diane Helentjaris, M.D., M.P.H. She was appointed effective May 25, 2010 following the retirement of David Suttle, M.D. (See attached list of Virginia Code sections related to the provision of maternal and child health services).

MCH programs and services in Virginia are provided at each of the four levels of the MCH pyramid to protect and promote the health of women and children, including those with special health care needs. The programs and services are funded by Title V, Title X, a number of federal categorical grants and state funds. OFHS continues to have strong relationships with organizations and other state and local agencies that address the needs of the maternal and child population. These include organizations such as the Virginia Chapter of the American Academy of Pediatrics, the Medical Society of Virginia, the Virginia Dental Association, free clinics, community health clinics, parent organizations, medical centers, Virginia Department of Medical Assistance Services, Virginia Department of Social Services, Virginia Department of Behavioral Health and Developmental Services, Virginia Department of Education, local school districts, and others.

The Division of Women's and Infants' Health (DWIH) assesses and advocates for the health needs of infants and of women, particularly women of childbearing age. Joan Corder-Mabe, R.N.C., M.S., W.H.N.P., serves as the division director. Title V, state funds and federal categorical grant funds, including Title X Family Planning funds, support the division work. The breast and cervical cancer screening program, Every Woman's Life (EWL), provides breast and cervical cancer screening, referral and follow-up to low income Virginia women. In 2008, Virginia was awarded a CDC grant to establish a WISEWOMAN program as a part of the EWL program. The program provides lifestyle counselors that provide health screenings, counseling, materials, education and referrals to community resources. The screenings include blood pressure, glucose, cholesterol measurement as well as assessing weight, medical history, tobacco use, adequate diet and physical activity. The WISEWOMAN program works closely with the Division of Chronic Disease and Control's Heart Disease and Stroke Prevention program, Diabetes Prevention and Control program and the Tobacco Use Control project. The division also provides comprehensive family planning services in local health departments (supported by Title X grant funds) to assist low-income women to plan and space their pregnancies. In the past, the Voluntary Sterilization program, managed by the DWIH, has utilized state funds to provide permanent birth control methods to low income individuals, male and female, age 21 and over, who wish to conclude their ability to reproduce children. A number of local health departments use Title V funds to provide prenatal care. Several programs aim at reducing infant mortality and morbidity through home visiting, regional coalition activities (Regional Perinatal Councils), mentoring pregnant teens (Resource Mothers), nutrition counseling, nurse case management, fetal and infant mortality reviews (FIMR), community-based projects and public and professional education. The Virginia Healthy Start program "Loving Steps", is administered in this division. The goal of "Loving Steps" is to reduce health disparities within the African American population in order to improve birth outcomes. Virginia's federally funded Healthy Start Initiative, which began in 1997, currently serves two urban areas, Norfolk and Petersburg, and one rural area, Westmoreland County. These communities were chosen because of their higher than average infant mortality and low birth weight rate along with a high rate of births to teens and their high rates of poverty and other risk factors. Loving Steps provides at-risk pregnant women, inter-conceptual women and at risk infants and toddlers with case management, health education, inter-conceptual care, and perinatal depression screening using the Edinburgh Postnatal Depression Scale. Loving Steps also works closely with the Resource Mothers program, the Regional Perinatal Councils and the Fetal/Infant Mortality Review (FIMR) program to improve birth outcomes. The Sickle Cell

program coordinates the follow-up of newly diagnosed newborns with sickle cell disease and includes public and family education, testing and counseling regarding the disease. In addition, DWIH staff participates in the Maternal Mortality Review Team that is located in the Virginia Department of Health's Office of the Chief Medical Examiner.

The Division of Child and Adolescent Health's (DCAH) mission is to give children, including children with special health care needs, a healthy start in life and help them maintain good health in the future. Joanne Boise, R.N., M.S.P.H., serves as the division director. The DCAH mission is accomplished through assessing health data, identifying resources, informing the public about child and adolescent health issues, assisting policy makers, supporting private and public health care providers, developing and implementing programs and information systems, identifying resources, providing clinical consultation and educational activities, and developing and distributing guidelines and educational materials. Programs administered in the division include the Teen Pregnancy Prevention Initiative, Newborn Screening Services, Early Hearing Detection and Intervention Program, Virginia Congenital Anomalies Reporting and Education System (birth defects registry), Early Childhood and School Age Health, Child Development Clinics, Bleeding Disorders Program, and Care Connection for Children. Staff co-lead Bright Futures Virginia, most recently overseeing the development of the Bright Futures-based web portal for parents, www.healthyfuturesva.com. In addition, division staff participates on the Part C Interagency Coordinating Council, the State and Local Advisory Team for the Comprehensive Services Administration, and the Foster Care Health Plan Work Group. The Childhood Lead Poisoning Prevention program originally was housed in the DCAH, but was transferred to the Office of Environmental Health within VDH. Collaborative efforts relating to lead poisoning prevention continue between the Office of Environmental Health and the DCAH.

The Children with Special Health Care Needs (CSHCN) program is located within the DCAH and consists of Care Connection for Children, the Child Development clinics and the Bleeding Disorders Program. Nancy Bullock, R.N., M.P.H. is the director of the CSHCN program. The Care Connection for Children program is the statewide network of centers of excellence for children with special health care needs (CSHCN) that provides leadership in the enhancement of specialty medical services; care coordination; medical insurance benefits evaluation and coordination; management of the CSHCN Pool of Funds: information and referral to CSHCN resources; family-to-family support; and training and consultation with community providers on CSHCN issues. The centers are geographically located to serve the entire state. Virginia resident children ages birth to 21 years are eligible for services if their disorder has a physical basis; has lasted or is expected to last for at least 12 months; and either requires health care and ancillary services over and above the usual for the child's age, or special ongoing treatments, interventions, or accommodation at home or school, or limits function in comparison to healthy age children; or is dependent on medications, special diet, medical technology, assistive devices or personal assistance. A limited amount of money (CSHCN Pool of Funds) is available to assist children who are uninsured or underinsured. This assistance is limited to families with a gross income at or below 300% of the Federal Poverty Level.

The Child Development Clinics, also managed by the Division of Child and Adolescent Health, is a specialized program for children and adolescents suspected of having developmental and behavioral disorders such as developmental delays, disorders of attention and hyperactivity, learning problems, mental retardation, and/or emotional and behavioral concerns. A professional team consisting of a pediatrician or nurse practitioner, nurse, social worker, educational consultant, and psychologist provide diagnostic assessment, treatment planning, follow-up care coordination and referral. Interagency coordination is provided with the Virginia Department of Education, local health departments, Part C early intervention services, mental health clinics, Head Start programs, Department of Social Services and others. Eligibility is limited to Virginia resident children under the age of 21 years. A sliding scale charge is based on income level and family size.

The Virginia Bleeding Disorders Program, a legislatively enacted program, was established to serve as a "safety net" for persons with inherited bleeding disorders. The Virginia Bleeding Disorders Program provides insurance case management that assists persons in considering their options and completing the insurance application and enrollment process. The program provides assistance in accessing specialty health care services and establishing a medical home, care coordination, information and referral, family-to-family support, training and technical assistance for community providers, transition from child to adult oriented health care system, and the promotion of quality assurance. A limited amount of money is also available to assist uninsured and underinsured persons to receive care that they would otherwise not be able to afford. Bleeding disorder centers are located in Norfolk, Fairfax, Richmond and Charlottesville. The Virginia Hemophilia Advisory Board, consisting of governor appointed members, provides a mechanism to address the statewide needs of persons with inherited bleeding disorders.

The Division of Dental Health's primary goal is to prevent dental disease. Karen Day, D.D.S., M.P.H., is the division director. Dental services are provided in approximately half of Virginia's localities to pre-school and school age children who meet eligibility requirements through the local health departments. Eligibility for these services may be determined by school lunch status and/or family income. Dental services are available at health department clinics or at dental trailers placed on school property. Adult care is available on a limited basis in certain localities. The Division of Dental Health also supports community fluoridation by monitoring water systems for compliance in conjunction with Virginia Department of Health Office of Drinking Water, reporting water system data to the Centers for Disease Control and Prevention Water Fluoridation Reporting System (WFRS), providing information about the benefits of water fluoridation to citizens and communities, and by providing grant funding for communities to start or upgrade fluoridation equipment. The division also engages in epidemiological studies to determine the level of need for dental care. Most recently 8,000 school children were surveyed to document the level of decay, fillings, missing teeth and dental sealants.

In the past the Division of Dental Health supported the School Fluoride Mouthrinse Program and provided funding for fluoride mouthrinse supplies, training on implementing school mouthrinse programs, and brochures and educational information regarding the program. This program was eliminated this year as a result of budget reductions. The division's "Bright Smiles for Babies" Program targets children from birth to three years old at highest risk for dental decay. The goal of the program is to increase early recognition of disease and provide prevention through training dental and non-dental health professionals on oral health education and anticipatory guidance, screening and risk assessment and fluoride varnish application. The division recently expanded the Bright Smiles for Babies program to provide training, presentations, educational materials and resources for parents/caregivers and providers regarding oral health for children with special health care needs. In the past it has been difficult for parents to find dentists who provide care to CSHCN. The Division of Dental Health surveyed Virginia's dentist in order to develop a provider directory. As a result of the responses received from the dentists, an interactive provider directory is now available to families of CSHCN on the VDH website.
<http://www.vahealth.org/dental/dentaldirectory/QuickSearch.aspx>

Funding for both the Dental Scholarship Program and the Dental Loan Repayment Program that provides funding for dental students with repayment through service in underserved areas was recently eliminated due to the economic turndown that has resulted in state budget reductions.

The Director of the Division of Nutrition, Physical Activity and Food Programs (formerly the Division of WIC and Community Nutrition Services) is Donna Seward, F.A.C.H.E. The division administers the Virginia Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) serving approximately 160,000 low to moderate income families through local health departments and mobile clinics. The WIC program goal is to enable women to deliver and nurture healthy children. The WIC program includes outreach and education components and encourages breastfeeding for new mothers. Effective October 1, 2010, the division will take over

the administration of two additional food programs, the Child and Adult Care Food Program and the Summer Food Service Program. The division implemented CHAMPION, the Commonwealth's Health Approach and Mobilization Plan for Inactivity, Obesity, and Nutrition to address the increase in obesity rates statewide. The program uses a community driven approach by providing communities with evidence based program models, technical assistance and limited grant funds to implement the community initiative. Grants are available statewide and include funding for programs and strategies that target health behavior, policy, and environmental change. Specifically, funding is provided for programs to address nutrition education, physical activity, and policy change in preschool settings, for parents of adolescents, to create active aging environments, promote worksite wellness, and support breastfeeding promotion.

The Statewide Breastfeeding Advisory Committee is comprised of stakeholders representing various organizations. The member organizations represent a wide variety of practice settings and create a multidisciplinary membership. They work in partnership with the Virginia Department of Health's Division of Women's and Infants' Health and the Division of Nutrition, Physical Activity, and Food Programs to aid in increasing the incidence and duration of breastfeeding among mothers. Representatives include such organizations as the American College of Nurse Midwives, the American Dietetic Association, universities, La Leche League, Medela, the Virginia Nurses Association and others.

The Division of Injury and Violence Prevention's primary goal is to prevent injuries, suicide and violence. Erima Fobbs, B.Sc., M.P.H. is the director. To reduce the impact of injury and violence, the division engages in injury assessment, the development and promotion of prevention programs and policies, training and community education. The division also promotes and disseminates safety devices, conducts public information campaigns and funds local prevention projects. The division works collaboratively with health, education, social service and mental health providers, law enforcement, fire and EMS providers, and a variety of other community groups across the Commonwealth. The division's unintentional injury programs address home, school and transportation safety including child passenger safety, infant safety, traumatic brain injury, fire and drowning prevention. The division's violence prevention programs address sexual violence, suicide, youth violence, including bullying, and intimate partner violence.

The goal of the Chronic Disease Prevention and Control Division is to reduce the human and financial burden of chronic diseases, which are the leading causes of death in Virginia. The division director is Ramona Schaeffer, M.S.Ed, C.H.E.S. The division's prevention and control efforts include the development of programs and policies, training and state action plans that outline goals and strategies for business, civic and governmental agencies to control chronic diseases such as arthritis, asthma, cancer, diabetes, or heart disease and stroke. The division focuses on promoting evidence-based interventions, monitoring the burden of chronic diseases in the state, developing partnerships with other state and local agencies, and evaluating outcomes of projects interventions. Other division efforts include outreach to promote health for persons living with disabilities and prevention of secondary chronic diseases, and to modify risk behaviors such as tobacco use, lack of physical activity and poor nutrition, which are major contributing factors leading to chronic diseases. The division manages numerous categorical CDC grants including the CDC funded Tobacco Use Control Program (TUCP). In addition, the Virginia Cancer Registry is located within this division.

The Office of Family Health Services is responsible for addressing several federal (e.g., Title V and Title X) and state mandates for improving the health of women and children. State statutes relevant to Virginia's Title V program authority are included in the attachment to this section.

Culturally Competent Care

The OFHS is committed to providing culturally competent care for the MCH populations. This is being accomplished in a number of ways. First, data is collected and analyzed according to different race and ethnic categories and used to inform program development including the targeting of resources. The race and ethnic categories have been standardized across data

collection systems that are housed in the OFHS DataMart. OFHS also collaborates with culturally diverse community groups to ensure their representation in needs assessment, program planning and evaluation. For example, findings from five minority focus groups were utilized in the development of web-based training for providers on identifying and addressing perinatal depression. Efforts are made to ensure that health promotion materials are culturally appropriate and translated into appropriate languages, with Spanish being the most prevalent. News releases regarding public health issues are placed in newspapers that are read in different racial and ethnic communities. OFHS staff participate in cultural competency trainings. For example, the Care Connection for Children staff participated in two days of training on cultural competency provided by the Georgetown University Center for Cultural competency. A recent in-service training on racial disparities sponsored by the Office of Minority Health and Health Equity was attended by a number of Title V staff. Contracts with the district health departments for maternal and child health services include a requirement that care must be provided in a culturally competent manner. To assure a representative OFHS workforce, position vacancies are posted in newspapers and on websites that are viewed by different racial and ethnic communities.

VDH contracts with Language Services Associates (LSA) for telephone interpreting and document translating. LSA offers interpreting and translating services in 212 languages, including all of the 50+ languages specifically required by VDH in their Request for Proposals. The Virginia Department of Health's Office of Minority Health and Health Equity developed a website that provides resources to assist health care providers to better meet the needs of the Commonwealth's diverse populations. The resources include training materials, research articles, assessment tools and a calendar of events. The website also provides language resources that include a list of commonly used clinical phrases in both English and Spanish. OHFS continues to work with the OHP to develop additional resources that specifically target the diverse MCH population. The website is available at <http://clasactVirginia.vdh.virginia.gov>.

In 1990, Virginia's State Health Commissioner created the Minority Health Advisory Committee (MHAC) to ensure that the health priorities and health concerns of Virginia's minority populations were adequately addressed by the Virginia Department of Health. The MHAC includes appointed representatives from local, state and federal public health agencies, University of Virginia's Center for Public Service, Virginia Commonwealth University's Department of Pharmaceuticals, Norfolk State University's Department of Political Science and Economics, Baptist General Convention of Virginia, Vietnamese Resettlement Association, Powhatan Society, Hispanic Committee of Virginia, private health care providers and consumers. MHAC's membership is intended to be representative of Virginia's minority and underserved populations. Their work includes advising and making recommendations to the VDH Commissioner, identifying limitations associated with existing laws, regulations, programs and services, identifying and reviewing health promotion and disease prevention strategies and supporting policies and legislation to improve accessibility and acceptability of health services.

Legislation requested by former Governor Kaine and adopted by the 2007 General Assembly gives greater emphasis on minority health issues by directing the State Health Commissioner to designate a senior staff member who is a licensed physician to direct the Department's minority health efforts. Michael Royster, M.D., M.P.H. has been appointed to this position and serves as the Director of Minority Health and Public Health Policy for the Department of Health.

/2012/ During the past year, the OFHS has been going through reorganization in order to combine functions and increase collaboration, efficiency and effectiveness. The new Division of Child and Family Health was created by combining the programs within the previous divisions of Dental Health, Women's and Infants' Health and Child and Adolescent Health. The previous division directors are currently program managers in their respective areas. Nancy Ford, B.S.N., M.P.H., is the Director of the new Child and Family Health Division. She has approximately 31 years of public health experience and previously served as the Director of Pediatric Screening and Genetic Services in the Division of Child and Adolescent Health.

The Division of Chronic Disease Prevention and Control and the Division of Injury and Violence Prevention were combined to create the new Division of Prevention and Health Promotion. Erima Fobbs, B.Sc., M.P.H., formerly the director of the Division of Injury and Violence Prevention is the director of the new division. Ramona Schaeffer, the former director of the Division of Chronic Disease Prevention and Control, remains as the chronic disease program manager.

Michael Welch, Ph.D. is the current director of the Division of Nutrition, Physical Activity and Food Programs following the retirement of Donna Seward. He has approximately 14 years of public health experience including his previous position as the Community Health Programs Manager (WIC, Lead Free Richmond, Dental and Chronic Disease) at the Richmond City Health Department.

The OFHS business unit is also undergoing some changes. Mr. Claiborne Watkins was recently appointed as the Deputy for Administration. Mr. Watkins previously served as the Director of Policy, Analysis, Procurement and Support Services for the Virginia Department of Alcoholic Beverage Control.

Future reorganization plans include the addition of a Policy and Evaluation Division. The division will consolidate the epidemiologists and the policy analysts in order to increase the standardization of data analysis and reporting, strengthen evaluation activities and increase the use of data in planning and decision making. //2012//

/2013/ During the past year, the OFHS completed its reorganization with the goals to combine and enhance functions and to increase collaboration, efficiency, and effectiveness. The current OFHS Director, Diane Helentjaris, M.D., M.P.H. is resigning and recruitment is underway for the new Director.

The Division of Child and Family Health is now comprised of Child Health, Reproductive Health, and Dental Health units. Nancy Ford, B.S.N., M.P.H., served as the director of this newly created division until her retirement in March 2012. Cornelia Ramsey, Ph.D., is the new director of this division effective May 25, 2012. The majority of programs in the former previous Divisions of Dental Health, Women's and Infants' Health and Child and Adolescent Health remained in the new division. However, the Every Woman's Life and WISEWOMAN programs are now included in the Division of Prevention and Health Promotion. Some additional program placement changes have been made within this new division. The sickle cell program was moved to the Child Health unit to be organizationally with the other Children with Special Health Care Needs programs. The Teen Pregnancy Prevention Initiative remains in the newly established Division of Child and Family Health, but has been relocated to the Reproductive Health unit of the division. The 2013-2014 state budget eliminates funding for this program. These programs will be transitioned under the abstinence program. Within the Reproductive Health unit, several new grant initiatives have resulted in increased capacity to work on expanded home visiting, abstinence, first-time motherhood, and pregnancy assistance fund for college students. In addition, state budget language requiring VDH to help increase enrollment in Plan First, the state Medicaid family planning waiver has also resulted in an additional staff person.

The Children with Special Health Care Needs Program remains within the Child Health unit. Nancy Bullock, the CSHCN director retired effective October 1, 2011. Sidnee' Dallas, M.Div., M.P.H., formerly with the VDH newcomer health program, started as the new CSHCN director in February 2012. While the program capacity and operations remains as described, the 2012 Virginia General Assembly eliminated a number of boards and advisory committees as a result of the Governor's Executive branch reorganization plan. The Virginia Hemophilia Advisory Board was eliminated with the requirement that the Virginia Board of Health continue to assure the development, implementation, and sustainability of a process for the receipt and consideration of advice and policy recommendations from, and on behalf of, persons suffering from hemophilia and other

related bleeding diseases.

Dental health capacity in Virginia will be experiencing changes in service delivery. The 2012 Virginia General Assembly expanded the authority for remote dental supervision of dental hygienists from three pilot health districts to statewide. In addition, the state budget for 2013-2014 calls for transitioning local health department dental services to a completely preventive model. The previous Dental Health unit and former Division of Dental Health director, Dr. Karen Day retired effective March 1, 2012. Recruitment for the dental program manager is currently underway.

The new Division of Prevention and Health Promotion continues to be led by Erima Fobbs, M.P.H. and is comprised of three units: Chronic Disease Prevention and Control; Health Promotion; and Injury and Violence Prevention. In addition to taking on the Every Woman's Life and WISEWOMAN programs, VDH obesity and physical activity initiatives have been relocated to this division under the Health Promotion unit. Previously these initiatives were under the formerly named Division of Nutrition, Physical Activity, and Food Programs.

The Division of Nutrition and Food Programs, renamed to reflect the movement of obesity and physical activity programs, continues to be led by Michael Welch.

A new Division of Policy and Evaluation has been created to provide leadership in data analysis, evaluation, and policy development in support of all OFHS programs. This new Division has five units: Education and Outreach; Epidemiology; Program Evaluation; Surveys and Analyses; and the Virginia Cancer Registry. Dev Nair, Ph.D., M.P.H., started as Director in February 2012. The Division incorporated functions of the previous Policy and Assessment Unit as well as some new areas. Janice Hicks who led this unit retired in September 2011. The newly formed Education and Outreach unit will expand OFHS capacity to provide more broad support and increase ability to provide culturally competent services. This unit has two new positions; one to specifically address special populations and one to provide outreach to Hispanic populations. This will help address the growing needs in light of changing demographics of Virginia's maternal and child health population to deliver more effective services. The Epidemiology unit combines staff previously in other divisions to provide more efficient data analyses for the office. The Program Evaluation unit will provide comprehensive evaluations of all programs on a cyclical schedule and include both grant required evaluation as well as broader and more systematic study of programs as they relate to cost/benefit; policy compliance; and other metrics. Surveys and Analyses contains the major public health surveys (BRFSS, PRAMS, YRBS) as well as provides legislative, policy analysis, and Institutional Review Board support. The Virginia Cancer Registry was moved into this division from the former Division of Chronic Disease Prevention and Control. //2013//

An attachment is included in this section. IIIB - Agency Capacity

C. Organizational Structure

The Virginia Title V program is housed within the Virginia Department of Health, one of twelve agencies within the cabinet level Health and Human Resources Secretariat. In January 2010, the newly elected Governor, Bob McDonnell, appointed Bill Hazel, M.D. as the Secretary of Health and Human Resources. Dr. Hazel is involved with numerous healthcare related associations and is a board certified orthopedic surgeon. Karen Remley, M.D., M.B.A., F.A.A.P., appointed by the previous governor Tim Kaine, has been reappointed as the State Health Commissioner. The Virginia Department of Health includes four deputy commissioners who provide oversight for Community Health Services; Public Health and Preparedness; Public Health; and Administration.

The Virginia Department of Health (VDH) is mandated by the Code of Virginia to "administer and provide a comprehensive program of preventive, curative, restorative and environmental health

services, educate the citizenry in health and environmental matters, develop and implement health resource plans, collect and preserve vital records and health statistics, assist in research, and abate hazards and nuisances to the health and environment, both emergency and otherwise, thereby improving the quality of life in the Commonwealth." In carrying out these responsibilities, VDH, in conjunction with the Board of Health, promulgates and enforces over 60 sets of regulations and manages over 70 federal and state grants.

In 1947, the Virginia General Assembly passed legislation requiring "each county and city to establish and maintain a local health department." Then in 1954, the Virginia General Assembly passed legislation that permitted the Department to organize the local health departments into 35 health districts which now include 119 local health departments. The local health departments are jointly funded by the state and the cities and counties that they serve. The local funding is based on the ability to pay with some localities contributing as little as 18% while others contribute as much as 45% match to state dollars. Each health district has a cooperative agreement that delineates the mandated basic health services that each district must provide and any additional services based on need and available funds. The General Assembly has authorized the local governments in Arlington and Fairfax to manage their own health departments and they operate under a contractual agreement with the state.

Section 32.1-77 of the Code of Virginia specifically addresses VDH's authorization to prepare and submit to the U.S. Department of Health and Human Services the state Title V plan for maternal and child health services and services for children with special health care needs. The Commissioner of Health is authorized to administer the plan and expend the Title V funds.

Within VDH's central office, the Title V Block Grant is managed by the Office of Family Health Services (OFHS). David Suttle, M.D., the OFHS director and also the Title V director retired on April 30, 2010 and Diane Helentjaris, M.D., M.P.H. was appointed as OFHS director on May 25, 2010. Dr. Helentjaris reports directly to the Chief Deputy Commissioner for Public Health. Other offices under the direction of the Deputy for Public Health include Drinking Water, Epidemiology and Environmental Health.

/2012/ Maureen Dempsey, M.D., F.A.A.P., was appointed as the Chief Deputy Commissioner for Public Health in November, 2010. //2012//

The administration of the Block Grant resides at the OFHS office level while divisions within the Office have specific responsibility for carrying out MCH programs. The divisions include Dental Health, Women's and Infants' Health, Chronic Disease Prevention and Control, Child and Adolescent Health, Nutrition, Physical Activity and Food Programs and Injury and Violence Prevention. The CSHCN program resides within the Office's Division of Child and Adolescent Health.

The mission of the OFHS is to provide the leadership, expertise and resources that enable all Virginia residents to reach and maintain their optimum level of health and well-being throughout life. In order to accomplish this, the office is organized into the Director's office and six divisions. The Director's office includes crosscutting functions which are comprised of the Business Unit and the Policy and Assessment Unit. The Business Unit includes budgeting, accounting, contracting, grants management, procurement and human resource functions. The Policy and Assessment Unit (PAU) mission is to assure that valid, reliable, and timely health information is available to direct effective policies and actions. More specifically the PAU provides leadership in the development and management of the Title V and the Preventive Health and Health Services (PHHS) block grants; manages special information technology projects; coordinates the legislative review process; manages the Behavior Risk Factor Surveillance System Survey (BRFSS), the Pregnancy Risk Assessment Monitoring System (PRAMS) and the Virginia Youth Survey (VYS), the Virginia Assessment Initiative (VAIP) and the State Systems Development Initiative (SSDI); creates and maintains a standard electronic repository of OFHS health-related data including linked datasets; develops and provides web-based tools to disseminate health

information for community health assessments; and provides training and consultation to OFHS staff regarding epidemiologic practices, statistical analysis and program evaluation.

/2012/ See Agency Capacity section for detailed information on the OFHS reorganization. //2012//

Title V funds are provided annually to the 35 health districts to support maternal and child health services. The district funding levels are based on an estimate of the proportion of low income (200% FPL) births within each of the districts. A total of approximately \$3.5 million is annually provided to the districts. Currently district Title V funding addresses the following areas: perinatal services, dental services, injury prevention, obesity prevention, infant mortality, breastfeeding, teen pregnancy prevention, child care safety, and access to care.

Organizational charts for the Virginia Department of Health and the Office of Family Health Services are attached.

/2013/ Diane Helentjaris, M.D., M.P.H, the current OFHS Director is resigning and recruitment for the new Director is underway. Details regarding the completed OFHS reorganization are in the Agency Capacity section. //2013// An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

Virginia's MCH Program, comprised of staff in the Office of Family Health Services, includes a highly skilled and diverse team of public health professionals representing a variety of disciplines. Thirty-six and a half full-time equivalent positions (FTEs) in the OFHS are funded by the MCH Block Grant. In addition, numerous district health department staff, including physicians, public health nurses, and support staff are also supported in part by Title V funds.

Senior level MCH staff in the Office of Family Health Services include the following:

Diane Helentjaris, M.D., M.P.H. was appointed as the Director of the Office of Family Health Services effective May 25, 2010 following the retirement of David Suttle, MD. Dr. Helentjaris previously served as the director of the Loudoun Health District and the Lord Fairfax Health District, the Richmond City Health Department's deputy director, director for the H1N1 Response, the Deputy State Epidemiologist, and Deputy Director of the Office of Epidemiology. She also serves as an affiliate faculty member in the Virginia Commonwealth University's Department of Epidemiology and Community Health.

/2013/ Dr. Helentjaris is resigning her position. Recruitment for the OFHS Director is currently underway. //2013//

Janice M. Hicks, Ph.D. has served as the Policy and Assessment Director since 1997 and as the Office of Family Health Services' Senior Policy Analyst since 1994. She has over 20 years of experience in planning, evaluation and legislative analysis. Dr. Hicks also has experience in teaching college level courses in Sociology, Research Methods, Evaluation, Social Theory, Family, and Criminology/Juvenile Delinquency. She also serves as an adjunct faculty member in the Virginia Commonwealth University's Department of Epidemiology and Community Health.

/2013/ Dr. Hicks retired in September 2011. //2013//

The Policy and Assessment Unit includes the grants coordinator (Robin Buskey), the State Systems Development Initiative (SSDI) Coordinator (Caroline Stampfel), the MCH Epidemiologist (Derek Chapman, PhD.), the Behavioral Risk Factor Surveillance System Coordinator (Susan Spain), a Senior Health Policy Analyst (Kim Barnes) who continues to serve as the agency HIPAA compliance officer, the OFHS liaison to the Department of Medical Assistance Services on

issues involving Medicaid and FAMIS and participates in special projects that include business intelligence applications, emergency preparedness and health information exchange. Marilyn Wenner serves as the PRAMS Coordinator, Shanee Harmon serves as the Virginia Youth Survey Coordinator (YRBS) and Michelle White is the Virginia Assessment Initiative Coordinator.

/2012/ Caroline Stampfel resigned in March 2011 to take a position as Senior Epidemiologist at the Association of Maternal and Child Health Programs (AMCHP). Kim Barnes was transferred to the Office of Information Management and is currently working on the health information exchange project. She continues to serve as the agency HIPPA compliance officer. //2012//

/2013/ Following Ms. Stampfel's resignation, Kristin Austin, formerly the PRAMS data analyst, accepted the position; the MCH Epidemiologist, and SSDI Coordinator. Ms. Austin resigned in the fall to accept a position at Virginia Commonwealth University. Christopher Hill is currently serving as the MCH Epidemiologist. He was previously the MCH Epidemiologist in the Wyoming Health Department. Both Robin Buskey and Michelle White resigned in 2011. Susan Spain resigned effective March 1, 2012. Shanee Harmon has taken over the role of the Behavioral Risk Factor Surveillance System Coordinator.

As a result of the reorganization, the Division of Policy and Evaluation was established. Dev Nair, Ph.D., M.P.H. is the new director. He is president-elect of the Virginia Public Health Association and a prior Director of Clinical Review Services at Virginia Health Quality Center (the federally designated quality improvement organization for the Commonwealth). He previously served as a deputy Medicaid director in Georgia. In this role he was responsible for clinical and quality operations with a primary focus on improving the health care of Medicaid recipients.

The Division of Policy and Evaluation includes the staff from the Policy and Assessment Unit and the Cancer Registry and consolidates the office epidemiology and evaluation functions as well as training. Efforts are continuing to fill a number of division vacancies resulting from resignations as well as new positions established in the division. //2013//

Karen Day, D.D.S., M.S., M.P.H., has served in her current capacity as Director of the Division of Dental Health with the Virginia Department of Health (VDH) since 1996. Prior to this position she served as Community Water Fluoridation Coordinator for the Division for three years and as a public health dentist for fifteen years. Dr. Day has taught graduate and undergraduate courses at Virginia Commonwealth University including biology, oral epidemiology, principals of public health and public health dentistry.

/2012/ The Dental Health program is now a part of the new Division of Child and Family Health. Dr. Day is currently the Dental Health program manager. //2012//

/2013/ Dr. Day retired in March 2012. Recruitment is underway for the Dental Health program manager position. //2013//

Nancy R. Bullock, R.N., M.P.H., the CSHCN Program Director, has over 40 years of experience in public health in Virginia. She served as a nurse consultant, program and division director at the state level and at the local level as a public health nurse and nurse manager. She has been the director of the CSHCN Program since 1991.

/2013/ Nancy Bullock, the CSHCN director retired effective October 1, 2011. Sidnee' Dallas, M. Div., M.P.H., formerly with the VDH newcomer health program, started as the new CSHCN director in February 2012. //2013//

Joan Corder-Mabe, R.N.C., M.S., W.H.N.P., was selected as the Director for the Division of Women's and Infants' Health in 2001. Previously she served as the perinatal nurse consultant and the Acting Division Director. She is responsible for programs including the Title X Family

Planning, the Virginia Healthy Start Initiative, the CDC Breast and Cervical Cancer Early Detection Program, Partners in Prevention, the Resource Mothers Program, Women's Health, the Regional Perinatal Councils, and the Comprehensive Sickle Cell Program. She and the division staff also provide consultation and technical assistance to the local health departments serving perinatal clients.

/2012/ The Women's and Infants' Health program is now a part of the new Division of Child and Family Health. Ms. Corder-Mabe is currently the Women's and Infants' Health program manager. //2012//

Joanne S. Boise has served as Director of the Division of Child and Adolescent Health since June 2001. With a background in nursing, she holds an M.S.P.H. in health policy and administration. Prior to joining VDH, Ms. Boise spent fifteen years in the managed care industry working locally and nationally; she has held positions in health policy, HMO operations, quality improvement, utilization management, and network management. She oversees the VDH newborn screening programs, CSHCN programs, early and school age childhood initiatives, and teen pregnancy prevention. She co-leads the Bright Futures Virginia effort and works closely with the Virginia Chapter of the American Academy of Pediatrics on a number of projects to improve well-child care. She was a member of Virginia's Core Team for the ABCD Screening Academy and continues to champion the medical home, routine developmental screening as part of well child care, and prompt referral to early intervention.

/2012/ The Child and Adolescent Health program is now a part of the new Division of Child and Family Health. Ms. Boise is currently the Child and Adolescent Health program manager. //2012//

/2013/ Nancy Ford served as the Director of the Division of Child and Family Health until her retirement in March 2012. Cornelia Ramsey, Ph.D., is the new division director effective May 25, 2012. //2013//

Donna Seward, B.S., has served in her current capacity as the Director of the Nutrition, Physical Activity and Food Programs (formerly the Division of WIC and Community Nutrition Services) since April 2000. She is responsible for the management of Virginia's WIC program and two new food programs -- the Child and Adult Care Food Program and the Summer Food Service Program. She also has responsibility for CHAMPION, the obesity prevention initiative. From 1976 to 2000 she served as the WIC Director at the local level in Texas. Her educational background is in health care management.

/2012/ Following Donna Seward's resignation, Michael Welch was appointed as the Division Director. //2012//

Erima S. Fobbs, B.Sc., M.P.H., is the Director of the Division of Injury and Violence Prevention (DIVP). Her MPH included a concentration on Epidemiology and Health Services Administration. She has over 22 years of experience in prevention and has directed Virginia's statewide injury and violence prevention program since 1994. She has also taught courses on the Epidemiology and Prevention of Intentional Injury as an adjunct assistant professor at MCV/VCU department of Preventive Medicine and Public Health and is a certified suicide prevention and bullying prevention program trainer.

/2012/ Erima Fobbs is currently serving as the Director of the new Prevention and Health Promotion Division. //2012//

In the fall of 2004, OFHS contracted with the Virginia Commonwealth University's Public Health program to hire a faculty level MCH epidemiologist. Derek Chapman, Ph.D. was hired in this jointly appointed position that is supported in part by SSDI funds. Dr. Chapman previously served as the Director of Research at the Tennessee Department of Health and has a number of years

of experience working with MCH data. The joint appointment of Dr. Chapman provides an opportunity for greater collaboration between the OFHS and the VCU Public Health program and has resulted in benefits for both OFHS and the University through increased opportunities for grants, student internships, technical assistance and publications. Dr. Chapman works closely with the division level epidemiologists to establish greater access to data including the development of the OFHS Data Mart, a repository of data selected and organized to support the surveillance and evaluation needs of the OFHS epidemiologists. The Data Mart consists of key datasets that are cleaned, aggregated, and standardized to enable automation of regular ongoing surveillance reporting and analysis. The data are used by all divisions for surveillance, assessment, program planning, grant applications, and grant reporting.

The OFHS Policy and Assessment Unit has taken advantage of the Council of State and Territorial Epidemiologists' (CSTE) 2-year fellowship program. Caroline Stampfel, the first CSTE fellow placed in the OFHS, was hired as an OFHS MCH epidemiologist following her fellowship. The second fellow, Andrea Alvarez, completed her CSTE fellowship and was hired by the VDH Office of Epidemiology. A third CSTE fellow will join the Policy and Assessment Unit in August 2010 for a 2-year fellowship.

/2012/ Gandarvaka Gray, a CSTE fellow, joined the Policy and Assessment Unit in August 2010. //2012//

/2013/ Gandarvaka Gray's CSTE fellowship will end in August 2012. She has been accepted into the UNC-Chapel Hill public health doctoral program. //2013//

The OFHS Policy and Assessment Unit has also hosted a number of MCHB Graduate Student Internship Program (GSIP) students over the years. Currently, a graduate student from the University of North Carolina is serving as a GSIP intern for the summer.

/2011/ Two new GSIP students will work with Policy and Assessment staff this summer. One will be working on PRAMS fact sheets while the other will be working on identifying state performance measures for the Title V Priority #8 - optimal child development. //2012//

In order to continue to increase our capacity and to better use our available resources, the Policy and Assessment Unit has created a team to review all research and evaluation proposals. The review team, made up of Policy and Assessment staff as well as research-related representatives from the Divisions, work closely with Division staff to review plans for research and evaluation activities to be completed in-house or through a contractor.

The benefits of this new review process include:

A decrease in the duplication of research and evaluation activities that occur across the OFHS divisions;

An increase in the amount of funding available for program activities and a decrease in the amount of funding spent on research and evaluation activities;

An increase in the research and evaluation capacity of OFHS program staff;

An increase in collaboration across the OFHS divisions;

An increase in the identification of qualified contractors;

An increase in OFHS staff support in developing their research activities; and

An increase in oversight of all research and evaluation activities to ensure that work that is contracted out is reasonable, cost-effective, and necessary.

/2012/ Beginning this year, the OFHS will manage and staff the agency Institutional Review Board (IRB). //2012//

/2013/ A new Coordinator for the State Child Fatality Review Team, Emily Gambill, was hired in July 2011. Ms. Gambill is participating in relevant workgroups and statewide

committees including representing Virginia's child fatality review efforts on the regionally based Southeastern Coalition on Child Fatalities. //2013//

Family Involvement

OFHS provides a number of opportunities for family input into the MCH and CSHCN programs. A parent feedback survey is used to assess the services provided by Care Connection for Children centers, Bleeding Disorders Program, and the Child Development Clinics. The Care Connection for Children (CCC) centers employ parents of CSHCN as parent coordinators. In addition, the centers have contractual relationships with the coordinators of Parent to Parent of Virginia, the Family to Family Network of Virginia and Medical Home Plus to provide outreach, support, mentorship, and training to parents. They have assisted the Care Connection for Children centers in establishing their family-to-family support services. Parents from Parent to Parent of Virginia provided input into Virginia's state CSHCN plan to meet the Healthy People 2010 goals. Parent focus groups have provided input for various MCH related programs. Family representatives serve on the Regional Perinatal Councils, the Hemophilia Advisory Board, the Fetal Alcohol Spectrum Disorder Task Force, the Virginia Early Hearing Detection and Intervention Advisory Committee and its Parent Subcommittee, and the Virginia Genetics Advisory Committee. OFHS staff also participates in a number of organizations with families such as the Virginia Chapter of the Hemophilia Foundation, Spina Bifida Foundation, Cystic Fibrosis Foundation, Virginia SIDS Alliance, Virginia Parents Against Lead, and the Virginia Congress of Parents and Teachers.

The federally funded Family to Family Health Information Center (F2FHIC), is based within the VCU Partnership for People with Disabilities, recognized by the federal Administration on Intellectual and Developmental Disabilities as a university center for excellence in developmental disabilities. The Center is a collaborative effort among three organizations: Center for Family Involvement at the Partnership for People with Disabilities, Parent to parent of Virginia, and Medical Home Plus. Each of these organizations has parent staff that have children with special health care needs. Through family support services, the Center for Family Involvement (home to Virginia's Family to Family Network) addresses the need for families to have adequate information, training and support to increase their skills as participants in decision-making processes regarding their child and the broader system of care. The Family to Family Network (Virginia's F2FHIC) works with over 750 families each year to support their development of skills as advocates, mentors and community leaders.

Dana Yarbrough, Executive Director of Parent to Parent of Virginia serves as Virginia's family liaison delegate to the Association of Maternal and Child Health Programs (AMCHP). Dana and Parent to Parent of Virginia currently work closely with Virginia's CSHCN program, Care Connection for Children.

E. State Agency Coordination

In Virginia, state health and human services agencies are organized under the jurisdiction of the cabinet level Secretary of Health and Human Resources who is appointed by the governor. The major health and human services agencies include the Department of Health, the Department of Medical Assistance Services, the Department of Behavioral Health and Developmental Services (formerly the Department of Mental Health, Mental Retardation and Substance Abuse Services), and the Department of Social Services. The Departments of Juvenile Justice and Corrections, and the Department of Education are located under different cabinet secretaries. The Health and Human Resources Secretariat also includes a number of advisory boards that provide opportunities for coordination including the Governor's Advisory Board on Child Abuse and Neglect, the Child Day Care Council and the Governor's Substance Abuse Services Council.

There are also ongoing opportunities to work with Virginia's health education programs and universities. For example, OFHS contracts with the Virginia Commonwealth University's (VCU) Department of Preventive Medicine and Community Health for the services of a faculty level MCH epidemiologist to work within the OFHS. A number of the state universities, including VCU, Virginia Tech, Eastern Virginia Medical School, George Mason University, James Madison University and the University of Virginia have been involved in activities such as trainings, including web-based training, research and report writing, web development and evaluations of programs. OFHS has contracts with university medical centers to provide child development services and CSHCN services through Care Connection for Children. Other contracts with University medical centers include sickle cell, genetic consultation/services and bleeding disorder services.

The Department of Medical Assistance Services (DMAS) continues to bring the public and private sector together to address issues related to service delivery for mothers and children. The Child Health Insurance Advisory Committee (CHIPAC) has representatives from state agencies, private industries, providers and consumers. An OFHS staff is a member of this committee.

An interagency agreement exists between VDH and DMAS for the coordination of Titles V and XIX services. The assignments of responsibilities as stated in the agreement are intended to result in improved use of state government resources and more effective service delivery by assuring that the provision of authorized Medicaid services is consistent with the statutory function and mission of VDH. The agreement has been modified to include a Business Associate Agreement for the purpose of data sharing. The current data sharing projects involve the exchange of blood-lead testing results, eligibility information and decedent information.

/2013/ The data exchange agreement between VDH and DMAS has been amended to include sharing of data to evaluate the Medicaid family planning waiver Plan First enrollment and effectiveness. //2013//

The interagency agreement also includes coordination of Medicaid and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). The agreement includes mechanisms to assist eligible women and infants to obtain Medicaid coverage and WIC benefits. In addition, the Maternal Outreach Program - a cooperative agreement which expands the VDH Resource Mothers Program - supports the coordination of care and services available under Title V and Title XIX by the identification of pregnant teenagers who are eligible for Medicaid and assisting them with their eligibility applications.

DMAS directs the EPSDT Program and collaborates with the VDH and DSS on specific components of the program. VDH interagency responsibilities include, when appropriate, (1) providing consultation on developing subsystem and data collection modifications and (2) collaborating on (a) modifying the Virginia EPSDT Periodicity Schedule based on Bright Futures, (b) developing materials to be included in the EPSDT Supplemental Medicaid Manual and other provider notices as may be required, (c) providing EPSDT educational activities targeted to local health departments, (d) implementing strategies that will increase the number of EPSDT screenings, and (e) making available current EPSDT program information and materials that are needed to communicate information to local health department patients.

The Department of Medical Assistance Services, in collaboration with the Departments of Health and Social Services, worked together to link high-risk pregnant women and infants to Baby Care. The program services include outreach and care coordination, education, counseling on nutrition, parenting and smoking cessation and follow-up and monitoring. This program has demonstrated significant improvements in birth outcomes. OFHS staff participate in trainings with DMAS staff on such topics as Bright Futures and EPSDT.

The OFHS contracts with the six regional sites that make up the Statewide Human Services

Information and Referral System, administered by the Virginia Department of Social Services, for information and referral services for the MCH Helpline. The system can be accessed from any location in the Commonwealth by dialing "211." The system has been helping Virginians since 1974. This number also serves as the state number for the National Baby Line to provide information and referral for prenatal care. Data documenting maternal and child health related service calls are collected and reported to the OFHS quarterly as required by the contract. This information provides data for future needs assessments and program. Copies of the most recent contracts are on file in the OFHS.

/2012/ The OFHS was awarded a federal First Time Motherhood grant that will focus on linking families with resources through 2-1-1 Virginia. The grant provides funding for community liaisons to work with each of the call centers and local and state agencies to ensure that up to date service information is available to families. The current contracts with the six regional centers will be combined with the First Time Motherhood funded contract with the Virginia Department of Social Services. Data documenting maternal and child health service calls will be collected and reported as in the past. //2012//

Children with Special Health Care Needs

The Division of Child and Adolescent Health's Care Connection for Children (CCC) and the Child Development Clinic Services (CDC) programs have provider agreements with the Department of Medical Assistance Services. Copies of these agreements are on file in the Office of Family Health Services and are reviewed periodically. The CCC and CDC programs bill Medicaid for physician, laboratory, psychological, and hearing services. In the past, DCAH worked with DMAS to revise several state-specific reimbursement codes used for CSHCN.

/2012/ Both the Care Connection for Children (CCC) and the Child Development Clinic Services (CDC) programs are now located in the newly created Division of Child and Family Health. //2012//

A collaborative relationship has also been established between the Care Connection for Children Program, the Social Security Administration Field Office in Virginia and the Disability Determination Services in the Virginia Department of Rehabilitative Services to enhance each program's roles and responsibilities pertaining to the SSI beneficiaries. Strategies for publicizing each program, facilitating application for benefits and services, expediting referrals, acquisition of medical and other evidence, and reciprocal training about programs available to children with disabilities are continuing.

An interagency agreement exists between VDH and the Department of Education (DOE) for the inclusion of educational consultants as members of the interdisciplinary teams in CDC and CCC centers. The consultants provide liaison services among the clinics and centers, the children's families and local education agencies serving the children. Duties include administering and interpreting developmental and/or educational evaluations; identifying learning styles, strengths, and weaknesses; recommending educational strategies and modifications; consulting with school personnel regarding modifications in school programs; monitoring and reevaluating progress of the children; and providing staff development. DOE provides the position and funding and contracts with a local school division to provide the supervision and fiscal management of the position. VDH provides the housing and secretarial support and participates in the evaluation of the educational consultants.

The Title V program has established and maintains ongoing interagency collaboration for systems building in some defined areas. The Title V program collaborates with DOE to develop and maintain guidelines for school health services for CSHCN, such as the First Aid Guide for School Emergencies and the Guidelines for Specialized Health Care Procedures. VDH and the American Lung Association have established the Virginia Asthma Coalition to assess needs, share information, and collaborate on the use of available resources.

Other Collaborative Agreements

The Commissioner of the Department of Health serves on the Early Intervention Agencies Committee that was established in 1992 through Section 2.1-760-768 of the Code of Virginia to ensure the implementation of a comprehensive system of early intervention services for infants and toddlers. A representative from the DCAH is an active participant on the Virginia Interagency Coordinating Council (VICC). At the local level, professional staff from the health departments and the Child Development Clinics serve on the local interagency coordinating councils.

The Comprehensive Services Act for At-Risk Youth and Families provides a comprehensive, coordinated, family-focused, child-centered, and community-based service system for emotionally and/or behaviorally disturbed youth and their families throughout Virginia. One representative from VDH/Title V serves on the State Executive Council and another serves on the State and Local Advisory Team (SLAT). Other representatives from the state and local health departments serve on workgroups. Local health departments and/or Child Development Clinic representatives may serve on local community policy and management teams and family assessment and planning teams.

The Title V funded programs are also coordinated with other health department programs that serve a common population group including Immunization, STD/AIDS, and Emergency Medical Services. Immunizations are provided as part of local health department services as are family planning and well-child services. Screening and treatment for STDs are provided in family planning clinics. Family planning, prenatal, and well-child patients may be referred to health department dental services.

OFHS works closely with the Department of Education to implement the Virginia Youth Survey (YRBS). The OFHS Dental program also works closely with local school districts, local schools and WIC programs to provide dental preventive services and surveillance.

The Breastfeeding Advisory Committee is comprised of Virginian stakeholders representing various organizations. The member organizations represent a variety of practice settings and create a multidisciplinary membership. They work in partnership with OFHS to aid in increasing the incidence and duration of breastfeeding among mothers. Representatives include such organizations as the American College of Nurse Midwives, the American Dietetic Association, universities, La Leche League, Medela, the Virginia Nurses Association and others.

The Virginia Chapter of the March of Dimes (MOD) continues as a significant partner in advocating for women and infants. The MOD has worked closely with Virginia's Healthy Start program and with the home visiting programs across the state.

The Commissioner's Infant Mortality Work Group, staffed by OFHS, involves members of the community who have credibility and can influence local families. In addition to medical/health professionals, a wide range of community members such as local educators, civic and business officials, the NAACP, and the AARP are included as members.

Established in 2010 by the Secretary of Health and Human Resources, the Interagency Taskforce on Obesity and Nutrition is a multi-agency work group that is led by the Commissioner of Health. The Taskforce, which has representation from the Departments of Health, Education, Agriculture, Aging, Human Resources Management and Social Services, and the Virginia Foundation for Healthy Youth, was formed to promote wellness and improve nutrition and physical activity, including offering healthier food and beverage choices to state employees.

Intra-agency and interagency collaboration will continue with the above mentioned agencies and others such as, WIC, the Office of Primary Care and Rural Health, Title X -- Federal Family Planning Program, the Commission on Youth, the Virginia Commission on Health Care, the VDH

Office of Minority Health and Public Health Policy, the Virginia Community Healthcare Association (formerly the Virginia Primary Care Association), and the Virginia Hospital and Health Care Foundation. In addition, Title V staff will continue to support community-based organizations that have been working to improve the health of the MCH population including organizations such as the Virginia Perinatal Association, the Virginia Association of School Nurses, the Virginia Chapter of the March of Dimes and numerous single disease oriented voluntary organizations.

/2013/ As a result of legislation passed in the 2012 Virginia General Assembly and signed by the Governor, VDH has convened a workgroup with the Departments of Education and Health Professions to revise guidelines for the recognition and treatment of anaphylaxis in the school setting. The workgroup also includes representatives from local school districts, Virginia Chapter-American Academy of Pediatrics, Virginia Association of School Nurses, Medical Society of Virginia, Office of the Attorney General, Virginia Nurses Association, and Virginia Academy of Family Physicians. The legislation requires local school boards to adopt and implement policies for the possession and administration of epinephrine in every school. The legislation also authorizes school nurses and trained school board employees to administer epinephrine to any student believed to be having an anaphylactic reaction. This workgroup is developing changes to the current Virginia School Health Guidelines to address concerns such as issuance of orders; standing protocols for possession, storage, and administration; training needs; requirements for the administration of epinephrine; liability questions; and potential regulatory needs. These new policies must be in effect in every school by the beginning of the 2012-13 school year. VDH will continue to work with DOE regarding training, technical assistance, and potential funding issues to assist schools in the implementation of the new requirements for stock epinephrine possession and administration as required by the Code of Virginia. This legislation and subsequent policies are intended to improve school capacity to respond to anaphylactic reactions and reduce potential mortality associated with these reactions. //2013//

Title V staff will continue to represent the MCH interests on numerous interagency councils, task forces and committees such as the Governor's Office for Substance Abuse Prevention (GOSAP), the Governor's Council on Substance Abuse Services, and the Governor's Advisory Board on Child Abuse and Neglect, and the Child and Family Behavioral Health Policy and Planning Committee. Title V staff represents the VDH on the legislatively mandated Children's Health Insurance Program Advisory Committee (CHIPAC).

To facilitate the work of the Secretary of Health and Human Resources, the Title V program staff will continue to provide analysis and recommendations to the Governor on legislation before the General Assembly that will directly affect VDH programs and women's and children's health in Virginia. OFHS staff will continue to review and comment on legislation, regulations, and standards of other state agencies from a maternal and child health perspective.

Copies of all interagency agreements are maintained on file in the Office of Family Health Services and are reviewed and amended as required.

See attached list of additional interagency workgroups, committees and advisory groups.
An attachment is included in this section. III E - State Agency Coordination

F. Health Systems Capacity Indicators

Reducing infant mortality is a major initiative of the Virginia Department of Health and priority of the Title V Maternal and Child Health Block Grant. Several of the Health Systems Capacity Indicators (HSCI) measured for the Title V application are relevant to the status of Virginia's perinatal health system and its relationship to infant mortality. Adequate prenatal care is associated with better pregnancy outcomes including reduced infant mortality. HSCI 4: The percent of women (15 through 44) with a live birth whose observed to expected prenatal visits are

greater than or equal to 80 percent using the Kotelchuck Index has fluctuated in Virginia over the past five years. In 2010, 73.8% of women with a live birth reached this threshold. This was lowest observed figure in the past five years. The highest percentage occurred in 2008 when 78.2% of women received adequate care. HSCI 5: Medicaid and non-Medicaid Comparisons show that the Medicaid population received adequate care in 70.5% of cases versus 75.1% for the non-Medicaid population. The disparities in the Medicaid versus non-Medicaid populations are evident across all HSCI 5. Only 75.4% of Medicaid enrollees started prenatal care in the first trimester versus 84.6% of non-Medicaid enrollees. However, the percent who started in the first trimester and those who obtained adequate care dropped more steeply among the non-Medicaid population. This suggests that although a higher proportion of Medicaid women are enrolling in prenatal care at later dates, once they are enrolled they are receiving the adequate number and timing of visits to a greater degree than non-Medicaid populations. This pattern was observed in 2009 as well when 74.1% of Medicaid women enrolled in the first trimester and 71% of them received adequate care. This compares to 85.9% of the non-Medicaid population enrolling in the first trimester, however, the percentage of those going on to receive the expected number of visits dropped to 78.4%.

First trimester entry into prenatal care exhibits racial disparities despite Medicaid or non-Medicaid status. White (non-Hispanic) females had the highest entry percentages at 91.1% (non-Medicaid) and 79.3% (Medicaid). Hispanics had the lowest levels regardless of Medicaid status (77.4% for non-Medicaid and 72% for Medicaid). Black (non-Hispanic) females had percentages of 85.5% for non-Medicaid and 76.2% for Medicaid.

Adequacy of care followed the same patterns as first trimester entry into care. White (non-Hispanic) females had the highest percentages at 77.6% (non-Medicaid) and 74.0% (Medicaid). Hispanic females had the lowest percentages at 64.6% (non-Medicaid) and 61.6% (Medicaid). Black (non-Hispanic) females had percentages of 74.4% (non-Medicaid) and 71.2% (Medicaid). Over the past ten years racial disparities in general have been narrowing due to decreases among whites who have seen levels of adequate care drop from 85.7% in 2001 down to 76.8% in 2010.

The low birth weight (less than 2,500 grams) percentage among Hispanics increased slightly from 2009 (6.1% for both Medicaid and non-Medicaid) across both the Medicaid and non-Medicaid groups. The levels actually decreased in both groups for both non-Hispanic whites (9.4% Medicaid, 6.4% non-Medicaid) and blacks (14.3% Medicaid, 11.9% non-Medicaid).

Despite this decline in adequate prenatal care, the percentage of low weight births and infant death rates declined statewide between 2009 and 2010. Among all women low weight births decreased from 8.3% to 8.1% and the infant mortality rate decreased from 7.0 to 6.8 per 1,000 live births. Overall, however a ten year period there has not been a significant decrease in either low weight births or infant mortality. Low weight births dropped in the Medicaid population from 10.6% to 10.1% and infant deaths dropped from 9.3 to 8.8 per 1,000 live births. Among non-Medicaid populations, the infant death rate did not decrease. It went from 5.1 per 1,000 live births to 5.3 per 1,000 live births. Among non-Hispanic blacks, the infant mortality rates observed were highest in both the Medicaid (13.6) and non-Medicaid (13.8) populations. The non-Medicaid rate was actually higher among blacks (non-Hispanic), which is not observed among whites (non-Hispanic) or Hispanics. Both Hispanic and non-Hispanic white populations on Medicaid had higher infant mortality rates than their cohorts without Medicaid. For Hispanics, the rates were 7.6 (Medicaid) and 5.9 (non-Medicaid). Among non-Hispanic whites, the rates were lowest observed, however the rate among white (non-Hispanic) Medicaid recipients was 5.7 compared to 3.6 among the non-Medicaid counterparts. Although the disparities remain between the Medicaid and non-Medicaid populations, the Medicaid population overall saw gains between 2009 and 2010 in HSCI 5 and most notable in the drop in the infant mortality rate.

The multi-faceted initiatives at VDH include both overall population and systems based approaches as well as multiple efforts aimed at improving perinatal outcomes among high risk

populations such as Medicaid enrollees. At the highest level, the State Health Commissioner has led an Infant Mortality Work Group for the past four years. This workgroup includes medical and health professionals as well as community and civic leaders who meet regularly to review data and collaborate to promote statewide initiatives and general awareness about the importance of reducing infant mortality. This workgroup has partnered with Healthy Mothers, Healthy Babies (HMHB), CDC, the White House, the Department of Defense, George Washington School of Public Health, and numerous public and private organizations in Virginia to implement the text4baby campaign. Women enroll into the service and receive three free text messages per week. These messages are timed to the due date or baby's date of birth and cover such topics as birth defects prevention, immunization, nutrition, mental health, oral health, and safe sleep. The messages also connect women to prenatal and infant care services and other resources. As of March 2012, over 12,000 Virginia women were enrolled in text4baby. Customized PSAs were developed by HMHB and have been distributed to local Virginia media.

The Silent Epidemic, a power point presentation was created as a method to provide a consistent message pertaining to infant mortality reduction strategies, including the need for the mother to receive early and adequate prenatal care. The Silent Epidemic has two components one designed to use with community leaders and one to use with professionals. Over the last two years it has been used for over 16 sessions including over 500 community and professional partners.

Guiding Virginia efforts to continuously assess its health systems capacity and relationship to perinatal outcomes, Virginia has administered the Pregnancy Risk Assessment Monitoring System (PRAMS) for the past four years. PRAMS obtains information regarding pregnancy experience and outcomes from a sample of new mothers. Low weight births are oversampled in Virginia in order to gain more insight on issues that may be faced in this population. These data are analyzed and presented annually to groups such as the Infant Mortality Work Group in order to keep abreast of system issues.

Multiple fatality review efforts are led by the VDH. Five Regional Perinatal Councils (RPCs) are funded to conduct Fetal and Infant Mortality Reviews to identify systems issues that can be addressed at the community level. In addition, the Office of the Chief Medical Examiner operates fatality review efforts including the State Child Fatality Review Team which reviews child deaths including infant deaths and the State Maternal Mortality Review Team which reviews all deaths to women within one year of the end of their pregnancy.

The Department of Medical Assistance Services (DMAS) continues to emphasize maternal and child health services. The Department's Division of Maternal and Child Health is devoted exclusively to the management of such services within the Medicaid and SCHIP populations. VDH continues collaborative efforts with DMAS to expand data sharing efforts and continue to analyze disparities in health systems capacity indicators. DMAS has recently developed a data warehouse which will be able to provide better quality and more timely data for internal analysis as well as collaborative efforts.

RPCs address health systems issues based on community need. The Central Virginia RPC conducted a survey to assess the current use of 17 alpha hydroxyprogesterone caproate (17 P) by providers and identify issues pertaining to obtaining and administering 17 P. RPCs staff disseminated the DMAS memorandum used to clarify the coverage of 17 P for fee-for-service and managed care enrollees. Additionally, staff partnered with DMAS to provide a webinar to clinicians on 17 P. This exemplifies using health systems data and targeting efforts to improve health care in the Medicaid population.

VDH has numerous other efforts to help reduce the disparities observed in low birth weight, adequate prenatal care, and infant deaths between the Medicaid and non-Medicaid populations. Approximately 3.5 million in Title V funding goes to Virginia's 35 health districts to support services including prenatal care. In FY 2011, 29 of the 35 health districts used Title V funds to

provide prenatal services including pregnancy testing, referral to private prenatal care providers, direct prenatal care, and case management services.

VDH continues to lead the state Home Visiting Consortium and directly administer ongoing programs such as the Virginia Healthy Start Initiative (VHSI) and Resource Mothers Programs. VHSI and Resource Mothers have implemented strategies to increase the number of pregnant women who enter prenatal care in the first trimester and keep their prenatal appointments which will increase those receiving adequate care. In FY 2011, 73% of new VHSI enrollees and 70% of new Resource Mothers enrollees entered prenatal care in the first trimester. The Maternal, Infant and Early Childhood Home Visiting project (MIECHV) will continue to fund local sites to improve early childhood systems of care including access to prenatal care. Virginia was recently awarded an additional \$6.2 million to increase funds for this project. Expansion of home visiting services through this project will increase the number of families who are linked to services and resources in Virginia.

To increase access to early prenatal services, a pilot project has begun with three emergency room (ER) departments within Virginia. All women diagnosed as pregnant during the ER visit will be provided with a completed Pregnancy Verification Form, which is required with the submission of Medicaid and FAMIS PLUS applications. The form was developed and approved by the DMAS for hospitals to revise and use as needed. Two hospitals are taking steps to integrate this form and the process into their electronic medical record. Three other hospitals are considering how to implement this process in their emergency departments. All women will be provided information at discharge regarding public assistance programs and directions on how to apply. The goal is to have the first prenatal appointment scheduled prior to discharge from the ER. Staff will continue to work with hospitals to implement this process. Collaboration will continue with the Virginia Neonatal Collaborative, a group of neonatology healthcare providers practicing at various high-risk facilities within Virginia, to provide data concerning neonatal mortality and transfer issues.

"A Healthy Baby Begins with You" preconception program was offered in January 2011. This national campaign, developed by the Office of Minority Health of the U.S. Department of Health and Human Services, is dedicated to raising awareness about infant mortality with an emphasis on the African-American community through the involvement of Historically Black Colleges and Universities (HBCUs). Forty-two peer educators were trained in January 2011 and have since developed several college projects. The preconception health messages support the identification and treatment of chronic disease prior to pregnancy. Other preconception messages regarding folic acid consumption, cessation of smoking, drug and alcohol use, and healthy diet are included. Education is also provided concerning early parenting decisions such as the importance of providing a safe sleep environment, lactation as the primary feeding method, and immunizations.

In September 2010, VDH received funds from the U.S. Department of Health and Human Services to implement the Pregnancy Assistance Fund Grant. The initiative seeks to provide support to both male and female pregnant and parenting students age 18-29 enrolled in institutions of higher education across Virginia. Primary program activities include the implementation of evidence informed peer counselor programs, the creation of Offices of Pregnant and Parenting Student Support, enhanced efforts to identify and refer for services student-parents experiencing sexual assault, domestic violence and stalking issues, and the development of program awareness campaigns initiated on select college campuses. In the coming year, VDH intends to expand the program to include two HBCUs. In addition, a media and marketing campaign consisting of an interactive website, television ads, and print materials will be completed and used to promote the support centers at each school.

Disparities in HSCI among Medicaid and non-Medicaid populations will continue to be monitored as VDH continues both statewide and targeted efforts to improve perinatal indicators of low birth weight; first trimester and adequate prenatal care; and infant mortality. The decrease in infant mortality among all women and the Medicaid population is encouraging and factors related to

decreases will be analyzed.

Increasing access to dental care and population-based prevention of dental disease across the life span is a Virginia MCH Title V priority. HSCI 7B measures the percent of EPSDT eligible children aged 6 through 9 years receiving dental services during the year. In Virginia, the percentage for 2011 was 58.9% which is nearly equal to the rate observed in 2010 of 59.0%. Since 2004, HSCI 7B has significantly increased from 32.8%. Two changes have occurred to help increase dental service utilization. For profit dental practice franchises opened in areas across to the state helping to mitigate the lack of Medicaid dental providers. These practices specifically target services to Medicaid eligible children. In addition, the implementation of the Medicaid Smiles for Children program and an overall increase of 30% in Medicaid reimbursements to dentists contributed to the significant increase in the percent of EPSDT children receiving dental services by increasing the number of dentists accepting Medicaid. Provider participation has more than doubled since the program began in 2005 growing from 620 to 1,571 dental providers.

The 2012 General Assembly passed legislation expanding VDH dental hygienist practice under remote supervision from three pilot sites to the entire state. Six full and part-time dental hygienists working under remote supervision during the pilot implemented a school-based dental sealant model. They screened 1,514 children and of those 59% received dental sealants on permanent molar teeth. A total of 3,186 permanent molar teeth were sealed for an average of 3.6 sealants per child. During the two-year period, the dental hygienists referred 722 children (48%) from the sealant program to a dentist for evaluation or treatment for fillings, root canals, and/or extractions.

In addition to the sealant programs provided under the pilot remote supervision protocol, preventive services were provided under existing practice protocols in the target health districts. These include the fluoride varnish program in Special Supplemental Nutrition Program for Women, Infants and Children (WIC) clinics; dental education programs; and a newly developed referral program that uses home visitors. Screenings and fluoride varnish application were provided for over 1,700 infants and young children; 1,263 of these children were referred to a dentist to establish a dental home. The dental hygienists provided dental health education to 13,105 individuals in settings such as schools and Head Start centers, as well as professional trainings for health providers. The dental hygienists also worked with local home visiting programs in the Cumberland Plateau and Lenowisco Health Districts. These specially trained home visitors provided care coordination for families that included assistance with obtaining a dental home, making and keeping dental appointments, and oral health education. In 2011, an oral health home visiting program was developed in the Southside District utilizing a dental assistant. As of June 2011, 422 high-risk children and pregnant women in the three districts had received home visiting services.

In FY 2011, the pilot dental sealant program expanded to include four additional health districts working under a general supervision protocol. For all hygiene school based prevention programs, schools with high enrollments in the National Free Lunch Program continued to be targeted for inclusion. A sealant database was used to capture sealants placed and sealants retained. All of the school based and clinical programs include capturing Medicaid reimbursement when available, for sustainability.

Medicaid recipients were also provided services through VDH District dental clinics. As of December 2011, 11,254 individuals received 17,184 patient visits in local VDH dental clinics. Of these patients, 51% were Medicaid recipients and 82% were ages 0-18 years. Approximately 4,700 Medicaid enrolled children received clinical services in District clinics in the first six months of FY 2011.

As a result of the 2013-14 General Assembly and state budget, VDH has been directed to transition its dental services to prevention only services. A work group is being formed to plan this transition and assure that dental services are provided to children statewide in the most

efficient and effective manner. As the pilot remote supervision dental hygienist experience has demonstrated, this model has great potential to provide preventive and ultimately cost beneficial services to significant numbers of children in various settings.

As VDH moves forward with implementing a the dental hygienist model practicing under remote supervision statewide and transitioning to a preventive service model, the percent of Medicaid children aged 6-9 receiving dental services will likely increase. The model of dental care delivery may differ, however, the pilot projects demonstrate ability to reach significant numbers of children. In addition, the state performance measures related to dental caries in low income children will continue to be monitored and guide program activities as appropriate.

Optimal child development is a Virginia MCH priority and HSCI 2,3, and 7A are measures related to the health care system's experience and ability to reach Medicaid children and parents through medical services and anticipatory guidance to help promote optimal development. The percentages of Medicaid and SCHIP enrollees less than one year receiving at least one initial periodic screen in 2011 are at 72.6% and 83.2%, respectively. The percent of Medicaid enrollees fell from an all time high of 95.8% in 2010, however, the 2011 figure is consistent with the 2009 data which indicated 72.9% received a screen that year. This may be a data reporting artifact, however, VDH does not compile these percentages. In the SCHIP population, the percentage slightly decreased from 89.5% in 2010 but remains much higher than the previous years. The percentage has doubled from the 2007 figure of 41.4%. The percent of potentially Medicaid-eligible children receiving a service paid by the Medicaid program was 79.5% in 2011. Although lower than the 2010 figure, this percentage remains higher than the previous three years.

VDH has several initiatives aimed at promoting optimal child development and assuring children receive EPSDT services. DMAS, in partnership with VDH/Title V and the Virginia Chapter of the American Academy of Pediatrics participated in the Assuring Better Child Health and Development Academy sponsored by the National Academy for State Health Policy. This program started in 2008 to promote use of standardized tools for developmental screening. Through WIC and 14 primary practice sites participating in the Virginia Systems Improvement Project (VSIP), training has been provided to promote use of the Ages and Stages Questionnaire™, a developmental screening tool, at the 9 month, 18 month, 24 month, and 48 month well child visits. DMAS has been monitoring paid claims for developmental screening which have increased from approximately 6,800 in 2009 to over 31,000 in 2011. The VSIP project has also incorporated training home visitors to conduct developmental screenings and work with the child's medical home to assess and refer for potential developmental problems.

Virginia's emphasis on improving and coordinating services for the early childhood population has moved forward. The Smart Beginnings Plan, the product of a public-private partnership with statewide stakeholder participation, has been incorporated into the Early Childhood Advisory Council (ECAC). The ECAC has convened subcommittees focused on health and parenting support on which Title V staff participate.

Virginia's Home Visiting Consortium programs continue to promote child development and work with families to assure that periodic well child visits are received in a timely manner. Funding through the MIECHV project will increase Virginia's overall home visiting capacity. An additional 6.2 million in funding was recently received and will go to fund sites in 38 high risk areas. These evidence-based home visiting programs will continue to help Medicaid and SCHIP children receive screenings. VDH Title V staff worked with the Part C Early Intervention (EI) program on an initiative to enhance EI eligibility for premature infants. This Prematurity Work Group reviewed the literature as well as data on late preterm births in Virginia, and recommended that EI eligibility criteria be extended to include infants born before or equal to 28 weeks gestation or those with a NICU stay of greater than or equal to 28 days. The EI program adopted these recommendations and has seen an increase in the number of infants under age 1 receiving services.

The Virginia Early Hearing Detection and Intervention Program (VEHDIP) has continued to work

closely with EI. A training session for EI providers on the EHDI 1-3-6 goals has been one of the most heavily attended and viewed Talks on Tuesday sessions, sponsored by EI's personnel development contractor. VEHDIP has continued to sponsor, in conjunction with the Department of Education (DOE), a Hearing Aid Loan Bank providing infants and children with temporary aids. Over 120 children received loaner aids in FY 2011.

VDH Title V staff continue to serve on the DMAS Children's Health Insurance Advisory Committee. This committee works to increase outreach, enrollment, and service improvement in Virginia FAMIS programs. The committee's goal is to improve the system's capacity to serve Virginia's children. DMAS is currently contracting for managed care Medicaid in Southwest Virginia, an area that has been limited to traditional fee-for-service Medicaid. Also, DMAS is currently piloting an integration plan to include children served by the Foster Care System under managed care rather than fee-for-service Medicaid. These efforts are intended to improve access to comprehensive services statewide.

VDH continues to sponsor the Bright Futures website, www.healthyfuturesva.com, which has information geared to parents and caregivers regarding child development, anticipatory guidance, and periodicity of recommended medical visits. The website received over 63,000 hits over the period April-September 2011. DMAS and VDH have worked together to integrate Bright Futures and medical home concepts into efforts to increase EPSDT services.

VDH continues efforts to identify potentially Medicaid eligible children through using a screening tool as part of its eligibility screening for local health department services. The FAMIS-Web VISION link uses existing data collected by VDH to help identify children and pregnant women who may qualify for state sponsored health insurance including Plan First, the state's Medicaid family planning waiver. Applications are generated and given to clients or faxed to the appropriate eligibility agency. Since the link first started in 2006, over 5,000 applications have been generated in efforts to assist potential eligibles.

VDH remains committed to strengthening its data systems and use of data in policy development and program planning. While not named as a specific MCH priority, strengthening data systems remains a cornerstone to enable assessment of all VDH efforts. In 2010, VDH remained at always having capacity and direct access to electronic databases for all HSCI 9A except for annual linkage of birth certificates to Medicaid eligibility or paid claims files. VDH and DMAS recently updated their data exchange agreement to expand evaluation of Plan First using enrollment and claims data. VDH plans to use its inter-generational birth file created to conduct further analysis on birth spacing including analysis on specific populations such as Plan First enrollees.

The VDH OFHS recently completed a reorganization which created a new Division of Policy and Evaluation to better develop and support data collection, analysis, and application efforts. Within this new division, a unit for epidemiology has been established. In addition, VDH continues to use the State Systems Development Initiative to fund portions of the MCH epidemiologist and MCH lead analyst. The OFHS Data Mart which allows desktop access for analysis of birth, death, WIC, newborn screening, hospitalizations, and birth defects for users dependent on level of access granted has been maintained. Plans to migrate data into the VDH Data Warehouse continue. The VDH Data Warehouse will add web-based reporting functionality to data currently accessed in the Data Mart. Multiple special analysis projects have been conducted using data accessed from the Data Mart. An example includes investigating a potential gastroschisis cluster using birth, hospitalization, and birth defects data.

Legislation in the 2012 General Assembly created an all payer claims database to capture all claims data. VDH is also leading statewide efforts to develop the statewide Health Information Exchange. Title V and MCH programs will continue to develop agreements with entities managing new and emerging datasets and utilize all available sources to analyze data related to maternal and child health.

The 2012 General Assembly passed legislation which would provide Medicaid coverage for legal immigrant pregnant women during the first five years of lawful residence in the United States. The bill also provides coverage under the Family Access to Medical Insurance Security (FAMIS) program for legal immigrant children and pregnant women during their first five years of lawful residence in the United States. Prior to the federal Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3), federal reimbursement for Medicaid and FAMIS coverage of these legal immigrants was not allowed under federal law during their first five years of legal residence. While this does not change the current federal poverty thresholds for eligibility as reported in HSCI 6 for Medicaid and SCHIP coverage, it will expand coverage to certain groups.

Nearly 1,000 pregnant women and 288 children are estimated to become eligible under this change.

The ability of MCH programs to obtain data on youth risk behaviors including tobacco use continues to improve. VDH, in collaboration with the Virginia DOE, administered the second Virginia Youth Survey (Youth Risk Behavior Survey) in the fall of 2011. VDH successfully completed weighted data collection for the 2011 Youth Risk Behavior Survey for the first time ever (HSCI 9B). All schools selected agreed to participate and the overall response rate was 62%. These data will improve performance measure monitoring and program evaluation and planning. VDH is currently analyzing survey results and preparing for public dissemination.

VDH continues to work closely with the Virginia Foundation for Healthy Youth (VFHY), formerly known as the Virginia Tobacco Settlement Foundation. This organization is responsible for statewide efforts to prevent and reduce youth tobacco use and childhood obesity. VFHY reaches more than 140,000 children through classroom-based prevention programs in hundreds of public schools, community centers, after-school programs, and prevention programs. The VFHY also administers the Virginia Youth Tobacco Survey and a state specific obesity telephone survey. The State Health Commissioner presented data obtained from the Virginia Childhood Obesity Survey at a special "Weight of the State" conference last year.

The Virginia Tobacco Use Control Project (TUCP) within VDH is CDC funded. The TUCP provides training, information, and materials to support the implementation of policies to help Virginians choose and maintain tobacco-free lifestyles. The program works closely with coalitions, health districts and partner organizations to reduce youth tobacco use, increase cessation support and increase clean indoor air.

An attachment is included in this section. IIF - Health Systems Capacity Indicators

IV. Priorities, Performance and Program Activities

A. Background and Overview

During the development of the 2011 Title V Block Grant application, the OFHS Management Team along with a number of our external partners, reviewed the previous Title V priorities, the National and State Performance Measures, the Health Systems Capacity Indicators, the Health Status Indicators as well as needs assessment data that included the qualitative data from the key stakeholder interviews, focus groups, and the district health nurse manager survey. As a result the following eight priorities were identified and will be used to focus OFHS activities and resources during the coming year:

1. Reduce infant mortality.
2. Reduce injuries, violence and suicide.
3. Increase access to dental care and population-based prevention of dental disease across the lifespan.
4. Decrease childhood obesity.
5. Decrease childhood hunger.
6. Improve access to health care services for children and youth with special health care needs by promoting medical homes in practice.
7. Promote independence of young adults with special health care needs by strengthening transition supports and services.
8. Support optimal child development.

In addition to the 18 National Performance Measures, Virginia has identified state level performance measures that will enable the state to monitor progress related to the state MCH priorities. The State Performance Measures include the following:

1. Percent of infants born preterm (gestational age less than 37 weeks).
2. Percent of women ages 18-44 who report good/very/good/excellent health.
3. Percent of 9th -- 12th graders who have ever been bullied on school property during the past 12 months.
4. The rate of childhood injury hospitalizations per 100,000 children ages 0 -- 19.
5. Percent of low income children (ages 0 -5) with dental caries.
6. Percent of low income third grade children with dental caries.
7. Percent of women with a live birth who went to a dentist during pregnancy.
8. Percent of children eligible for WIC that are enrolled in WIC, ages 0 -5.
9. Percent of eligible children in daycares that participate in the Child and Adult Care Feeding Programs (CACFP).
10. Percent of eligible children participating in the Summer Food Service Program (SFSP).

B. State Priorities

As part of the 2010 Five-Year Needs Assessment, Virginia developed eight statewide priorities. The following shows the relationship between Virginia's maternal and child health (MCH) priorities and specific measures that are required elements of the annual block grant report: national performance measures (NPM), national outcome measures (NOM), state performance measures

(SPM), state outcome measures (SOM), health systems capacity indicators (HSCI), and health status indicators (HSI). The priorities are not ranked. The issue of health disparities is a cross cutting issue that underlies each of the priorities.

Priority 1: Reduce infant mortality.

Reducing infant mortality is a major initiative of the Health Department. The State Health Commissioner established the Infant Mortality Work Group which not only includes medical/health professionals, but also a wide range of community members such as local educators, civic and business officials, NAACP and the AARP. The workgroup has developed strategies and actions that can be undertaken over the next few years to improve birth outcomes and reduce infant mortality.

National Outcome Measure 01:	Infant mortality rate per 1,000 live births.
National Outcome Measure 02:	The ratio of the black infant mortality rate to the white infant mortality rate.
National Outcome Measure 03:	The neonatal mortality rate per 1,000 live births.
National Outcome Measure 04:	The postneonatal mortality rate per 1,000 live births.
National Outcome Measure 05: live	The perinatal mortality rate per 1,000 births plus fetal deaths.
Health Status Indicator 01A:	The percent of live births weighing less than 2,500 grams.
Health Status Indicator 01B:	The percent of live singleton births weighing less than 2,500 grams.
Health Status Indicator 02A:	The percent of live births weighing less than 1,500 grams.
Health Status Indicator 02B:	The percent of live singleton births weighing less than 1,500 grams.
Health Systems Capacity Indicator 04: or Kotelchuck Index.	The percent of women with a live birth during the reporting year whose observed to expected prenatal visits are greater than equal to 80 percent on the
National Performance Measure 08:	The rate of birth (per 1,000) for teenagers aged 15 through 17 years.
National Performance Measure 11:	The percent of mothers who breastfeed their infants at 6 months of age.
National Performance Measure 18: first	Percent of infants born to pregnant women receiving prenatal care beginning in the trimester.
State Performance Measure 01:	Percent of infants born preterm (gestational

age less than 37 weeks).

State performance Measure 02: Percent of women ages 18-44 who report good/very good/excellent health.

Priority 2: Reduce injuries, violence, and suicide among Title V populations.

Unintentional injuries remain a leading cause of death for persons aged 1 to 64. The majority of these deaths are preventable. In 2010, 2,571 Virginians died as a result of unintentional injuries. Of these 325 were under the age of 24 years old. Suicide took the life of 104 individuals aged 10-24 and 134 individuals aged 0-24 died as a result of homicide. There is also a need for continued efforts to promote healthy behaviors to reduce morbidity and mortality. Concerns relating to injury, violence and suicide were identified in the needs assessment. The key stakeholders identified the need for expanded prevention and education services for children relating to health issues, and the need for increased education for the prevention of risky behaviors among adolescents. Activities to address this priority include continuing population-based prevention education and provider training on the identification of violence and appropriate documentation and referral.

Health Status Indicator 03A: The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

Health Status Indicator 03B: The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

Health Status Indicator 03C: The death rate per 100,000 from unintentional injuries due to motor vehicle among youth aged 15 through 24 years.

Health Status Indicator 04A: The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.

Health Status Indicator 04B: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.

Health Status Indicator 04C: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

National Performance Measure 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes 100,000 children.

National Performance Measure 16: The rate (per 100,000) of suicide deaths among youths aged 15 through 19 .

State Performance Measure 03: Percent of 9th-12th graders who have ever been bullied on school property during the past 12 months.

State Performance Measure 04: The rate of childhood injury hospitalizations per 100,000 children ages 0-19.

Priority 3: Increase access to dental care and population-based prevention of dental disease across the lifespan.

The key stakeholders indicated that there is a growing number of persons who are experiencing limited access to medical and dental care. In 2000, the first Surgeon General's report on oral health identified a "silent epidemic" of dental and oral diseases that burdens some population groups. Oral diseases can place a major burden on low-income and underserved individuals in terms of pain, poor self-esteem, cost of treatment, and lost productivity from missed work or school days. Dental disease and access to dental care is a chronic problem among low-income populations in Virginia. In the public hearings, the need to increase access to dental services for women and children was identified. The lack of access to dental care was also a finding from the key stakeholder interviews and was identified as a significant need by the district health nurse managers. The Dental Health Program's approach to this includes infrastructure building services such as oral health surveillance and recruitment of public health dentists. The program also maintains a quality assurance program for public health dentists. Population-based services include dental education, community water fluoridation, and the fluoride mouth rinse and varnish program. A number of local health departments provide clinical dental services.

National Performance Measure 09: Percent of third grade children who have received protective sealants on at least one permanent tooth.

State Performance Measure 05: Percent of low income children (ages 0-5) with dental caries.

State Performance Measure 06: Percent of low income third grade children with dental caries.

State Performance Measure 07: Percent of women with a live birth who went to a dentist during pregnancy.

Health Systems Capacity Measure 07B: Percent of EPSDT eligible children aged 6 through 9 years who have any dental services during the year.

Priority 4: Decrease childhood obesity.

According to recent data, Virginia has the 27th highest rate of overweight youths ages 10-17. Recent data collected by the Virginia Foundation for Healthy Youth through a youth-reported telephone survey indicates that the highest childhood obesity rates are found in Southwest Virginia, with 28%, closely followed by Southeast Virginia, with 24%. Over the past decade, overweight/obesity has significantly increased in children living within the Commonwealth of Virginia. According to the National Survey of Children's Health in 2003, almost one-fourth (24 percent) of Virginia's children are overweight and 15 percent are at risk for being overweight. The 2007 survey found that approximately 31% of Virginia children ages 10-17 were overweight or obese. Lack of regular physical activity, accessibility to calorie dense foods, larger portion sizes, family lifestyles and lack of interest in health and media messages contribute to the childhood overweight dilemma. In addition, many children live in areas that are not conducive to safe physical activity. This approach to the overweight issue includes population-based services such as public awareness and education and coordinating school and community based physical activity programs as well as an infrastructure level approach to monitor obesity data and policy

development.

National Performance Measure 11: The percent of mothers who breastfeed their infants at 6 months of age.

National Performance Measure 14: Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

Priority 5: Decrease childhood hunger.

More than 218,000 children and teens in Virginia face hunger. Adequate nutrition is critical to growth and development of a healthy individual. It is the foundation for physical and mental health. Without adequate nutrition, the body is at risk for multiple diseases and a weakened immune system as well as behavioral problems and mental illness. This is particularly important for children due to the potential for long term consequences. While there are various nutrition programs available, not all are accessed by those who could benefit. Activities to address this priority include monitoring and outreach to assure that children who may eligible for nutritional assistance received those benefits to help improve overall health and well-being.

State Performance Measure 08: Percent of children eligible for WIC that are enrolled in WIC, ages 0 to 5.

State Performance Measure 09: Percent of eligible children in daycares that participate in Child and Adult Care Feeding Programs (CACFP).

State Performance Measure 10: Percent of eligible children participating in the Summer Food Service Program (SFSP).

Priority 6: Improve access to health care services for children and youth with special health care needs by promoting medical home in practice.

Having a medical home has been identified as an important way to ensure that children and especially CSHCN receive the comprehensive care that they need. In the medical home concept a physician provides primary care that is easily accessible, family centered, coordinated, and culturally appropriate. In 2010, approximately 42 percent of Virginia CSHCN received coordinated, ongoing, comprehensive care within a medical home. The key stakeholders and the OFHS management team identified the need for increased access to care and the need for coordinated and culturally-appropriate care. Some activities related to this priority include collaborating with other community agencies and state level groups to expand the availability of medical homes (infrastructure building services) and working with families to ensure that children are referred to a medical home (enabling services).

National Performance Measure 01: The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

National Performance Measure 03: The percent of children with special health care needs ages 0 to 18 who receive

care

coordinated, ongoing, comprehensive
within a medical home.

Priority 7: Promote independence of young adults with special health care needs by strengthening transition supports and services.

Transitioning CSHCN to adult health and support services have been a challenge faced in Virginia and across the nation. In 2010, 45% of Virginia CSHCN were reported to receive the services necessary to make the transitions to adult life. The Virginia Title V CSHCN program has identified this need as a priority for its MCH program. All CSHCN programs have developed specific tools and monitoring activities to assist with improving transition for CSHCN.

National Performance Measure 06:

The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work and independence.

Health Systems Capacity Indicator 08:
than 16 years

The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN Program.

Priority 8: Support optimal child development.

Supporting optimal child development is a MCH priority in Virginia which extends across numerous programs and initiatives. The 2007 National Survey of Children's Health identified 26% of children in Virginia ages 4 months-5 years to be at moderate or high risk for developmental, behavioral, or social delays. Title V programs and collaborative efforts across state agencies and community based organizations can help identify risks at early ages and provide and promote appropriate education and intervention to promote optimal child development.

National Performance Measure 12:

Percentage of newborns who have been screened for hearing before hospital discharge.

Health Systems Capacity Indicator 02:

The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

Health Systems Capacity Indicator 03:

year
screen.

The percent State Children's Health Insurance Program enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100
Numerator	145	174	169	147	
Denominator	145	174	169	147	
Data Source		Newborn Screening Program	Newborn Screening Program	Newborn Screening Program	Trend analysis
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	100	100	100	100	100

Notes - 2011

2011 data not yet available. Entry is an estimate based on performance in previous years.

Notes - 2010

2010 data from Virginia Newborn Screening Program.

Numerator = number receiving appropriate follow-up (linked to appropriate specialist)

Denominator = number of confirmed cases

Evidence = info from PCP or specialist, oral or written.

Notes - 2009

2009 data from Virginia Newborn Screening Program.

Numerator = number receiving appropriate follow-up (linked to appropriate specialist)

Denominator = number of confirmed cases

Evidence = info from PCP or specialist, oral or written.

a. Last Year's Accomplishments

During FY 2011, the Virginia Newborn Screening Program (VNSP) continued to screen all newborns delivered in Virginia for the twenty-eight disorders consistent with the recommendations published by the US Department of Health and Human Services' Secretary's Advisory Committee on Heritable Disorders in Newborns and Children. VNSP works in partnership with Virginia's Division of Consolidated Laboratory Services (DCLS). During 2010, VNSP nurses gained increased access to data within the DCLS database that resulted in an increase in follow-up information being documented within the system. VNSP staff communicates with the primary healthcare provider (PCP) of the infant within 24 hours of notification from DCLS on presumptive positive screening results. The PCP is provided guidance concerning additional

testing and referrals to specialists. Presumptive positive screenings, abnormal and unsatisfactory results are followed at one month, three month and six month intervals to assure that confirmed cases were appropriately referred for treatment. Pediatric specialists in the areas of endocrinology, pulmonology and hematology, partner with the PCP to provide care to infants with presumed positive and abnormal screening results.

Support continued for the metabolic treatment centers at Eastern Virginia Medical School and at the Departments of Medical Genetics of University of Virginia and Virginia Commonwealth University. Under contractual agreements, these centers provide: (1) consultation for providers to facilitate early diagnosis and treatment of infants with abnormal screening results; (2) laboratory services to monitor blood levels and make recommendations for modification of diet and metabolic formula; (3) patient and family education; (4) coordination of genetic testing for the family to assist in making informed decisions; and (5) provision of data and long-term case management information to the VNSP.

The Newborn Screening Program Manager continued to serve on the New York Mid-Atlantic Consortium for Genetic and Newborn Screening Services (NYMAC) Advisory Council and participated in NYMAC activities and initiatives. The NSP, Senior Nurse, became responsible to the national newborn screening database to ensure Virginia data is correct and factual on the website.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintain screening of twenty-eight inborn errors of body chemistry--metabolic, endocrine, and hematologic.			X	
2. Monitor all abnormal newborn screening results and conduct follow up per protocol including aggressive follow-up on all critical results.			X	
3. Provide metabolic formulas and modified low protein food products to patients diagnosed through VNSS who are <300% of the federal poverty level.		X		
4. Maintain the Virginia Infant Screening and Infant Tracking System (VISITS) birth defects database and ensure that all newborn screening diagnosed cases are included in VISITS.				X
5. Maintain contracts with medical specialists statewide to provide metabolic treatment and consultation.	X			
6. Refer all newborn screening diagnosed cases to Care Connection for Children, the CSHCN program for care coordination.		X		
7. Continue newborn screening related educational activities to healthcare providers and consumers.				X
8. Distribute the newborn screening Parent Brochure to doctor's offices and requesting birthing hospitals.		X		
9. Review and make recommendations regarding proposed legislation or policies addressing newborn screening issues.				X
10.				

b. Current Activities

VNSP continues to identify newborns with heritable disorders and assuring follow-up by the following activities: screening all infants for 28 inborn errors of body chemistry; tracking and

following up all abnormal results; and maintaining contracts for three metabolic treatment centers. VNSP refers diagnosed cases to Care Connection for Children (CCC), which is part of the Children with Special Health Care Needs Program. CCC care coordinators assist families of newly diagnosed children in obtaining medically necessary metabolic formulas and required dietary supplements; maximizing available insurance benefits; and making referrals to community-based services.

This year the VNSP nursing supervisor left the position and a new supervisor was hired. A wage position was hired to assist with newborn screening follow-up activities.

VNSP began working with the DCLS to provide DNA analysis and follow-up of abnormal cystic fibrosis screenings. This process required intensive training and follow-up support to the primary care providers while the change occurred. Data reveals that all infants with one or more identified mutations indicative of cystic fibrosis have been followed and are continuing to be followed. This project also resulted in a successful quality assurance plan, developed and implemented by the senior nurse, to follow each infant with one or more mutations through diagnosis. The change has been supported by specialist in the field of cystic fibrosis.

c. Plan for the Coming Year

In FY 2013, VNSP will continue to: ensure screening of all infants for this panel of inborn errors of body chemistry; track and follow up on all abnormal results and assure that confirmed cases are referred into treatment in a timely manner; and provide necessary education and technical assistance to providers.

Planning for the addition of Severe Combined Immunodeficiency (SCID) screening, initiated in FY11, will continue. The Genetics Advisory Committee has recommended the addition of SCID to the Virginia newborn screening panel. A workgroup will provide a complete analysis of this addition. A registered nurse will be hired to assist with the project. When DCLS has the required technology, Virginia will have the capability to initiate screening for SCID. VNSP will produce and disseminate parent and professional education materials, provider training, relevant forms, and other needed items associated with adding new disorders.

Critical congenital heart disease (CCHD) is also being considered for inclusion to the panel of newborn screening. The Governor of Virginia has issued an Executive Directive requiring that a workgroup be convened to examine all aspects of screening, diagnosis, transfer and treatment of CCHD. VDH received grant funding from HRSA to start a demonstration project in partnership with the University of Virginia to document all aspects of care and to conduct an evidence-based model of care. Telemedicine will be included in the demonstration project.

VNSP will implement a paperless system of documentation and communication to PCP. The current electronic record storage system may be utilized to receive and send faxes from individual staff computers and then file the documentation within the secured server. This should increase efficiency while assuring confidentiality.

Educational opportunities will be conducted, by request, to hospital nursing departments. Site visits to hospitals have resulted in an increased visibility of the VNSP and requests for education have increased. Education is provided in partnership with DCLS to enhance the quality and use of programmatic data and to ensure greater quality of data collected on filter paper devices, proper sample collection techniques, and greater knowledge of the screened disorders.

ACT sheets, developed by the American College of Medical Genetics, will be customized to include Virginia specific resources and added to the VNSP website. Measures to track consumer and professional utilization of program educational resources will be completed by tracking hits to the VNSP web site and tracking the distribution of other educational resources.

DCLS data and Vital Records birth certificate data will continue to be matched to improve quality of contact and demographic information and follow up services.

VNSP will continue contracts with the three metabolic centers for medical management for diagnosed children. Staff will continue participation in the NYMAC.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	102934					
Reporting Year:	2010					
Type of Screening Tests:	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment (3)	
	No.	%			No.	No.
Phenylketonuria (Classical)	102791	99.9	49	1	1	100.0
Congenital Hypothyroidism (Classical)	102791	99.9	529	29	29	100.0
Galactosemia (Classical)	102791	99.9	158	2	2	100.0
Sickle Cell Disease	102791	99.9	74	72	72	100.0
Biotinidase Deficiency	102791	99.9	391	6	6	100.0
Cystic Fibrosis	102791	99.9	425	11	11	100.0
Homocystinuria	102791	99.9	149	0	0	
Maple Syrup Urine Disease	102791	99.9	117	2	2	100.0
beta-ketothiolase deficiency	102791	99.9	3	0	0	
Tyrosinemia Type I	102791	99.9	19	0	0	
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	102791	99.9	87	3	3	100.0
Argininosuccinic Acidemia	102791	99.9	6	0	0	
Citrullinemia	102791	99.9	6	0	0	
Isovaleric Acidemia	102791	99.9	32	2	2	100.0
Propionic Acidemia	102791	99.9	392	1	1	100.0

Carnitine Uptake Defect	102791	99.9	97	2	2	100.0
3-Methylcrotonyl-CoA Carboxylase Deficiency	102791	99.9	15	1	1	100.0
Methylmalonic acidemia (Cbl A,B)	102791	99.9	392	0	0	
Multiple Carboxylase Deficiency	102791	99.9	392	0	0	
Trifunctional Protein Deficiency	102791	99.9	20	0	0	
Glutaric Acidemia Type I	102791	99.9	6	1	1	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	102791	99.9	1541	4	4	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	102791	99.9	32	5	5	100.0
Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency	102791	99.9	20	5	5	100.0
3-Hydroxy 3-Methyl Glutaric Aciduria	102791	99.9	15	0	0	
Methylmalonic Acidemia (Mutase Deficiency)	102791	99.9	392	1	1	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	60	65	65	70	70
Annual Indicator	59.8	59.8	59.8	59.8	77.1
Numerator					
Denominator					
Data Source		National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey

Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	77.1	78	80	80	80

Notes - 2011

Indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010.

This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments

The 2009/10 National Children with Special Health Care Needs Survey indicates that 77.1% of families of CSHCN are partners in decision-making and are satisfied with the services they receive. This outcome is not comparable to prior survey years. Virginia, however, was one of nine states that did score significantly higher than the U.S. percentage of 70.3%.

All of the Child Development Clinics (CDC) surveyed families to determine their level of satisfaction with care received. Survey results from FY 2011 show a CDC network average satisfaction rate of 98%, with a range from 95% to 100%. Survey response rates for the CDC continue to be a problem for some clinics, with three clinics reporting response rates under 25%. Response rates for the other six CDC ranged from 28% to 90%. Several CDC also surveyed referral sources separately from the family, especially in cases where the Department of Social Services is serving as the child's legal guardian.

CSHCN staff continued to partner with many parent organizations including local/regional support groups, Parent to Parent of Virginia, and the federally funded Virginia Family-to-Family (F2F) Network of Virginia. These family organizations and local and state partners collaborate and educate on behalf of children and young adults with special needs and their families, and assist them in obtaining timely access to information, resources, support, and services. Five Care Connection for Children (CCC) centers continued to employ parents of CSHCN as parent

coordinators and two of them maintained family resource libraries. The sixth CCC center has a family advisory group in conjunction with the hospital's advisory group.

The Virginia Bleeding Disorders Program (VBDP) continued to host routine meetings of consumer advisory boards for three of the four Comprehensive Bleeding Disorder Programs (CBDP). It also hosts parent networking events. Parents and families are co-trainers with CBDP staff on new parent programs and serve on discussion panels for health care provider training. Seventy-five percent of the CBDP have paid staffs who are also consumers.

Each CCC continued to have advisory committees with participation of parents and CYSHCN to increase family and community involvement in addressing issues relevant to the needs of the special needs population.

The CSHCN program is administering the HRSA-funded Systems Improvement Grant, Virginia Systems Improvement Project (VSIP). The Virginia F2F Network of Virginia at the Center for Family Involvement at the Virginia Partnership for People with Disabilities has an important role in the VSIP. One of the aims of the VSIP is to enhance the role of families as partners. Through a contract with the F2F Network of Virginia, two part-time parents serving as cultural liaisons provided information/referral services and family-centered trainings to over 100 parents of CSHCN and professionals in the African-American and Latino communities. The cultural liaisons recruited eight cultural brokers to support their work in minority communities. In addition, the F2F Network of Virginia has assisted in identifying parents as faculty for the Medical Home Learning Collaborative training sessions that are central to the VSIP.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Include family members and youth with special needs as members of committees and advisory boards of the CSHCN program.				X
2. Provide family-to-family support as a basic service of Care Connection for Children (CCC) centers.			X	
3. Work with Family to Family Health Information and Education Center and other family organizations to enhance the ability of families to partner in decision-making.				X
4. Administer parent satisfaction surveys at CCC centers, Child Development Clinics (CDC), and the Virginia Bleeding Disorders Program (VBDP).				X
5. Monitor activities and outcomes; adjust CSHCN state plan for meeting HP 2020 goals as needed.				X
6. Review and make recommendations regarding proposed legislation or policies addressing CSHCN.				X
7.				
8.				
9.				
10.				

b. Current Activities

Through the VSIP, two part-time cultural liaisons at the F2F Network of Virginia provide information/referral services and family-centered trainings in African-American and Latino communities. Parents have continued to be included as faculty in VSIP Learning Collaborative training sessions.

CSHCN staff continue to partner with many parent organizations including Parent to Parent of Virginia and the F2F Network of Virginia. Five CCC centers continued to employ parents of CSHCN as parent coordinators and two of them maintained family resource libraries. The sixth CCC center has a family advisory group in conjunction with the hospital's advisory group. The CCC centers continue to enhance family-to-family support services.

Under the VSIP grant, Virginia's F2F Network and Parent to Parent of Virginia issued a revised edition of the Care Coordination Notebook: Financing and Managing Your Child's Health Care. This publication is available in both English and Spanish. Over 7,000 hard copies were distributed to families of special needs children and organizations serving families such as the Care Connection Centers, Head Start and Early Intervention providers. The Notebook contains information on public and private insurance, SSI, and community resources for families of special needs children such as Early Intervention and Special Education.

Advisory committees continued to include parent/family representatives, and programs continued to include parent and/or consumers on staff.

An attachment is included in this section. IVC_NPM02_Current Activities

c. Plan for the Coming Year

Strengthening family partnerships will continue to be a high priority for the CSHCN Program. The F2F Network of Virginia will continue to employ cultural liaisons to enhance outreach and information/referral services to parents of minority populations and to train and support cultural brokers to help sustain this outreach effort beyond the term of the VSIP project.

Families will continue to serve on advisory boards of all CSHCN Programs. The CCCs will have parents of CSHCN as members of CCC teams and will continue to enhance family-to-family support services. The CCC centers will survey families to determine their satisfaction with the services and make necessary changes to best meet identified needs. VBDP will continue to host routine meetings of consumer advisory boards of the CDBP.

As the panel of newborn screening disorders is modified to include new conditions, families affected by those conditions will be invited to participate in planning education for providers and parents. VDH will implement a demonstration project to develop, disseminate, and validate screening protocols and otherwise support point of care screening specific to critical congenital heart disease (CCHD). The CCHD Advisory Group will be convened in the upcoming year and include parental input.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	60	60	60	65	65
Annual Indicator	43.9	43.9	43.9	43.9	42.4
Numerator					
Denominator					
Data Source		National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events					

over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	43	43.5	44	45	46

Notes - 2011

Indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010.

This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments

National Survey of CSHCN results for 2009/10 indicate that 42.4% of all Virginia CSHCN received coordinated, ongoing, comprehensive care within a medical home. Although this figure is slightly lower than the 2005/06 results (43.9%), the difference is not statistically significant. Racial disparities persist across this outcome with White CSHCN most likely to meet this outcome (48.6%) versus Black CSHCN (31.7%) or Hispanic CSHCN (33.1%). Families of CSHCN with the lowest incomes (0-99% Federal Poverty Level) were also least likely to have their CSHCN meet this outcome (29.1%) versus those in families with the highest incomes (400% or greater Federal Poverty Level) (54.9%). While most CSHCN have a usual source for sick or well care (91.9%), the responses related to care-coordination and family-centered care components bring the overall outcome down.

CHSCN in Title V programs have high rates of having a medical home. In FY 2011, 98.3% (up from 93.6% in the prior year) of the clients in the CDC network and 100 percent of both the CCC network and the VBDP had a primary care provider. About 80% of clients in the Sickle Cell Program (SCP) had a designated primary care provider.

All children seen for CDC, CCC, SCP, and VBDP services were screened to determine if they had a primary care provider. Families without a primary care provider received encouragement to establish a medical home and were informed of choices to obtain one. CDC have a performance goal to improve communication with the medical home by sending the clinic's final report to the

medical home within fourteen days of completion of the CDC evaluation, with an average of 70% meeting the target.

VBDP team members at Virginia Commonwealth University contributed to an article to the Virginia Chapter of the American Academy of Pediatrics (VA-AAP) Fall 2010 newsletter "To Bleed or Not to Bleed?: VCU Health Systems' Lifespan Coagulation Disorders Center." The article summarized the services of the comprehensive treatment center and ways specialty providers can collaborate with community physicians providing a medical home for persons with bleeding disorders.

The EHDI and Newborn Screening Program (NSP) worked to identify the medical home while conducting follow up on abnormal/failed test results. EHDI follow-up staffs have made this a priority activity in working toward meeting the 1-3-6 goals.

The centerpiece of VSIP is a Medical Home Learning Collaborative which involves working with 14 primary care practices to promote developmental screening of young children, as well as coordination between the practices and Early Intervention services and home visiting programs. This Learning Collaborative has been implemented in partnership with the Virginia Community Healthcare Association (VACHA) and the VA-AAP. Comprised of Community Health Centers, Migrant Health Centers, and Rural Health Centers, the VACHA is coordinating the Learning Collaborative (LC) under the direction of VDH. Several Community Health Centers are participating in the LC.

By promoting routine developmental screening using a validated screening instrument, and connecting "at risk" children with Early Intervention (EI) services, the LC addresses both comprehensive care and care coordination. In the past year, the participating LC practices attended two face-to-face learning sessions, as well as initiating their practice quality improvement projects to enhance developmental screening and increase referrals to appropriate services.

Another VSIP initiative involves training staffs from Virginia's Home Visiting Consortium (HVC) member organizations -- a collaboration of publicly funded home visiting programs that serve young families (pregnancy through age five). In FY 2011, training for the HVC focused on developmental screening and medical home. Over several months, statewide training was completed on developmental screening; home visitors were trained on the importance of screening and use of the Ages and Stages Questionnaire. A train-the-trainer format was used that resulted in 365 home visitors completing the training across the state.

Also through VSIP, a focus group study was completed on health disparities in minority populations of CSHCN families. This effort specifically sought to address the extent to which African American and Hispanic families report having access to coordinated, family centered care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with other community agencies to expand the availability of medical homes for CSHCN.				X
2. CCCs, CDCs, and the Bleeding Disorders Program work with families to ensure that children served are referred to a medical home and to a dentist.			X	
3. Partner with state AAP, Medical Home Plus, Division of Dental Health, and other organizations to provide training and technical assistance to primary care practices on the medical home				X

concept.				
4. Monitor activities and outcomes; adjust CSHCN state plan as needed.				X
5. Review and make recommendations regarding proposed legislation or policies addressing CSHCN.				X
6. EHDI and NSP follow-up include emphasis on medical home			X	
7. EHDI and NSP staff educate hospital staff on importance of identifying a medical home on newborns prior to discharge				X
8.				
9.				
10.				

b. Current Activities

CCC, CDC, SCP, and VBDP staffs continue to assist families in finding medical homes for CSHCN. On hospital site visits, EHDI and NSP staffs emphasize with nursery staff the significance of identifying a medical home prior to discharge. Increased use of hospitalists in newborn and intensive care nurseries has resulted in a disconnect with identifying a medical home for many infants. Hospital staffs have been responsive to the issue at site visits.

Assisting families with locating a medical home and providing technical assistance and training for health professionals about the medical home concept continues to be a high priority. Strategies of the VSIP include continued implementation of the Learning Collaborative on developmental screening in the medical home with an emphasis on the use of standardized screening tools, early identification, care coordination, and family-centered care. Participating medical practices attended two additional Learning Sessions this year. Work continues with Virginia’s HVC to enhance the skills of home visitors through training and technical assistance and to better define the role of home visitors as care coordinators in support of primary care practices. A web-based training module on medical home was developed and is in use with home visiting program staff.

CCC and VBDP staff worked with the Dental Health Program to implement the State MCH Oral Health Service Systems Grant, which is designed to improve access to dental care for CSHCN. ***An attachment is included in this section. IVC_NPM03_Current Activities***

c. Plan for the Coming Year

As resources allow, lessons learned from the VSIP LC will be shared statewide, and the CSHCN program will continue to assist the VA Chapter of the American Academy of Pediatrics in promoting medical home in practice.

CCC and VBDP staffs will continue to partner with the Dental Health Program on improving access to dental care for CSHCN.

Staff will follow the current work of the National Academy for State Health Policy on medical homes and partner with the Department of Medical Assistance Services to explore ways that Medicaid/SCHIP policy may be used to promote medical homes. CCC centers, CDC, and VBDP will continue to monitor the status of clients and refer their clients without a medical home to resources.

EHDI and NSP staff will continue to promote the importance of a medical home with hospital discharge staff, and will develop and provide training as resources allow.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	70	75	75	75	75
Annual Indicator	63.7	63.7	63.7	63.7	65.2
Numerator					
Denominator					
Data Source		National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	65.2	65.2	67.5	67.5	70

Notes - 2011

Indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010.

This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments

The National CSHCN Survey results for 2009/10 show that 65.2% of all Virginia CSHCN had adequate health insurance coverage. This was an increase from 63.7% in 2005/06, however it is not statistically significant. Virginia and national data show that levels of health insurance adequacy decrease as the number of areas the child qualifies on as CSHCN increase. CSHCN

with functional limitations also have higher reported levels of inadequate insurance. No significant differences were reported between those with public versus private insurance.

CCCs, CDCs, and VBDP prepared their annual plans based on the HP 2020 outcomes for CSHCN. All are required to refer all eligible children without insurance to either Medicaid or FAMIS (SCHIP) and to refer potentially eligible recipients to SSI. They are also required to follow-up with families to determine the outcome of the applications.

A major component of the CCC program and the VBDP is the provision of insurance case management to assist families in obtaining, understanding, and using health insurance. Extra emphasis is provided to clients transitioning from pediatric to adult health care to ensure continuous insurance coverage as the client ages out of public insurance and their parent's private insurance. VBDP clients receive medical insurance case management through a contract with Patient Services Incorporated (PSI), a non-profit organization with a mission to help people who live with certain chronic illnesses or conditions locate suitable health insurance coverage to enable them to access optimal medical treatment. PSI also provides assistance to VBDP clients with the cost of health insurance premiums. In September 2010, implementation of legislation allowing children to stay on their parents' insurance until age 26 years, and the establishment of the federal pre-existing condition insurance plan (PCIP) offered patients a new options for health insurance. The cap on Pool of Funds (POF -- payment for direct services) usage to \$15,000 per patient for medications allowed the program to serve more patients and leverage compassionate use programs.

In FY 2011, 99.4% of the CDC network, 92.8% of the CCC network, and 89% of VBDP clients had health insurance coverage. In the CDC program, 12.7% of clients under age 16 years were also receiving SSI; for the CCC program and VBDP, the figures were 15.4% and 13.8%, respectively.

In FY 2011, 227 clients (CCC: 208 and VBDP: 19) received financial assistance from the CSHCN POF, a drop from 263 in FY 2010. These clients are those who are not eligible for public insurance, who cannot afford or obtain private insurance, or whose insurance does not cover the needed service. Medications and durable medical equipment continue to be the most requested POF services. POF guidelines are evaluated at least twice a year and modified as needed to ensure financial integrity.

The EHDI program, in partnership with the Department of Education, continued to sponsor a Hearing Aid Loan Bank. The latter arranges for loaner devices and their fitting, for families to use while waiting for a permanent device. In FY 2011, the Bank provided aids to 122 clients for an average duration of eight months. This represents a significant gap-filling service to augment available financial resources for families.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Refer 100% of eligible children in the CCCs, CDCs, and the Bleeding Disorders Program to Medicaid, FAMIS, and SSI.		X		
2. Provide health insurance case management as a basic service of the CCC centers and the Bleeding Disorders Program.		X		
3. Monitor activities and outcomes; adjust the CSHCN state plan as needed.				X
4. Work with other agencies to identify issues and remove				X

obstacles that cause underinsurance.				
5. Provide financial assistance from the CSHCN Pool of Funds for the uninsured and underinsured clients of CCC and VBDP.		X		
6. Review and make recommendations regarding proposed legislation or policies addressing CSHCN.				X
7. Contract for a Hearing Aid Loan Bank to assist families with temporary aids.		X		
8.				
9.				
10.				

b. Current Activities

CDCs, CCCs, and VBDP continue to refer all potentially eligible children to Medicaid, FAMIS, and SSI programs and follow-up with families to assure that applications are processed. The majority of clients continue to have health insurance coverage. VBDP included out-of-pocket costs in their contract with PSI to enable families to afford the co-pay costs in the PCIP program. VBDP and CCC assist clients with enrolling in manufacturer compassionate use programs to reduce utilization of the POF. VBDP expanded its insurance consultation for all CSHCN with a centralized referral and consultation liaison available to all CSHCN social workers.

Clients are receiving POF financial assistance with approximately 140 served in six months of FY 2012. The limited number served is due to lack of funds. Covered services include durable medical equipment, medications, and specialty physician office visits. POF guidelines were modified so that they no longer cover diagnostic testing, therapies, hospitalizations, and dental orthodontic and prosthodontic appliances.

The Hearing Aid Loan Bank continues to provide aids on loan with appropriate fitting.

Staff continues work with DMAS to identify issues and remove obstacles that cause underinsurance of CSHCN receiving Medicaid and FAMIS. Special efforts were made in FY 2012 regarding hearing aid coverage.

The Care Coordination Notebook-Financing and Managing Your Child's Health Care which explains health insurance and waivers was revised.

An attachment is included in this section. IVC_NPM04_Current Activities

c. Plan for the Coming Year

CDCs, CCC centers, and VBDP will continue to refer all potentially eligible children to Medicaid, FAMIS, PCIP, compassionate use, and SSI programs and follow-up with families to assure that their applications are processed. They will continue to provide insurance consultation to explore all insurance options. They will continue to provide annual plans based on the HP 2020 outcomes for CSHCN.

Clients will continue to receive assistance from the CSHCN POF as long as financially feasible. The increase in the cost to provide infrastructure and enabling services has decreased the amount of funds that can be allocated to support payment for direct services via POF. POF guidelines for the use of funds have steadily become more stringent, and the utilization of funds will continue to be closely monitored.

Work with DMAS will continue to identify issues and remove obstacles that cause underinsurance of CSHCN receiving Medicaid and FAMIS. Updated manuals and training by DMAS will be provided for CCC centers, VBDP, and CDCs as they are available.

VBDP will analyze the effects of its policies on out-of-pocket costs to understand trends in underinsurance. Staff will provide data and information on insurance status and gaps in coverage

to child health advocates and coalitions working to increase insurance coverage for children in Virginia.

The Hearing Aid Loan Bank will continue to provide gap-filling services to families of children with hearing loss. During FY 2012, staff worked with DMAS to clarify and communicate Medicaid policy on reimbursement for fitting these devices. This resulted in freeing up funds to serve other clients without such coverage. Staff will continue to monitor data in FY 2013 to assess the ongoing impact.

The VSIP grant supported a revision of the Care Coordination Notebook -- Financing and Managing Your Child's Health Care in FY 2012. This document provides an overview of how health insurance works; how to understand and use deductibles and co-insurance; a comprehensive summary of public waiver programs available to families; and sample advocacy letters for use with insurers such as an appeal or claim reconsideration. This Notebook will continue to be used and distributed in FY 2013.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	85	90	94	94	94
Annual Indicator	89.6	89.6	89.6	89.6	67
Numerator					
Denominator					
Data Source		National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	67	67	70	70	70

Notes - 2011

Indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010.

This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments

The 2009/10 National CSHCN Survey shows that 67% of community-based service systems are organized so families can use them easily in Virginia. These results are not comparable to prior survey results. These results were varied on the number of areas for which the child qualified as a CSHCN.

The CSHCN Program maintained the CCC network of six Centers of Excellence. The centers provided information and referral to resources, care coordination, family-to-family support, and assistance to families with the transition from child to adult oriented health care systems, and training and consultation with community providers on CSHCN issues.

The network of nine CDC provided multidisciplinary diagnostic evaluations of children suspected of having developmental and/or behavioral disorders. CDCs offered trainings and technical assistance to providers in the community and served as training sites for psychology students.

The VBDP supported a statewide network of comprehensive care centers for clients of all ages with inherited bleeding disorders and their families. It implemented training for clients, families, and health care professionals and school personnel on several topics including home infusion, new parenting programs, genetic testing and coagulation treatment updates. Collaboration continued with the Virginia Hemophilia Foundation (VHF) and the Hemophilia Association of the Capital Area (HACA) to facilitate training and networking events for clients. Staff from several CBDDP provided medical support and education for the VHF's annual "Camp Youngblood" for children and siblings with bleeding disorders at the VHG's family camp.

The SCP supported clinical services for clients of all ages with sickle cell disease. Contracted partners also delivered educational programs and support services to affected individuals.

Child Health Programs staff served on the state Interagency Advisory Committee to the Early Intervention Program, and the State and Local Advisory Committee to the Comprehensive Services Administration. This involvement assures that the CSHCN program is connected to other systems serving children with special needs.

In FY 2011, the CCC network provided care coordination and pool of funds services to 3,501 clients. An additional 1,800 children and their families benefited from CCC information and referral services. The VBDP served 282 clients (161 persons ages 0-21 and 121 persons 21 years and older). The CDC network served a total of 4,180 clients. Multidisciplinary, comprehensive diagnostic evaluations with follow-up medical conferences and care coordination were provided for 2,366 new clients. An additional 250 clients were assessed for eligibility for Virginia's Medicaid Developmental Disability Waiver. Another 1,564 clients received other

services, including developmental screens, medical treatment, and family consultations. The SCP clinical network provided services to 1,065 clients (992 persons age 0-18 and 73 persons 19 years and older).

CCC staff continued to provide care coordination services for newly diagnosed infants identified through newborn screening (bloodspot); an automatic electronic referral has been designed but not fully implemented. All CSHCN staff maintained close working relationships with local EI programs. Another useful resource is the Hearing Aid Loan Bank. EHDI staff continued to refer infants diagnosed with hearing loss to the EI Program, and provided training on the 1-3-6 EHDI goals to EI providers.

All of the networks in the CSHCN Program continued to evaluate their services and make changes as needed. Staff worked with families and community agencies to continue to strengthen the system of care for CSHCN.

Assisting CSHCN and their families to deal with emergencies continued. The Hampton Roads CCC site was part of a local effort to promote emergency preparedness for individuals with special needs, resulting in significant local and some national attention. This included creation of an application for electronic media called "Pinch of Prevention" that provides information on resources for emergency preparedness.

In follow up to the NICHQ collaborative on newborn hearing screening, EHDI staff has communicated lessons learned as "best practices" to other sites. An example is the emphasis on hospitals clearly identifying the medical home prior to discharge; another is to provide "just in time" education to primary care providers regarding screening results.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide leadership in planning, developing, and implementing efforts to improve services to CSHCN.				X
2. Provide care coordination for CSHCN from birth through twenty years of age in CCC and persons of all ages in VBDP.		X		
3. Provide a system of services for people with bleeding disorders through the Bleeding Disorders Program.	X			
4. Provide diagnostic and evaluation services for children from birth through twenty years of age through the Child Development Clinics.	X			
5. Partner with others to coordinate care for children with developmental and behavioral programs through the Child Development Clinic network.		X		
6. Monitor activities and outcomes; adjusted the CSHCN state plan as needed.				X
7. Participate in statewide committees and interagency councils for CSHCN issues.				X
8. Provide training and technical assistance.				X
9. Review and make recommendations regarding proposed legislation or policies addressing CSHCN.				X
10. Provide follow up on newborn blood spot and hearing screening.		X		

b. Current Activities

Long-standing programs (CCC, CDC, SCP, and VBDP) continue to operate, marketing their services locally. The VSIP continues to be implemented. In addition to the strategies described

earlier, a study is underway with parents of children identified with hearing loss to determine whether the child was connected to EI services, and the factors that influenced the parents' decision to enroll or not enroll with this program. Anecdotal information indicates that despite referrals of children with hearing loss, the enrollment in EI is not occurring consistently.

The automated electronic referral from newborn screening diagnoses to CCC has been challenging and multiple efforts have been made to correct defects. Referrals from EHDI to EI have continued. EHDI staff developed and delivered multiple trainings to EI providers on EHDI, the 1-3-6 goals, and revised protocols.

Under the VSIP grant, Virginia's F2F Network and Parent to Parent of Virginia issued a revised edition of the Care Coordination Notebook: Financing and Managing Your Child's Health Care. This publication is available in both English and Spanish. Over 7,000 hard copies were distributed to families of special needs children and organizations serving families such as the Care Connection Centers, Head Start and Early Intervention providers. The Notebook contains information on public and private insurance, SSI, and community resources for families of special needs children such as EI and Special Education.

An attachment is included in this section. IVC_NPM05_Current Activities

c. Plan for the Coming Year

CDCs will continue to strengthen relationships with other community providers to coordinate services, reduce duplication of services, determine unmet needs, and assure that the children with the greatest need are served. Clinics continue to provide annual plans based on the HP 2020 outcomes for CSHCN.

The CCC centers will continue in their mission to develop family-centered, culturally competent, and community-based systems of referral and care and to simplify access to these systems for families. Mechanisms will be explored to electronically capture the number of persons served by CCC's family to family services.

VBDP will continue collaboration with the CBDP and VHF to facilitate training and networking events for clients. SCP will continue to provide services to families and conduct educational events locally.

National case management certification will continue to be a goal for CCC staff. The number is steadily increasing toward the goal of 60%.

The NSP and EHDI programs will continue to partner with the EI Program, CCC, and health care provider systems to improve systems for timely diagnosis and referral.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	8	45	45	55	55
Annual Indicator	37.8	37.8	37.8	37.8	44.9
Numerator					
Denominator					
Data Source		National	National	National	National

	CSHCN Survey	CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.				
Is the Data Provisional or Final?				Final
	2012	2013	2014	2015
Annual Performance Objective	47	48	49	50
				2016
				51

Notes - 2011

Indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010.

This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments

Data from the National CSHCN survey for 2009/10 indicate that 44.9% of youth with special health care needs in Virginia received services necessary to transition to adult life. This was an increase from the 2005/06 survey result of 37.8% although not statistically significant. CSHCN with public insurance only met this outcome in 29.3% of respondents versus 52.2% of those with public insurance. Transition continues to be a priority area for Title V CSHCN programs.

Virginia's plan to meet HP 2020 outcomes for CSHCN includes numerous activities to facilitate the development of a transition system for CSHCN that will assure that YSHCN participate as decision-makers and as partners; have access to health insurance coverage; and have a medical home that is responsive to their needs. Specific activities have been included in the contractual arrangements with local managers of the clinics and centers in all CCC, CDC, VBDP, and SCP

networks. These include identification of all open cases of children age 14 years and above to prioritize the group targeted to receive transition services for health care, education, social, and employment needs. CCC and the VBDP are identifying "adolescent friendly" specialists to assist with transitions. Having educational consultants located in CCC, CDC, and hemophilia clinics has greatly enhanced communication with the local schools regarding transition services for youth.

CDC focused on serving younger children to identify developmental, behavioral, and emotional problems as early as possible. When appropriate, adolescents were invited to participate in the interpretive interview of their evaluation findings and recommendations, either with their parents or by having their own separate individual interpretive interview. Recommendations related to transition to adult life were included. Clients were referred to their local school systems and/or rehabilitative services.

The CCC care coordinators continued to update their Transition Tool Kit. The kit includes specific worksheets organized by aspects of transition to be used during encounters with the client and family. These worksheets help to identify the client's strengths and challenges during the transition process. They also serve as a measure of progress toward transition over time. The minimum goal is to provide at least five transition encounters between the client, family, and care coordinator. Divided into five age groups between ages 14 and 21 years, the worksheets provide a mechanism to prompt and track progress towards that goal. The kit also includes a sample emergency information form for families to complete and provide to caregivers, emergency rooms, day care providers, and other relevant persons who may be part of the youths' care network.

The SCP distributed and implemented a transition manual to assist those clients. This year saw variation in how the transition manual has been used, with varying success. In total, 249 youth were in the SCP transition program.

Comprehensive bleeding disorders programs (CBDP) implemented the Hemophilia Advisory Board's approved strategies that include identifying core competencies for adequate patient transition to be monitored via pre/post test, developing a portable, accessible medical record (which is password protected) to be given to the patient and family, and ensuring the availability of affordable, comprehensive, continuous health insurance. VBDP hosted regular conference calls among CDBP staff to enhance implementation of these strategies. VCU and UVA CDBP continued to conduct transition clinics to assist youth in their transition from youth to adulthood.

CCC staff partnered with the Departments of Education and Rehabilitative Services to implement the state's 2011 Transition Forum.

Staff participated with the New York Mid Atlantic Consortium for Genetic and Newborn Screening Services (NYMAC). Two other regional consortia and NYMAC are piloting transition initiatives. Information from these initiatives was broadly shared with stakeholders.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide transition of services from pediatric to adult health care services in the CCCs, CDCs, Bleeding Disorders and Sickle Cell Programs.		X		
2. Monitor activities and outcomes; adjusted the CSHCN state plan as needed.				X
3. Review and make recommendations regarding proposed legislation or policies addressing CSHCN.				X

4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CDC, CCC, SCP and VBDP continue to assist youth in the transition to adult care. Staff is also providing training and support for pediatric and adult health care providers to promote the development of youth as partners in health care decision-making. One CCC site convened a teen group in an effort to encourage participation and facilitate systems changes for transition. While there was initial success with this group, ultimately participation fell off and the staff is exploring other options.

The SCP center at Virginia Commonwealth University is engaged in a research project to evaluate the effectiveness of the transition manual and its use. Feedback is being obtained from adult care providers to share with pediatric sickle cell providers regarding the transition process. Youth are being "tested" on transition.

An attachment is included in this section. IVC_NPM06_Current Activities

c. Plan for the Coming Year

CDC, CCC, SCP, and VBDP will continue to assist older children in the transition to adult care. The Transition Tool Kit will continue to be updated and shared with community partners. CCC staff will partner with the Departments of Education and Rehabilitative Services to implement the state's 2013 Transition Forum.

The SCP will continue its critical look at the transition process to date. The evaluation process in place a VCU will be expanded to all contracted clinics.

The CCC program directors, in the context of identifying quality measures, have determined that transition will be the focus of a quality improvement project for the coming year. This will allow the team to identify specific barriers and prioritize those which can be impacted by VDH/contractors, and those that need a broader systems intervention.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	87	87.5	87.5	88	88
Annual Indicator	79.6	73.2	70.3	76.1	
Numerator					
Denominator					
Data Source		National	National	National	

		Immunization Program	Immunization Program	Immunization Program	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	75	75	77.5	77.5	80

Notes - 2011

Data for 2011 is unavailable for this measure. Due to the change in the reported vaccine series (4:3:1:3:3 to 4:3:1:3:3:1) an estimate based on trend is also unavailable.

Notes - 2010

2010 data not yet available for the 4:3:1:3:3 vaccine series from NIS. Entry is for the 4:3:1:3:3:1 vaccine series that is reported on NIS for 2010.

Notes - 2009

National Immunization Program Data Calendar Year 2009 from CDC website.

a. Last Year's Accomplishments

Immunization data indicate that coverage rates are trending upward. In 2010, the rate for 4:3:1:3:3:1 increased to 76.1%. The Division of Immunization administers the Vaccines for Children program through which many children are eligible to receive immunizations at no or low cost. Two major areas of focus were to improve Health Department Coverage Rates working with private providers and the Head Start Health Advisory Committee. Coverage rates that were targeted included Hepatitis A, Rotavirus, flu vaccines and Pertussis (TDAP).

In FY 2011, Title V continued activities to help increase immunization rates focused on the provision of child care health consulting activities, including assessment. The Title V Early Childhood Projects director, along with the contracted state child care health consultant, supervised Healthy Child Care Virginia (HCCV) training and technical support activities for public health nurses and other professionals serving as child care health consultants. Key consulting activities are to provide CASA immunization audits and help child care centers institute system changes to support all attendees reaching and maintaining up-to-date immunizations. The director provided consultation to the Virginia Department of Social Services (DSS) to work with child care providers in developing their knowledge and ability to assure complete immunizations among child care attendees. A part-time contracted coordinator provided ongoing consultation and technical assistance to the field. Five health districts used Title V funds to support activities related to increasing immunization rates through assessment, early childhood asthma management, and child care health consultant activities.

The Commonwealth established a Virginia text4baby program in 2009 with continuing efforts in 2011 to increase penetration and use. An educational program of the National Healthy Mothers, Healthy Babies Coalition (HMHB), text4baby delivers timely health tips via a new free mobile

phone information service providing timely health information to pregnant women and new mothers during pregnancy and through a baby's first year using text messaging.

Title V funds support case management activities that help increase immunizations. Roanoke health district used some of their Title V allocation to support their CHIP case management program for low-income children ages 0-5. Resource Mothers, a lay-person support program available in 87 communities, continued to assist teen parents in getting their infants properly immunized. In FY 2011, 85.3% of infants were up to date on immunization at the year's end.

The Virginia Immunization Information System (VIIS), the state immunization registry, continues to be developed through the Division of Immunization, Office of Epidemiology. Other activities included provision of immunizations through all local health departments; development and implementation of local immunization action plans; collaboration with public and private sector partners such as WIC and Medicaid HMOs; and surveillance, CASA assessment and evaluation activities led by the VDH Division of Immunizations, Office of Epidemiology.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide funding to local health districts to deliver child care health consultation services to help increase immunization rates.				X
2. Promote Bright Futures Guidelines to increase utilization of preventative health care.				X
3. Support home visiting programs such as CHIP and Resource Mothers.		X		
4. Participate in Project Immunize Virginia Coalition.				X
5. Collaborate with stakeholders to publish information regarding immunization requirements including distribution of New Parent Kits.		X		
6. Review and make recommendations regarding proposed legislation or policies addressing access to health care, particularly immunizations.				X
7. Provide support to the Virginia Immunization Information System as needed.				X
8.				
9.				
10.				

b. Current Activities

Title V staff continue to work with the Division of Immunization to promote vaccination in keeping with the recommended schedule. Title V supported activities continue to have a major emphasis on working with child care providers to improve immunization rates and other health indicators. The Early Childhood Project director and contracted coordinator sustained the number of child care health consultants to approximately 300 statewide. In FY 2012, three local health districts are using Title V funds to support child care health and safety. Health Districts review CASA results to determine how they can work with local child care providers to improve rates within their areas. Education, training, and outreach activities are being conducted for child care and Head Start staff to monitor immunization records.

Title V continues to partner with DSS in reaching child care providers. A quarterly Child Care Health and Safety electronic newsletter reaches over 10,000 child care professionals throughout the state. It is archived on the VDH web site. Topics focus on timely issues such as the

importance of immunizations and keeping medical records up-to-date, health insurance, pandemic flu and disease prevention, mental-health and social-emotional competence, and working with CSHCN.

Virginia continues to collaborate with the Healthy Mothers, Healthy Babies Coalition and Home Visiting Consortium to promote text4baby throughout the state.

An attachment is included in this section. IVC_NPM07_Current Activities

c. Plan for the Coming Year

The contracted child care health consultant will continue providing technical assistance to field staff through the end of the State Early Childhood Comprehensive Systems grant cycle. Consultation and partnering with Project Immunize Virginia, the VDH Division of Immunization, Head Start Collaborative, and DSS Divisions of Child Care Programs and Licensing will continue to assist with infrastructure building and quality enhancement activities. The Child Care Health and Safety Newsletter will continue to be published electronically quarterly.

Child Health will sustain the partnership as appropriate with the statewide immunization registry as they continue to expand the VIIS system, which currently contains over nine years of immunization histories available to health care providers and schools. In addition to recording immunizations, the system also provides up-to-date recommendations for immunization scheduling, generates recall notices, develops immunization reports, identifies areas of under-immunized populations, and maintains an inventory and ordering module for providers. This is administered through the Office of Epidemiology, Division of Immunization. In the coming year, system programming will be developed to link the results of newborn hearing screening to the immunization registry to make getting test results easier for primary care providers. The expectation is that this will be an incentive for more primary care practices to participate in the registry and have even better data capture.

VDH maintains the Bright Futures web site (www.healthyfuturesva.com) launched in July 2009. This site uses short videos to personify anticipatory guidance themes and the periodicity visit schedule. The site covers key themes on child development, oral health, healthy weight/nutrition, and medical visits through age four including immunizations. Immunizations for early and middle childhood as well as adolescents were added to the site in 2011. The Bright Futures web site will be maintained and updated; the marketing and promotion plan is updated as resources allow.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	16	15.8	15.6	15.4	12
Annual Indicator	16.7	15.5	14.5	12.3	12.1
Numerator	2605	2369	2188	1915	
Denominator	155692	153155	151243	156210	
Data Source		VA birth data & NCHS pop estimates	VA birth data & NCHS pop estimates	VA birth data & NCHS pop estimates	Trend estimate

Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	12	12	12	12	12

Notes - 2011

2011 data not yet available. Entry is an estimate based on performance in previous years.

Notes - 2010

2010 birth data used for number of births to teens. Denominator entry is an estimate based on previous year.

Notes - 2009

Number of teen births from Vital Records 2009 data. Denominator from NCHS 2009 population estimates.

a. Last Year's Accomplishments

Virginia has seen a steady decline in the teenage birth rate over the past decade and this trend is significant when considering the decrease that has occurred since 1999. However, in 2005-2007 these decreases appear to have leveled off. Nationally in 2010, a record low for US teens births was reached (ages 15-19 34.3 per 1,000), a decrease of 12% for 15-17 year olds and 9% for 18-19 year olds. In 2010, the teen birth rate in Virginia decreased to a low of 12.7 per 1,000 15-17 year old females. The provisional 2011 estimate is a good indication that Virginia will continue to see a decline in teen births.

Programs continued to operate in the seven identified health districts with adjusted budgets. Statewide budget reductions in September 2009 caused funding to be reduced. Programs had to recalculate appropriated monies and work plans to reflect the new funding levels. Preliminary analyses still suggest that rates may be increasing among older (18-19 year old) Hispanic teenagers. An example of a local community initiative is the Norfolk Health Department (NHD) launched an innovative public awareness campaign targeting teens in Hampton Roads. Entitled WTW (Worth the Wait), this novel initiative commenced in recognition of "Teen Pregnancy Prevention Month" (May 2011) and features a talent competition akin to the celebrated network television program American Idol. Young people between the ages of 10 and 18 were invited to create imaginative 30 or 60 second television public service announcements (rap, spoken word or song) on teen pregnancy prevention, abstinence, STD or HIV prevention. Auditions were held at the NHD, and judged by a panel of celebrity judges (including 2011 Miss Virginia and a recording producer.) The top 5 contenders were featured on the WTW Facebook page, accessible online at www.facebook.com/wtw4teens. WTW Facebook friends voted on their favorite entries or through Constant Contact (social media marketing tool). Winners were showcased on the June 4, 2011 WTW Community Day, a fun-filled day of interactive training and activities centering on skill development for smart choices and life skills. The Worth the Wait Teen Pregnancy Prevention Campaign was designed as a peer to peer sustainability outreach program with the goal to interface prevention information, education and work to change risk behaviors of teens and

orchestrated by NHD health promotion and child development staff.

Sites have leveraged funds with existing adolescent reproductive health clinic services and continue to seek funding from local foundations and funding sources. Sites have promoted youth leadership by nominating local teens to the National Campaign to Prevent Teen Pregnancy's Youth Ambassador Program. Staff have utilized training opportunities with Training3 consultants by coordinating a train-the-trainer workshop for TPPI sites that target teens in foster care. Staff have partnered with VDH Family Planning staff to coordinate site supervision efforts.

Family planning clinics provide reproductive health services and education in all local health department clinics. In 2011, family planning clinics served 1,099 adolescents under age 15 and 6,986 adolescents ages 15-17.

The Resource Mothers program provides lay mentors to pregnant and parenting teens. Part of their work is to help the participant avoid a subsequent pregnancy. In FY 2011, there were 1,017 new enrollees and a total of 2,096 were served. A total of 33,689 home visits were conducted.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinate administration of teenage pregnancy prevention programming in seven health districts: Alexandria, Crater, Eastern Shore, Norfolk, Portsmouth, Richmond City, and Roanoke City.				X
2. Evaluate teenage pregnancy prevention programs.				X
3. Continue effort to integrate HIV, STD, and teen pregnancy prevention messages.				X
4. Develop the statewide adolescent sexual health plan.				X
5. Develop the skills and capacity of youth service providers to serve the target population through information networks.				X
6. Review and make recommendations regarding proposed legislation or policies addressing teens and their access to health care and other health related services.				X
7.				
8.				
9.				
10.				

b. Current Activities

TPPI funding has been reduced by half, making it imperative for the sites to operate at maximum potential for return on investments. The central office has level-funded each site, shifted the program in one locality from a contractor to the local health district, and provided specific options for implementing evidence-based or evidence-informed programs with a common evaluation. Staff continue to monitor program implementation, provide technical assistance to sites, share information on current literature, and support analysis of evaluation data. Staff provided technical assistance in response to the federal funding announcements for the Personal Responsibility Education Program and Abstinence Education Grants. The Virginia rate of pregnancies among teens ages 10-19 years declined by 22% from 2000 to 2009, and was highlighted in a press release from the commissioner. VDH received the Abstinence Education Grant, a coordinated grant application process was conducted and a .75% time Abstinence Education Coordinator was hired within the Reproductive Health Unit. The Virginia Abstinence Education Grant Program funds seven health districts. Staff coordinated train the trainer workshops for three evidence-

based curricula and conducted site visits to provide technical assistance and program evaluation methods. Staff have provided support for collaborative relationships with other state agencies and selected VDH units that focus on teen pregnancy prevention.

An attachment is included in this section. IVC_NPM08_Current Activities

c. Plan for the Coming Year

The 2013-2014 state budget for Virginia does not contain further funding for the Teen Pregnancy Prevention Initiative. The seven health districts that had been specified in state budget language will no longer receive these funds after July 1, 2012. Central office staff will implement an action plan to merge and coordinate TPPI and Abstinence Education programming and will monitor program implementation, provide technical assistance to program sites, share information on current literature, and support analysis of evaluation data. The TPPI Coordinator has been reassigned to the VDH Family Planning staff and will continue with visit coordination, provide technical assistance on evidence-based or evidence-informed programming along with the Abstinence Education Program Coordinator, as needed. Program staff will research youth development programming and social networking strategies to communicate with youth and teen populations.

Family planning clinics in local health departments will continue to provide reproductive health services and education to teens. The Resource Mothers program will continue providing lay mentoring services to pregnant and parenting teens with the goal of avoiding a repeat pregnancy.

Performance Measure 09: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	39	40	41	55	55
Annual Indicator	29.6	45.3	49.4	49.4	49.4
Numerator	180	391	44567	44567	44567
Denominator	608	863	90299	90299	90299
Data Source		Crater Health District Survey	Statewide Dental Assessment	Statewide Dental Assessment	Statewide Dental Assessment
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016

Annual Performance Objective	50	50	52.5	52.5	55
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Notes - 2011

Estimate for 2011 not yet available. Data source is Virginia Statewide 3rd Grade Public School Dental Assessment, 2009.

Notes - 2010

Estimate for 2010 not yet available.

Notes - 2009

Data source is Virginia Statewide 3rd Grade Public School Dental Assessment, 2009.

a. Last Year's Accomplishments

Local health department dental clinics provided 34,949 visits for individuals and 135,621 clinical services valued at more than \$11.6 million during FY 2011. Approximately 65% of all dental visits were for school-aged children and 8,794 dental sealants were placed. The Dental Health Program, Virginia Department of Health (VDH), provided support to the local health department dental clinics through conducting a quality assurance program, assisting with recruitments, collecting patient services data, providing workforce development, and orienting new dental staff. In FY 2011, two training sessions in pediatric dentistry were provided for dentists, assistants and hygienists working in 22 health districts. On-site quality assurance clinic reviews were completed for nine dental clinics in six health districts. Two districts received assistance in recruitment and orientation of new dental staff. Cumberland Plateau, Peninsula, Piedmont, Roanoke, Thomas Jefferson, Norfolk and Western Piedmont Health Districts used Title V funds to provide dental services to school age and preschool children to include education and dental varnish placement, as well as sealants.

In FY 2011, the pilot dental sealant program in the central region expanded to include three health districts (Crater, Piedmont and Henrico). An additional 21 schools were added to the sealant program with expansion into Henrico Health District. In this central region, 385 children received 1,364 sealants. Schools with high enrollments in the National Free Lunch Program continued to be targeted for inclusion in this program. A sealant database was used to capture sealants placed and sealants retained. In addition, Medicaid reimbursement for sealants was implemented in this central region program.

In FY 2010, the Dental Health Program was awarded a federal grant (Grants to Support Oral Health Workforce Activities) from the Health Resource and Services Administration. This workforce grant provided funding for preventive services programs in Cumberland Plateau, Lenowisco and Southside Health Districts. VDH dental hygienists in these areas operated under the new remote supervision practice protocol that allows VDH employed dental hygienists to provide preventive services in these underserved areas without the direct or general supervision of a dentist. Additional funding from this source was received in FY 2011, allowing for program expansion into five additional health districts (Central Shenandoah, Central Virginia, Danville/Pittsylvania, Lord Fairfax and Rappahannock-Rapidan). These districts operated school-based dental sealant programs and health department fluoride varnish programs, in addition to providing community oral health education. The Dental Health Program provided training, technical assistance and management support to these programs. In FY 2011, these programs combined to provide more than 1,980 sealants in elementary and middle schools and 677 dental varnish applications.

A statewide survey of 7,838 third grade children was completed in the school year ending in 2009, which included a sample of 201 schools across the state. VDH used the Basic Screening Survey Tool and assistance from the Association of State and Territorial Dental Directors to complete the survey. Results showed that half of the children examined had a dental sealant on at least one permanent molar. When controlling for other factors, children with dental insurance

and treated tooth decay were twice as likely to have dental sealants. Children in the central and eastern regions of the state appeared to have greater access to dental sealants than their peers in the northern region. White children were more likely to have dental sealants than Asian, black or Hispanic children.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Seven health districts utilize MCH funding to provide services, including dental sealants.	X			
2. District health department dental programs placed 8,794 sealants in FY 2011.	X			
3. Maintain a data entry program to record the number of oral health services provided by local health department dental programs.				X
4. Recruit and orient new dentists; provide on-site review of programs.				X
5. Develop and distribute educational materials regarding dental sealants.	X		X	
6. Train local public health dental staff on pediatric dentistry to provide a competent oral health workforce.		X		
7. Review and make recommendations regarding proposed legislation or policies addressing children's access to dental care through a practice change for dental hygienists.				X
8. Provide education regarding dental sealants and other oral health topics to school-aged children.			X	
9. Continue and expand school-based dental programs	X			
10.				

b. Current Activities

The Dental Health Program provides support to local dental programs for recruitments, orientations, and technical assistance. District dental quality assurance reviews have completed in Chesterfield, Rappahannock-Rapidan, Norfolk, Mount Rogers and Cumberland Plateau (hygiene program). As of December 31, 2011, local health department dental clinics had provided 17,184 patient visits with 67,909 services valued at more than \$5.5 million. More than 70% of services were for children 5-18 years of age; providers placed 5,276 dental sealants on these children's teeth. A dental training program on pediatric dental topics was provided to all district and central office clinical staff in February 2012.

The ongoing pilot dental sealant program in the central region continues in three health districts in FY 2012, with four additional schools participating in the targeted areas. To date, more than 650 dental sealants have been placed for 200 children. The original workforce grant district programs, operating under the remote supervision model, continue to be active in the schools and communities in Southside, Lenowisco and Cumberland Plateau Districts. Also continued into 2012 are the workforce grant hygienists working under the general supervision model for preventive programs initiated in Lord Fairfax, Central Shenandoah, Rappahannock-Rapidan, Pittsylvania-Danville and Central Virginia. These hygienists have provided 2,408 children with more than 8,600 sealants.

An attachment is included in this section. IVC_NPM09_Current Activities

c. Plan for the Coming Year

The Dental Health Program anticipates providing ongoing technical assistance and guidance for new and existing local health department dental programs through site visits, recruitment, orientation, data collection, and training. In FY 2013, local health department dental clinics will continue to provide comprehensive dental care services, including sealants, to school aged children with approximately the same workforce capacity and production as FY 2012.

The dental sealant program pilot will continue to expand beyond the existing districts and schools. Continued funding from the CDC oral disease prevention grant for preventive interventions has been requested to improve management and technical assistance infrastructure for school sealant programs. The development of comprehensive plans, including a sealant program plan and a surveillance and evaluation plan, are approved grant funded activities that will allow for targeted expansion of the sealant program in 2013 and beyond. Legislation has now been signed into law and will be effective July 1, 2012 that expands the "remote supervision of hygienists" practice model to all VDH hygienists. This will significantly improve our opportunities and efficiency in the delivery of sealants in school based settings.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	1.9	1.9	1.9	1.8	1.3
Annual Indicator	2.4	1.5	1.4	1.2	1.1
Numerator	36	22	21	18	
Denominator	1508669	1510607	1537640	1532720	
Data Source		VA Death data & NCHS pop estimates	VA Death data & NCHS pop estimates	VA Death data & NCHS pop estimates	Trend estimate
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	1	1	1	0.9	0.9

Notes - 2011

Data for 2011 not yet available. Entry is an estimate based on trend.

Notes - 2010

Numerator data from 2010 Death Certificate File. Denominator from NCHS population estimates.

Notes - 2009

Numerator data from 2009 Death Certificate File. Denominator from NCHS population estimates.

a. Last Year's Accomplishments

In 2010, the death rate to children ages 14 and under caused by motor vehicle crashes dropped to 1.2 per 100,000 children which is half the rate observed in 2007. The decreasing trend observed over the past ten years is statistically significant. According to a new report released by the Centers for Disease Control and Prevention, Virginia's death rates from unintentional injuries among children and adolescents from birth to age 19 has declined by 45 percent from 2000 to 2009. Virginia's rate surpasses the 30 percent decline seen nationally. Decreased deaths from motor vehicle accidents represent the single biggest area of decline.

The Division of Prevention and Health Promotion (DPHP) coordinates a child passenger safety program that promotes proper safety seat restraint use for children from birth until they transition to the vehicle safety belt; increases risk perception and correct usage of child restraints among parents and care givers through outreach and education; provides proper installation education through community safety seat check stations and events; and addresses financial barriers that prohibit access to safety seats through the Low Income Safety Seat Distribution and Education Program (LISSDEP). The child passenger safety program is funded through Highway Safety Funds, Traffic Revenues and the MCH Block grant. In 2011, DPHP distributed approximately 16,000 child safety seats to families in need, inspected over 600 seats through safety seat check events, and distributed over 165,000 pieces of education resource materials. In addition, the health care provider-focused First Ride Safe Ride Program which promotes the safe transportation of newborns from the first ride home continued to expand during 2011 with 20% of maternity hospitals in Virginia receiving staff training.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinate statewide child restraint distribution and education program.				X
2. Disseminate child restraint devices.		X	X	
3. Provide public and provider education materials.		X		
4. Review and make recommendations regarding proposed legislation or policies addressing motor vehicle safety issues for children.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DPHP continued to support 145 Low Income Safety Seat Distribution and Education Program distribution sites, maintain a network of 107 child safety seat check stations, conduct at least 25 community safety seat check events, provide hospital training and resources through the First Ride, Safe Ride project, and engage in various parent and caregiver awareness activities.

DPHP is actively utilizing media to promote targeted child passenger safety messages that are culturally and linguistically appropriate, contain minority audience representation, and focus on high-risk populations. To date, five media interviews have been conducted. In addition, six

magazine advertisements have been printed in local parenting magazines and one PSA campaign has aired on radio stations across Virginia. Media messaging has focused on urging parents and caregivers to keep their children in a booster seat until they fit properly in a vehicle safety belt. In the upcoming months, media activities will include a TV PSA that will target the Northern region of the state to encourage parents to not drive distracted and eight additional magazine ads to promote the proper use of child safety seats. Additionally, a teen driver safety project will occur including five high school safety summits, exhibits at sporting events and other venues that target teens, and the development of a distracted driving curriculum that will be included in the mandatory driver's education program at state high schools.

An attachment is included in this section. IVC_NPM10_Current Activities

c. Plan for the Coming Year

DPHP staff will continue to disseminate child restraint devices; provide technical assistance to parents and caregivers; coordinate state and local child restraint outreach and education activities; partner with health care providers; and collaborate with state community and highway safety partners to implement a variety of strategies to prevent injuries associated with motor vehicles, particularly those experienced by children under the age of eight. In 2013, DPHP's goal for the child passenger safety program is to expand services to 10 new safety seat check stations across the Commonwealth, conduct 30 safety seat check events, and provide First Ride, Safe Ride training to an additional 15 maternity hospitals. In addition, DPHP will create a parent-friendly website on child passenger safety and promote the new website to parents. Staff will continue to monitor and educate the public and providers on state and federal legislation that impacts child passenger safety. DPHP will continue work to expand efforts to address child passenger safety with high risk audiences.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	43	49	50	51	52
Annual Indicator	49.8	42.7	46	42.8	40.8
Numerator					
Denominator					
Data Source		National Immunization Program	National Immunization Program	National Immunization Program	National Immunization Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and					

therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	42	43	44	45	46

Notes - 2011

2011 Data not available. Entry is an estimate based on CDC's Breastfeeding National Immunization Data for birth cohort 2008.

Notes - 2010

2009 Data not available. Entry is an estimate based on CDC's Breastfeeding National Immunization Data for birth cohort 2007.

Notes - 2009

2009 Data not available. Entry is an estimate based on CDC's Breastfeeding National Immunization Data for birth cohort 2006.

a. Last Year's Accomplishments

The Division of Community Nutrition (DCN) worked with the University of Virginia (UVA) Office of Continuing Medical Education to develop a web-based training course in lactation management. The web address for the course is www.breastfeedingtraining.org. The course offers free continuing education units to physicians, nurses, dietitians, pharmacists, and other healthcare professionals. BreastfeedingTraining.org course has been in operation since 2007. Five new modules were added in FY 2011. BreastfeedingTraining.org now encompasses 19 training modules ranging in topics from the history of infant feeding to making a hospital-based practice "Baby-Friendly." There were 4,146 newly registered healthcare professionals registered for the course during FY 2011, bringing the total to 11,661.

VDH's Virginia Breastfeeding Advisory Committee (VBAC), which now has 24 members, continues to hold quarterly meetings in Richmond. The Advisory Committee continued to make efforts to gain wider representation from other areas such as workplace, insurance companies, and day care centers. The 2009-2014 Strategic Plan contains four goals and numerous objectives for each goal. The all of the goals for the Strategic Plan were met and the VBAC has begun efforts to develop a new plan. The Mayor of Richmond City formed a Breastfeeding Commission during FY 2011. Four members of the VBAC were invited to take part in this historic endeavor and are working with the City of Richmond to develop a Strategic Plan to increase exclusive breastfeeding rates within the City.

DCN houses the Virginia WIC Program. The Virginia WIC Program completed a pilot study on the use of single-user electric breast pumps during FY 2011. The results indicated that over the course of five (5) years, WIC will save \$1,388,693.80 in choosing to move forward the use of single-user electric breast pumps for Virginia WIC participants.

DCN used the funding awarded from the United States Department of Agriculture (USDA) to continue to develop and promote the Breastfeeding Peer Counselor Program in Virginia. USDA funding to develop and manage the program is issued in two-year grant funding. DCN continued to recruit and hire new WIC breastfeeding peer counselors. During FY 2011, there were 93 breastfeeding peer counselors (78 paid state employees and 15 volunteer employees) throughout Virginia who continue to work within the Virginia WIC Program. VDH held regional conference calls with all 93 WIC breastfeeding peer counselors and all 35 district breastfeeding coordinators each quarter to keep them abreast of policy and procedure changes and updates to the WIC breastfeeding peer counselor program.

DCN began working with the University of Virginia (UVA) Health Systems Department of Pediatrics to conduct research to investigate whether viewing a short, inexpensive prenatal video focused on breastfeeding increases the rate of breastfeeding initiation, duration, and exclusivity among low-income, WIC-eligible women in a US setting both in hospital and following discharge until six months of age. Once informed consent has been obtained and the participant is enrolled into the study, an enrollment questionnaire is administered asking baseline data. Participants are then randomized to receive either the intervention (viewing the Injoy Videos' Better Breastfeeding video) or the sham therapy (viewing the Injoy Videos' Your Healthy Pregnancy: Prenatal Nutrition and Exercise video). Research assistants load the assigned video for the participant to view at the time of enrollment. Chart reviews are performed to collect data regarding delivery. Follow-up telephone interviews are administered to women delivering their babies at 35 weeks gestation or more at one, three, and six months postpartum to collect data regarding infant feeding practices. During FY 2011, there have been 156 women enrolled into the research study.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue the Virginia Breastfeeding Advisory Committee.				X
2. Continue the Breastfeeding Peer Counselor Program.		X		
3. Promote breastfeeding during Breastfeeding Awareness Month.			X	
4. Distribute breastfeeding educational materials to WIC clients.			X	
5. Review and make recommendations regarding proposed legislation or policies addressing breastfeeding.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DCN is continuing to work with UVA to host the web-based training course in lactation management (Breastfeedingtraining.org) and a web-based performance improvement initiative (BreastfeedingPI.org). BreastfeedingPI.org coordinates the development of activities to meet the American Board of Pediatrics Maintenance of Certification requirements. Over 21,000 health care professionals from 23 different countries have completed BreastfeedingTraining.org. A total 265 physicians (10% Virginia licensees) have started and 42 have completed the PI initiative.

The VBAC now has 27 members and continues to hold quarterly meetings in Richmond. Newly developed bylaws were accepted and the new Strategic Plan is being developed. Through the work of the VBAC, the Commissioner sent letters of recognition of 12 hospitals that received an IBCLC Care Award

VA WIC Program is currently developing a Strategic Plan to increase the breastfeeding rates. The Breastfeeding Peer Counselor (BFPC) Program in continues to grow in the Virginia WIC Program. There are now 123 total BFPC. DCN holds regional conference calls with all WIC BFPC and all district breastfeeding coordinators each quarter to keep them abreast updates to the WIC BFPC program.

DCN began working with the UVA Dept of Peds to conduct research to investigate whether

viewing a short, inexpensive prenatal video focused on breastfeeding increases the rate of breastfeeding among low-income, WIC-eligible women. A total of 379 are enrolled.

An attachment is included in this section. IVC_NPM11_Current Activities

c. Plan for the Coming Year

DCN will continue to offer BreastfeedingTraining.org and BreastfeedingPI.org websites to promote and emphasize exclusive breastfeeding and achievement of Healthy People 2020 goals. The DCN/UVA CME collaborative websites are recognized as one of the premiere training and quality improvement initiatives with more than 800 new users per month. DCN and UVA's CME Office have developed a two year plan to ensure that the project will be self-sustainable in two years. DCN plans to develop an additional five modules and work with UVA to develop a electronic management platform for facilities (hospitals, private practice) to allow self monitoring of performance improvement data. The DCN/UVA partnership will continue to seek grant opportunities and begin to develop materials for publication based on results from PI initiative.

The VBAC will continue to hold quarterly meetings and seek wider representation. The VBAC will continue to develop a new Strategic Plan for 2012-2017. The VBAC also plans to begin its efforts to collaborate with the Health Commissioner's Infant Mortality Work Group on breastfeeding endeavors by working to increase the number of birthing hospitals in Virginia that are implementing part or all of the 10 Steps to Successful Breastfeeding as part of the Baby-Friendly Hospital Initiative. The VBAC will also be working with several interagency workgroups to establish a corporate meeting, for dialogue among Virginia birthing facilities.

DCN will continue to manage the BFPC in each of the 35 health districts. DCN continues to seek training opportunities and continuing education for peer counselors to keep them abreast of the latest lactation management research. DCN will continue to hold quarterly regional conference calls with all 123 WIC breastfeeding peer counselors and all 35 district breastfeeding coordinators to update them on policy and procedure changes and WIC breastfeeding peer counselor program updates. The State Breastfeeding Coordinator and Breastfeeding Peer Counselor Liaison will also hold annual face-to-face meetings with each region throughout the year to provide training and regional networking. Breastfeeding peer counselors continue to work within the WIC Program to promote and support breastfeeding in each locality. DCN will work to form a collaboration between the WIC breastfeeding peer counselor program and Virginia hospitals.

DCN will work with UVA to continue research on whether viewing a short, inexpensive prenatal video focused on breastfeeding increases the rate of breastfeeding initiation, duration, and exclusivity among low-income, WIC-eligible women. The project plans to continue enrollment through August 2012 and UVA expects to meet the goal of 600 persons. Data collection will end February 2013. Following data analysis, the final report should be completed by June 2013.

Performance Measure 12: Percentage of newborns who have been screened for hearing before hospital discharge.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	100	100	100	100	100
Annual Indicator	97.8	96.9	96.8	96.5	99.0
Numerator	104863	101757	99774	99351	97990
Denominator	107261	104990	103061	102934	98943
Data Source		Virginia	Virginia	Virginia	Virginia EHDI

		EHDI program & VA Birth data	EHDI program & VA birth data	EHDI program & VA birth data	program & VA provisional birth data
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	100	100	100	100	100

Notes - 2011

Data from the Virginia Early Hearing Detection and Intervention System, 2010 and the number of provisional occurrent births from Virginia Health Statistics, 2010.

Notes - 2010

Data from the Virginia Early Hearing Detection and Intervention System, 2010 and the number of provisional occurrent births from Virginia Health Statistics, 2010.

Notes - 2009

Data from the Virginia Early Hearing Detection and Intervention System, 2009 and the number of occurrent births from Virginia Health Statistics, 2009.

a. Last Year's Accomplishments

During FY 2011, the Virginia Early Hearing Detection and Intervention Program (VEHDIP) continued to administer the state's newborn hearing screening program as required by the Code of Virginia. VEHDIP continued to make improvements to the Virginia Infant Screening and Infant Tracking System II (VISITS II), provided technical assistance to hospitals, revised the protocols for audiologists, hospitals and primary medical providers, and improved follow-up.

In FY 2011, VEHDIP collaborated with the Office of Information Management and developed a Requirements Document for the on-line audiology reporting module. This module will allow approved and screening audiology sites to report infant hearing screening and diagnostic results directly into the VISITS II web-base system. This module will also provide audiology practices the ability to run data reports.

VISITS II greatly improved the program's ability to track and follow-up on infants in need of follow-up testing and diagnosis. VEHDIP reduced the number of infants lost to follow-up by almost 15% between 2009 and 2010. VEHDIP worked to assure that hospitals continued to screen all newborns for hearing loss prior to discharge and report required data through VISITS II. VEHDIP staff conducted hospital site visits. New system users were trained on reporting requirements and the revised program protocols.

VEHDIP continued to collaborate with a variety of organizations to develop and provide trainings to stakeholders through different training methods. Staff facilitated regional trainings of local

Early Intervention (EI) Managers on VEHDIP goals, processes, referrals, and enrollment information. VEHDIP participated in a Talks on Tuesday training session on "Everything You Always Wanted to Know About Hearing but Were Afraid to Ask", which is the most viewed Talks on Tuesday session. VEHDIP, in collaboration with EI and Virginia Commonwealth University Partnership for People with Disabilities, developed and released two thirty minute interactive training modules on the 1-3-6 EHDl goals.

VEHDIP continued to collaborate with bordering state programs and providers to facilitate reporting of resident infants born and followed-up in neighboring states. VEHDIP concluded the 6 month Learning Collaborative activities with 3 audiology and 3 medical home practices and developed a list of recommendations for improvement. These recommendations will be shared with audiologist during the scheduled site visits in 2012. The program applied for and was awarded a Cooperative Agreement from the Centers for Disease Control and Prevention (CDC) for VEHDIP systems' improvements. VEHDIP was also awarded a grant from the Health Resources and Services Administration (HRSA) focused on improving follow-up. This funding will help support family-to-family support services, increase outreach activities to diverse cultures, and increasing awareness and education activities among parents and stakeholders.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Enhance, implement, and evaluate the Virginia Early Hearing Detection and Intervention Program.				X
2. Maintain and improve the Virginia Infant Screening and Infant Tracking System database.				X
3. Provide training for hospital staff.				X
4. Provide hospitals with quarterly updates on program strengths and areas of need.				X
5. Provide annual report to hospitals' CEOs.				X
6. Monitor newborn hearing screenings results and ensured retesting as needed.				X
7. Monitor hearing screenings for out of hospital births.				X
8. Collaborate with other states to track resident infants born in border states.				X
9. Review and make recommendations regarding proposed legislation or policies addressing newborn hearing screening and access to services.				X
10.				

b. Current Activities

In FY 2012, the VEHDIP Program continues to conduct numerous activities related to screening, follow-up, family-to-family support, and information systems and policy improvements.

Hospitals continue the aim to screen all newborns for hearing loss prior to discharge and to report required data through VISITS II. VEHDIP continues to provide technical support and training to hospital staff. Screening performance measures are disseminated in quarterly status reports to hospital programs and annual reports to hospital CEOs. Hospitals not meeting data reporting requirements receive targeted interventions. Screening performance measures are shared with audiologists through quarterly reports.

Lessons learned from the Virginia Learning Collaborative are provided to audiologists during

scheduled site visits. VEHDIP is working to identify opportunities for collaboration with the Home Visiting Consortium. The Loss & Found PSAs, focused on highlighting the importance of follow-up hearing testing and diagnosis, will air in the Richmond and Tidewater area.

Two 30-minute online modules for primary care providers will be released.

VEHDIP collaborated with the Preconception and Pregnancy Information Connection Project (2-1-1) to increase exposure of newborn hearing screening resources. VEHDIP continues to collaborate with EI to increase accuracy of enrollment data obtained from local programs.

An attachment is included in this section. IVC_NPM12_Current Activities

c. Plan for the Coming Year

In FY 2013, the VEHDIP Program will continue routine operations. Hospitals will receive quarterly surveillance reports providing feedback on screening, referral, and other reporting performance measures. Hospital staff will continue to be trained in data reporting requirements using VISITS II. Six site visits will be conducted as part of a quality improvement initiative. Six site visits to audiology practices will be conducted.

The audiology reporting module in VISITS II will be released the summer of 2012. VEHDIP staff will conduct training of users of this module. VEHDIP will also initiate activities to link hearing results from VISITS II to Virginia Immunization Information System (VIIS). The audiology reporting module will be monitored for use and enhancements made based on identified issues and user needs. Linkage from VISITS II to VIIS and other child health systems will be initiated. A post-implementation survey among hospital users will be conducted and suggestions for improvement will be incorporated where feasible. Tracking, surveillance, follow-up, and awareness activities will be implemented based on analysis of data. Role-based web access will be assessed for primary care providers.

The revised 1-3-6 Follow-up Plan will be evaluated with a continued focus on lost to follow-up and lost to documentation. Referrals for infants identified with co-morbidities will be made to EI. Infants with extended hospital stays, infants transferred, and infants born at less than thirty-seven weeks gestation will be monitored closely, in an effort to assess their hearing and follow-up needs.

A second round of Loss and Found PSAs will be conducted in targeted markets. This will include airing Loss and Found, a PSA featuring real families whose infants were found to have hearing loss through newborn hearing screening.

Collaborative efforts with stakeholders will continue to be further developed. VEHDIP will disseminate timely and comprehensive data to healthcare professionals, policymakers, and other stakeholders. The program will promote the use of 1-3-6 on-line interactive training for home visitors in the EHDIP process.

VEHDIP will develop a plan to engage and educate otolaryngologist and obstetricians on the EHDIP 1-3-6 goals. VEHDIP will continue to collaborate with the VEHDIP Advisory Committee to monitor trends, address gaps, and improve follow-up services in Virginia.

Virginia's family-to-family support services for parents diagnosed as deaf/hard of hearing, Guide By Your Side (GBYS), will become embedded into the F2F Network of Virginia. Follow-up activities will continue to be monitored quarterly and activities altered based on findings and availability of resources.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	5	4.9	4.9	4.8	4.8
Annual Indicator	7.3	7.2	7.4	7.1	8.7
Numerator			146190	143821	170759
Denominator			1981269	2026525	1972993
Data Source		National Survey of Children's Health	Current Population Survey, US Census Bureau	Current Population Survey, US Census Bureau	Current Population Survey, US Census Bureau
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	8.5	8	7.5	7.3	7

Notes - 2011

State survey data not available.
Data from the Current Population Survey, U.S. Census Bureau for 2010.

Notes - 2010

State survey data not available.
Data from the Current Population Survey, U.S. Census Bureau for 2009.

Notes - 2009

State survey data not available.
Data from the Current Population Survey, U.S. Census Bureau for 2008. The data source was changed in order to gather a more timely measure than offered by the National Survey of Children's Health.

a. Last Year's Accomplishments

VDH continued to collaborate with state and local partners to help reduce the percent of children without health insurance. VDH programs continued integrating outreach, education, and application assistance where feasible. VDH participated in the state mandated Children's Health Insurance Advisory Committee.

The WebVISION-FAMIS-PlanFirst application link continued to be used by local health departments since statewide implementation began September 2005. In FY 2011, five health districts used Title V funds to support clinic-based and case management efforts to identify, refer, and assist with enrollment or re-enrollment processes for publicly funded children's health insurance programs.

Information regarding publicly supported children's health insurance programs (FAMIS programs for Medicaid and SCHIP) is distributed through the OFHS programs as appropriate and posted on the Bright Futures web site (www.healthyfuturesva.com).

VDH continued participation in the Robert Wood Johnson funded Maximizing Enrollment for Kids grant awarded to the Virginia Department of Medical Assistance Services. The health commissioner serves on the steering committee. Representatives from OFHS serve on a workgroup related to reaching those who are eligible for publicly funded health insurance programs but are not enrolled.

The early childhood e-newsletters for FY 2011 included important links to web sites to support medical home and health insurance. The FY11 Child Care Health Consultant (CCHC training) included training on the medical home and health insurance for child care providers and for the children in their care. Healthy Child Care Virginia (HCCV) continues to work with Head Start through association meetings and the health advisory committee to provide relevant updates regarding health insurance programs for children. The HCCV web site received a range of visits from 2,100 to 35,000 per month.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with partners to increase enrollment in state sponsored health insurance programs.				X
2. Participate in initiatives and coalitions aimed to reduce uninsured rates.				X
3. Fund local health districts for outreach and enrollment activities.		X		
4. Support surveillance, monitoring, and dissemination of data related to children's health and insurance status.				X
5. Maintain and improve data system enhancement to generate public insurance application for potential eligibles served in local health districts.				X
6. Review and make recommendations regarding proposed legislation or policies addressing children's access to healthcare.				X
7.				
8.				
9.				
10.				

b. Current Activities

Collaboration continues with multiple state and local partners to help reduce uninsured rates. Integrating outreach and referral activities into program efforts as well as participating in the state mandated Children's Health Insurance Advisory Committee continues. Use of the WebVISION FAMIS and PlanFirst link is ongoing.

In FY 2012, health districts used Title V funds to support clinic-based and case management

efforts to identify, refer, and assist with enrollment or re-enrollment processes for publicly funded children's health insurance programs.

Representatives from OFHS are participating in the Robert Wood Johnson funded Maximizing Enrollment for Kids grant awarded to the Virginia Department of Medical Assistance Services (DMAS). In FY 2012 VDH collaborated with DMAS and the Virginia Department of Education (DOE) to promote FAMIS programs at TDap immunization events being held for rising 6th graders at schools, local health departments, and community sites. In addition, representatives from DMAS and WIC met to discuss potential areas of opportunity for maximizing enrollment among clients not enrolled in both FAMIS and WIC programs. Other areas for collaboration between VDH and DMAS being investigated include collaboration on media campaigns and targeted efforts such as the Pregnancy Assistance Fund grant.

An attachment is included in this section. IVC_NPM13_Current Activities

c. Plan for the Coming Year

VDH will continue to collaborate with multiple state and local partners to help reduce uninsured rates. Integrating outreach and referral activities into program efforts as well as participating in the state mandated Children's Health Insurance Advisory Committee will continue. Use of the WebVISION FAMIS and PlanFirst link will continue to facilitate enrollment of health department clients into appropriate FAMIS health insurance programs.

VDH representatives will continue to participate in the Robert Wood Johnson funded Maximizing Enrollment for Kids grant awarded to the Virginia Department of Medical Assistance Services (DMAS). Plans include continued promotion of FAMIS programs through school health and TDap events; collaboration in media and outreach activities with a focus on opportunities with the WIC program; and providing information and resources through targeted opportunities such as the Pregnancy Assistance Fund grant.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	30	30	29	29	22
Annual Indicator	32.4	32.0	33.5	30.0	30.0
Numerator	27881	29158	32617	26425	26371
Denominator	86033	91047	97298	88162	87830
Data Source		WIC Program	WIC Program	WIC Program	WIC Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	29	28	27	26	25

Notes - 2010

Data from WICNet, 2010

Notes - 2009

Data from WICNet, 2009

a. Last Year's Accomplishments

Prior to 2010, there was a significant increasing trend in the percentage of overweight or obese 2-5 year olds on WIC. However, due to the drops in 2010 and 2011, this trend is no longer significant. In both of these years, 30% of WIC participants ages 2-5 had a BMI at or above the 85th percentile.

VDH continues to require that all health districts develop objectives in their annual WIC Services Plans to reduce childhood obesity in children ages 2-5 through utilizing state approved nutrition education curricula and materials.

Changes to the WIC food package were also made during FY 2011 including the addition of soy milk, frozen fruits and vegetables, and whole wheat bread and tortillas. VDH has collaborated on content development and the promotion of HealthBites to WIC participants and the public. It is an interactive website designed to help parents and families learn about good nutrition, exercise and other healthy lifestyle choices. WIC participants receive nutrition education credits for completing online modules which will be launched in October 2011.

VDH provided technical assistance and funding to 15 communities to implement evidence based obesity prevention programs (e.g. BodyWorks and Business Case for Breastfeeding). In 2011, VDH provided Color Me Healthy tools and resources to all WIC clinics as and evidence-based program emphasizing nutrition, physical activity and staff wellness. A staff training was held in November 2010 for WIC Coordinators and staff. Staff also participated in an Interagency Taskforce on Obesity and Nutrition to coordinate activities of multiple state agencies including Department of Education and Department of Agriculture.

Through a partnership with the University of Virginia's (UVA) Office of Continuing Medical Education, VDH launched the Pregnancy Weight Gain guidelines continuing education modules (CME): www.prenatalnutritiontraining.org in February 2011. These modules provide information on the epidemiology of obesity; current Institute of Medicine weight gain guidelines for pregnancy; common barriers and issues women have in regards to nutrition during pregnancy; and considerations for women with special needs. UVA's Office of Continuing Medical Education continues to provide progress reports on the usage of the Infant and Toddler Feeding and Pregnancy Weight Gain Guideline modules.

Through a partnership with the Virginia Breastfeeding Advisory Committee, VDH selected, promoted, and provided training for the Business Case for Breastfeeding. The Business Case for Breastfeeding offers resources to help lactation specialists and health professionals educate employers in their communities and teaches them how to successfully present the need for lactation programs to businesses. In FY 2011, VDH funded worksites to implement the Business Case for Breastfeeding.

Virginia Department of Health's (VDH) Obesity Prevention Team, in partnership with the University of Virginia's Office of Continuing Medical Education, developed a series of interactive, web-based modules that provide evidence-based guidelines for infant and toddler feeding. The infant and toddler feeding course provides health care professionals with detailed information regarding good nutrition and feeding practices, as well as resources to offer parents and caretakers. Topics include: nutrition for optimal growth; developmental milestones including mouth patterns, feeding abilities, and hand and body skills; hunger and satiety; and feeding throughout the first years of life. The modules are available at www.infantandtoddlerfeeding.org.

In addition, VDH began administering the Child and Adult Care Food Program and the Summer Food Service Program on October 1, 2010.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinate with the Department of Education to pilot fitness assessment and evidence-based physical education curriculum in 2-3 VA school divisions to promote healthy eating and physical activities.			X	
2. Provide funding to local health districts to implement evidence based obesity prevention interventions.			X	
3. In partnership of University of Virginia, the Virginia Department of Health launched the Pregnancy Weight Gain guidelines continuing education modules (CME) for physicians, nurses, dietitians, and other healthcare providers.			X	
4. Provide Business Case for Breastfeeding trainings and resources to worksites promoting worksite breastfeeding.			X	
5. Provide Color Me Healthy trainings to private daycares and preschools promoting healthy eating and physical activities.			X	
6. Conduct media campaigns to promote physical activity and healthy weight for children and women of childbearing ages.			X	
7.				
8.				
9.				
10.				

b. Current Activities

The obesity prevention program (OPP) awarded 7 mini-grants to local health districts to implement evidence-based obesity prevention programming that address policy, systems and environmental change strategies in their communities. This funding is through the Preventive Health and Health Services (PHHS) Block Grant.

OPP is partnering with the Department of Education to pilot Welnet, an online fitness assessment, and "Five for Life", an evidence-based physical education curriculum for K-12 in 2-3 school divisions using PHHS funding.

OPP continues to partner with the Virginia Foundation for Healthy Youth to address childhood obesity issues in Virginia. In February 2012, the obesity prevention supervisor and Virginia Head Start program representatives attended a CDC-sponsored workshop on addressing childhood obesity in early care and education settings.

DPHP is recruiting an obesity prevention coordinator to work on programs for children and women of childbearing age. DCN promotes breastfeeding as a childhood obesity prevention strategy by providing resources and trainings to businesses to encourage lactation support policies. Six regional trainings were held promoting the Business Case for Breastfeeding. Through ARRA and CPPW, VDH established lactation support programs in worksites.

DCN is collaborating on development and promotion of HealthBites to WIC clients and the public. In FY 2012, 15 of 22 modules were released including physical activity and screen time reduction. **An attachment is included in this section. IVC_NPM14_Current Activities**

c. Plan for the Coming Year

The obesity prevention program (OPP) continues its mission to promote healthy eating and physical activity throughout Virginia by providing funding, educational resources and technical assistance to expand evidence-based obesity prevention activities, and by supporting the implementation of policy, environmental and system change strategies to prevent obesity as identified in the 2011 Surgeon General's National Prevention Strategy.

OPP will provide mini-grants to 10 local health districts through a competitive process for the implementation of evidence-based obesity prevention programs addressing policy, systems and environmental (PES) changes. Funded health districts will be required to implement one or more of 2011 National Prevention Strategies.

Through a contractual agreement with the Department of Education, OPP will fund up to five school divisions to implement an online fitness assessment (Welnet) and Five for Life, a physical education curriculum. This funding will allow five school divisions to purchase Welnet applications and Fit for Life curriculum packages in order to track students' health and fitness assessment data and communicate results to students and parents. The Five for Life curriculum is designed to improve the fitness levels of students and provide them with the knowledge, skills and abilities to live a fit and healthy life by engaging them in fun, meaningful lessons that promote activity, proper nutrition and higher levels of fitness.

As part of a childhood obesity prevention strategy, OPP will promote breastfeeding in worksites to help educate employers about the value of supporting breastfeeding employees in the workplace and provide worksite lactation support and privacy for breastfeeding mothers to express milk.

OPP will also offer Color Me Healthy trainings for Head Start classes, private daycares and preschools. This is a program developed to reach children ages four and five with fun, interactive learning opportunities on physical activity and healthy eating. It is also designed to stimulate all of the senses of young children: touch, smell, sight, sound, and, of course, taste. Through the use of color, music, and exploration of the senses, Color Me Healthy teaches children that healthy food and physical activity are fun.

September is National Childhood Obesity Awareness Month. During this month, OPP will conduct a series of media campaigns to promote physical activity and healthy weight for women of childbearing ages and for children 0-5 years of age throughout Virginia. VDH will contract with Virginia Broadcasting Services to buy radio and newspaper ads to target five rural areas of VA with high rates of childhood obesity.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	6.4	6.2	6.1	6	5.5
Annual Indicator	6.3	6.2	6.3	5.8	5.6
Numerator	6821	6637	6590	6001	
Denominator	108417	106578	104979	102934	
Data Source		VA Birth data	VA Birth data	VA Birth data	Trend Estimate
Check this box if you cannot report the numerator because					

1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	5.5	5	4.5	4	3.5

Notes - 2011

2011 data not yet available. Entry is an estimate based on performance in previous years.

Notes - 2010

2010 data. Virginia is still using the old birth certificate, so indicator measures women who ever smoked during pregnancy.

Notes - 2009

2009 final birth data. Virginia is still using the old birth certificate, so indicator measures women who ever smoked during pregnancy.

a. Last Year's Accomplishments

2010 Virginia birth certificate data reveals that 5.8% of women self-reported smoking during pregnancy. This reflects a statistically significant downward trend in smoking rates from 8.97% in 1999 to 5.8% in 2009. Pregnancy Risk Assessment Monitoring System (PRAMS) data for combined 2007-2008 indicates that 12.5% of new mothers smoked in the last three months of pregnancy and 22% reported smoking prior to pregnancy. PRAMS data also indicates that 7.0% of all infants born in Virginia are exposed to smoke.

Virginia Healthy Start Initiative (VHSI), Resource Mothers, Family Planning, and local health department maternity clinics assessed for tobacco use during pregnancy and the interconception period; provided smoking cessation education and counseling to women who smoke; educated women on the hazards of second hand smoke for infants and children; and provided referrals to smoking cessation programs. In addition, all of the mentioned programs collaborated and referred pregnant women, especially teens, to the Virginia Quitline. The Quitline has established pregnant women as a priority and provides counseling and support seven days per week. More intensive treatment services are available to callers who have expressed a desire to quit smoking and enroll into a multiple session service with counselor-initiated calls. All services are available in English and Spanish. A separate TTY line is available for the hearing impaired.

In FY 2011, the Resource Mothers Program reported that 190 (18.8%) newly pregnant teens enrolled reported that they smoked at conception. By the time of delivery, 118 (62%) had stopped smoking.

VHSI provided case management services to 296 high-risk pregnant, postpartum, and interconception women. All women were screened for tobacco use.

The health risks and smoking cessation referral sources were included in healthcare provider presentations conducted by VDH staff. Two presentations focused on Sudden Unexplained Infant Death. Another presentation was a case study of an infant death and showcased the programs and services of VDH that may have decreased the risk of infant mortality.

During FY 2011 the Bristol Baby Basics Moms Club a community led intervention developed from the Southwest Virginia Perinatal Councils findings offers learning modules on 6 core topics to all pregnant women at any stage of their pregnancy. These topics include information on substance use, including tobacco. The West Central Perinatal Council, Lynchburg community action team

targets eleven high-impact services areas known to improve birth outcomes to include smoking cessation. The B.A.B.E program encourages early and adequate prenatal care and offers stickers for smoking cessation classes; women's use the stickers to purchase items from the B.A.B.E. store. Community Voices in Lynchburg provides on-going training to community Lay Health Advisors which includes information on dangers of tobacco use and the importance of smoking cessation, safe sleep classes. The East Central Perinatal Council's Henrico Community Action Team distributed information from the One Tiny Reason to quit project.

Staff partnered with the University of Virginia Office of Continuing Medical Education, Virginia Department of Behavioral Health and Development Services, the Virginia Department of Medical Assistance Services, and the Alliance for the Prevention and Treatment of Nicotine Addiction to conduct the conference, "Screening for High Risk Behaviors in Pregnancy" on August 20, 2011. The conference focused on how to screen for substance use including a session on "Tobacco Use and Exposure to Secondhand Smoke" using the Screening, Brief Intervention, and Referral to Treatment (SBIRT) technique. Over 50 persons including physicians, social workers and nurses attended.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide guidance to women in the family planning and prenatal clinics regarding the risk of smoking.		X		
2. Provide case management to pregnant women and refer them to smoking cessation programs.		X		
3. Provide smoking cessation programs through appropriate VDH programs.	X	X		
4. Review and make recommendations regarding proposed legislation or policies addressing smoking and the availability of cessation programs.				X
5. Focus all RPCs, through FIMR, to monitor smoking and to initiate smoking cessation programs sensitive to the culture of individual areas within the state.	X			X
6. Initiate evaluation of PRAMS data to provide another benchmark defining smoking within the perinatal population of Virginia.				X
7.				
8.				
9.				
10.				

b. Current Activities

The Maternal, Infant and Early Childhood Home Visiting project's five sites assess for tobacco use during pregnancy and the interconception period; provide smoking cessation education and counseling to women who smoke; educate women on the hazards of second hand smoke for infants and children; and provide referrals to smoking cessation programs including Virginia's Quitline.

The Resource Mothers Program continues to monitor smoking status in all participants and reports this measure as a performance measure for the program. Smoking cessation is encouraged and appropriate referrals are made when indicated.

Regional Perinatal Councils are increasing the knowledge and services available related to

smoking cessation and creation of a safe sleep environment by partnering with community agencies. Outcomes include: providing Safe Sleep Saves Babies Lives curriculum to the Girl Scout Councils; training trauma center staff in safe sleep education; providing cribs for low-income families in need of safe cribs; and supporting two safe sleep baby showers that included safe sleep education. Partnerships also include membership on the Consortium for Infant and Child Health and the Respiratory Health Work Group.

Southwest Virginia Perinatal Councils continues Bristol Baby Basics Moms Club a community led intervention developed from the Southwest Virginia Perinatal Councils findings offers learning modules on 6 core topics.

An attachment is included in this section. IVC_NPM15_Current Activities

c. Plan for the Coming Year

Child fatality reviews involve examination of the precise details of child deaths to determine how they could have been prevented and to make recommendations for education, training, and intervention. Child death reviews highlight changes needed in health care, education, social services, and death investigation practices. The current focus of review is infant deaths from SUID, SIDS, and co-sleeping at the time of death, including the smoking indicator.

Virginia Healthy Start Initiative (VHSI), Resource Mothers, Family Planning, Maternal, Infant and Early Childhood Home Visiting project, and local health department maternity clinics will continue to assess for tobacco use during pregnancy and the interconception period; provide smoking cessation education and counseling to women who smoke; educate women on the hazards of second hand smoke for infants and children; and provide referrals to smoking cessation programs. In addition, all of the mentioned programs will continue to collaborate and refer pregnant women the Virginia Quitline.

All Resource Mothers Program and VHSI sites will continue implementing Florida State University's "Partnering for a Healthy Baby". This curriculum covers topics relevant to pregnancy, including the message of smoking cessation.

Virginia Perinatal Councils' work plans are being revised for FY 2012. They will continue with the Virginia FIMR model and will use the Baby Abstracting System and Information Network (BASINET).

The Office of Family Health Services will disseminate published PRAMS fact sheets related to safe sleep position, data tables on smoking before and during pregnancy, and infant exposure to smoke.

The Division of Child and Family Health (CFH) is collaborating with the Virginia Chapter of the March of Dimes and others to evaluate perinatal outcomes of the CenteringPregnancy prenatal care model within Virginia by participating in the development and adoption of core outcome indicators. CFH provides input and support in the development of a statewide consortium of practitioners engaged in establishing CenteringPregnancy groups to share issues and lessons learned pertaining to model implementation. VDH staff serves on the data subcommittee of this consortium which is developing a statewide evaluation plan including a standard reporting form on birth outcomes. VDH is supporting the Virginia Commonwealth University Center for Health Disparities in partnership with the March of Dimes to submit a StrongStart grant application regarding CenteringPregnancy which will include smoking status as a performance measure.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	5.4	5.2	5.2	5.2	5.2
Annual Indicator	6.2	9.5	7.6	6.7	5.8
Numerator	33	51	41	37	
Denominator	532781	535634	542386	550965	
Data Source		VA Death data & NCHS pop estimates	VA Death data & NCHS pop estimates	VA Death data & NCHS pop estimates	Trend estimate
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	5.5	5.2	5	4.8	4.5

Notes - 2011

Data for 2011 not yet available. Entry is an estimate based on trend.

Notes - 2010

2010 data from death certificates and 2010 NCHS population estimates.

Notes - 2009

2009 data from death certificates and 2009 NCHS population estimates.

a. Last Year's Accomplishments

The Division of Prevention and Health Promotion (DHP) maintains a youth-focused suicide prevention program funded by the MCH Block Grant and a Substance Abuse and Mental Health Services (SAMHSA) grant. DHP was awarded the 3-year SAMHSA grant for the third time in August of 2011. The program utilizes school, campus, and community based approaches to suicide prevention. In 2011, DHP contracted with two sub grantees, Bristol Crisis Center and Mental Health America of Central Virginia, to work within their local communities to build and maintain local coalitions, coordinate local awareness campaigns, educate and train school staff on suicide prevention/intervention, and train and provide resources to youth serving community organizations. A third sub grantee affiliated with James Madison University managed the Campus Suicide Prevention Center of Virginia. The Center worked with colleges and universities across the state to build the infrastructure necessary for improved suicide prevention and mental health promotion on Virginia campuses. DHP also coordinated evidence-based gatekeeper trainings (e.g., Question Persuade Refer [QPR], safeTALK, and Applied Suicide Intervention Skills Training [ASIST]) for K-12 school staff, college faculty, and staff and youth serving

community organizations. The trainings are evaluated and have consistently demonstrated that they make participants feel more prepared and inclined to help someone at risk for suicide.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote staff gatekeeper training using the evidence based ASIST, Safe Talk, and QPR programs.				X
2. Provide resources and training to initiate implementation of evidence based secondary school suicide assessment and prevention program.		X		
3. Coordinate statewide education to promote recognition of warning signs and encourage help-seeking.		X		X
4. Review and make recommendations regarding proposed legislation or policies addressing suicide prevention and access to services.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DPHP continues to co-chair the Interagency Suicide Prevention Committee with the Department of Behavioral Health and Developmental Services (DBHDS) which plans to host an ASIST training-for-trainers for local Community Service Board staff (the public mental health option in Virginia) and update Virginia's Suicide Prevention Across the Lifespan Plan in 2012. DPHP worked with Department of Education to create a draft of the new guidelines that contains the latest information on suicide prevention, intervention and postvention, as well as sample announcements, letters to parents, and protocols for documenting students in crisis. The newly updated guide is scheduled to be released spring of 2012. Sixty-four gatekeeper trainings (QPR, safeTALK, and ASIST) have been scheduled for completion throughout FY 2012 and the 2012 schedule for the Recognizing and Responding to Suicide Risk (RRSR) training series has been set. Five RRSR training sessions will take place between March and October 2012 in different regions of the state and will reach an estimated 250 mental health clinicians.

An attachment is included in this section. IVC_NPM16_Current Activities

c. Plan for the Coming Year

DPHP will continue to provide evidence based gatekeeper (QPR, safeTALK, ASIST) training for schools, colleges, and youth serving organizations. DPHP will continue to work with secondary schools in Virginia to promote early identification and help seeking behaviors for suicidal youth through evidence based models (RESPONSE high school based program). DPHP will also partner with the Campus Suicide Prevention Center of Virginia to encourage campuses to adopt comprehensive suicide prevention and mental health promotion programming. DPHP will continue to partner with the Department of Behavioral Health and Developmental Services, Department of Veteran Services, and other stakeholders to improve the primary health and mental health care response to suicide risk through education, training, and policy development. DPHP will also partner with the University of Michigan and Survey Sciences Group to offer ten colleges in Virginia the opportunity to take part in the 2013 Healthy Minds Study. The Healthy Minds Study is a national study collecting information on mental health issues on college campuses. The Healthy Minds Study will provide campuses with information on the mental health of their student body (anxiety, eating disorders, depression, and suicide), utilization of on campus

mental health resources, and associations between students' mental health and academic outcomes.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	91.5	91.5	92	92	92.5
Annual Indicator	83.9	87.6	86.1	84.9	83.3
Numerator	1258	1201	1208	1205	
Denominator	1499	1371	1403	1419	
Data Source		VA birth data	VA birth data	VA birth data	Trend estimate
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	85	85	87.5	87.5	90

Notes - 2011

2011 data not available. Entry is an estimate based on trend analysis.

Notes - 2010

2010 data from birth certificates and licensure & certification listing of Level III/IV facilities. Invalid birthweights and invalid hospital codes were excluded from the measure.

For 2005 and forward, stricter criteria was used for determining which hospitals are "facilities for high-risk deliveries and neonates" based on the state regulations for licensure of hospitals at the specialty and subspecialty levels of infant care (defined for the measure as Level III and Level IV hospitals).

Notes - 2009

2009 data from birth certificates and licensure & certification listing of Level III/IV facilities. Invalid birthweights and invalid hospital codes were excluded from the measure.

For 2005 and forward, stricter criteria was used for determining which hospitals are "facilities for high-risk deliveries and neonates" based on the state regulations for licensure of hospitals at the specialty and subspecialty levels of infant care (defined for the measure as Level III and Level IV hospitals).

a. Last Year's Accomplishments

In Virginia, 84.9% of very low weight births occurred at facilities for high-risk neonates in 2010. There is no significant increase or downward trend.

All local health departments offer pregnancy testing and, if positive, provide patient counseling and referral for prenatal care within two weeks.

Regional Perinatal Councils (RPCs) continue to use Fetal Infant Mortality Review (FIMR) as a method of identifying issues pertaining to access of care. Closing of obstetrical, neonatal, and/or high-risk maternity services is confirmed with health district directors for information sharing and issue resolution. East Central conducted a survey to assess the current use of 17 alpha hydroxyprogesterone caproate (17P) by providers and identify issues pertaining to obtaining and administering 17P. RPCs staff disseminated the Department of Medical Assistance Services (DMAS) memorandum used to clarify the coverage of 17 P for fee-for-service and managed care enrollees. Additionally, staff partnered with DMAS to provide a webinar to clinicians on 17P.

Southwest Virginia Perinatal Council continued Bristol Baby Basics Moms Club (BBMC) a community led intervention developed from FIMR finding; this project offers learning modules on 6 core topics to all pregnant women at any stage of their pregnancy. BBMC recorded 240 encounters with pregnant women.

RPC staff began interviewing and reviewing records of low birth weight babies; results will be provided during FY 2013. The West Central Perinatal Council, Lynchburg community action team will continued using strategies to target eleven high-impact services areas: medical home/preconception care, obstetric care, home visiting, substance use and tobacco, domestic violence, mental health, family planning, nutrition support, breastfeeding and safe sleep through Childbirth and Family education department and the Centering Pregnancy Program at Virginia Baptist Hospital. Lynchburg Community Voices classes will continue.

The Health Commissioner's Infant Mortality Work Group (HCIMWG) is a diverse workgroup comprised of both lay and healthcare professionals. HCIMWG was convened to examine issues pertaining to infant mortality within Virginia. The PowerPoint, called the Silent Epidemic was created as a method to provide a consistent message pertaining to infant mortality reduction strategies, including the need for the mother to receive early and adequate prenatal care. The Silent Epidemic has two components one designed to use with community leaders and one to use with professionals. Over the last two years it has been used for over 16 sessions including over 500 community and professional partners.

Through the FIMR, Maternal Death Review, and use of Pregnancy Risk Assessment Monitoring System (PRAMS) data, entry into prenatal care is monitored, issues identified, and community-based recommendations implemented and evaluated for effectiveness. The FIMR process includes an evaluation of the system of healthcare delivery for mothers and infants. Within the process, RPCs have monitored obstetrical and neonatal healthcare systems to identify any issues pertaining to access to appropriate healthcare

Resource Mothers and Virginia Healthy Start Initiative (VHSI) staff continue to provide information to participants about the signs and symptoms of preterm labor. Teaching about the signs and symptoms of preterm labor is a standard of care for these two programs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct Fetal Infant Mortality Reviews (FIMR) to identify barriers to care and made systems changes to address barriers.				X
2. VHSI local sites continue outreach to programs and clinics that provide pregnancy-testing services to increase referrals		X		X

early in pregnancy.				
3. The OFHS staff serve on the regulatory work group that will review the hospital neonatal regulations during the next year.				X
4. As trending data becomes apparent through FIMR concerning access to care, regional activities will occur.	X	X		X
5. Review and make recommendations regarding proposed legislation or policies addressing availability and access to appropriate care.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

RPCs were trained and began to document FIMR components using the Baby Abstracting System and Information Network (BASINET) web-based system. This system provides standardized documentation and reporting tools and is used to identify and report issues related to health and human services gaps impacting pregnancy outcomes.

RPCs staff used The National Center for Cultural Competence's Cultural and Linguistic Competence tool to complete a self-assessment to move forward with plans to incorporate cultural and linguistic appropriate interventions in their community action plans.

Staff continue to support the work of the HCIMWG. One project this year was to conduct a survey of all birth hospitals regarding the prenatal and postpartum patient education.

RPCs continue to provide consultation on issues that impact pregnancy outcomes through collaborations with partners in their areas.

The Office of Minority Health and Health Policy are supporting the use of telemedicine. Virginia Commonwealth University Health System and the University of Virginia have established partnerships and telemedicine links between local health clinics. This collaboration provides real-time distant consultation services (including live video feed of patient ultrasound studies while being performed) and education to ancillary support staff, health care providers, and community.

VHSI provides case management services including screening and education about prenatal care access and signs of preterm labor.

An attachment is included in this section. IVC_NPM17_Current Activities

c. Plan for the Coming Year

VHSI local sites will continue case management services to participants that include screening and education about access to prenatal care and the signs and symptoms of preterm labor.

Virginia Regional Perinatal Councils' work plans are being revised for FY 2013. They will continue with the Virginia FIMR model and will use BASINET. These tools will be used to identify and report statewide and community issues related to transfers involving high-risk deliveries and neonates. A review of the FIMR model will be completed in the next six months with a goal of determining the best manner to acquire fetal infant mortality information and to share it.

The Health Commissioner's Infant Mortality Work Group will continue to discuss issues and trends in improving outcomes of neonatal care throughout the Commonwealth. The work group is committed to creating messages that will inform lay and healthcare professionals within Virginia of the needs of high-risk pregnancy families. A PowerPoint presentation will be updated with

current data and information and potential strategies to provide a consistent message pertaining to infant mortality reduction strategies, including the need for the mother to receive early and adequate prenatal care. It is expected a subgroup will use the results from the Childbirth and Early Parenting Hospital Survey to develop a work plan to follow-up on this survey.

Health departments that provide perinatal services will continue to provide education regarding the signs and symptoms of preterm labor. Twenty-nine of the 35 health districts using MCH funds address perinatal issues particularly access to obstetrical care, breastfeeding support and reduction in low weight birth. Staff in the OFHS provide technical assistance in carrying out district plans.

Collaboration will continue with the Virginia Neonatal Collaborative, a group of neonatology healthcare providers practicing at various high-risk facilities within Virginia, to provide data concerning neonatal mortality and transfer issues.

Telemedicine collaborative efforts will continue. Staff have provided support for staff at the Mid-Atlantic Telehealth Resource Center to submit a Innovations grant application to expand the use of telemedicine for high-risk obstetrics within health districts.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	91	91	91	91	92
Annual Indicator	83.2	84.6	82.8	81.9	85.3
Numerator	90225	90150	86890	84268	84364
Denominator	108417	106578	104979	102934	98943
Data Source		VA birth data	VA birth data	VA birth data	VA Provisional Birth Data
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	87	87	87.5	87.5	90

Notes - 2011

2011 provisional birth certificate data.

Notes - 2010

2010 birth certificate data.

Notes - 2009

2009 final birth data.

a. Last Year's Accomplishments

The percent of infants born to women who received prenatal care in the first trimester (with the target being 91%) has reflected a statistically significant downward trend from 84.6% in 2000 to 81.9% in 2010.

Within the Department of Health system, 22 local health departments provide prenatal care. Health departments that do not provide prenatal care have guidelines in place to assist women in obtaining direct medical services with a local provider. All health departments refer eligible clients to Medicaid and/or Nutrition, Physical Activity and Food Programs for services. In 2009, there were 15,878 maternity patients. This is a slight decrease (0.6%) from 15,984 patients in 2008. Overall, the maternity caseload is trending upward.

Virginia Healthy Start Initiative (VHSI) local sites targeted outreach to providers, programs, and clinics that provide pregnancy testing services to increase referrals early in pregnancy to assist women in accessing prenatal care. Of those enrolled in FY 2011, 73% of women entered prenatal care in the first trimester.

Resource Mothers conducted outreach to teens and those serving teens in order to increase awareness of the need for prenatal care in the first trimester. Of those enrolled in 2011, 69.9% received prenatal care in their first trimester, which was an increase over the 2010 rate (66.8%).

The Health Commissioner's Infant Mortality Workgroup (HCIMWG) is a diverse workgroup comprised of both lay and healthcare professionals. HCIMWG was convened to examine issues pertaining to infant mortality within Virginia. At each HCIMWG meeting, education is provided to the members on issues pertaining to perinatal health.

Through the Fetal Infant Mortality Review (FIMR), Maternal Death Review, and the use of PRAMS data, entry into prenatal care is monitored, issues identified, and community-based recommendations implemented and evaluated for effectiveness.

The Virginia Home Visiting Consortium, an interagency public and private group that includes all those programs using home visiting as a major intervention to improve pregnancy and childhood health, collaborated with VDH to apply for the Maternal, Infant and Early Childhood Home Visiting Grant. Early entry into prenatal care was chosen as the performance measure for the Maternal Health Benchmark.

The Regional Perinatal Councils (RPCs) continue to initiate partnerships to improve access into prenatal care. The South West RPC partnered with 2-1-1 VIRGINIA to increase obstetrical providers' awareness of 2-1-1 VIRGINIA as an information and referral source for their clients by adding 23 new agencies and updating 43 agencies. They replicated the Baby Basics Moms Club in the Project Link of Roanoke and New River Valley.

RPCs supported efforts to pilot Centering Pregnancy groups in Southwest, West Central and Northern Virginia.

Safe sleeping environment continues to be topic of interest in many communities and the RPCs continue to provide consultation and guidance to communities on their development of projects and activities. Eastern Virginia Perinatal Council (EVPC) formed a Safe Sleep Work group and participated in maternity fairs with a safe sleep display and "Safe Sleep" baby showers reaching a total of 111 people.

West Central collaborated with the City of Charlottesville leaders who sponsored a community Health Summit on Obesity and Pregnancy. East Central convened a conference to educate consumers and providers about the risk of obesity in pregnancy with an attendance of 67 providers, 83 non-clinicians (consumers and lay-health providers).

The Northern Virginia RPC shared Fetal and Infant Mortality findings during an Inova Hospitals' OB Grand Round including over 100 maternity care nurses. This RPC distributed 500 sleep sacks to low-income pregnant women and new mothers and partnered with the Inova Congregational Health Partnership to find medical homes for over 125 pregnant women and new mothers. Special events were used to reach 5,000 faith community members. This RPC partners with Postpartum Support International together are sponsoring a three-track conference for professionals, consumers and volunteers on Perinatal Mood and Anxiety Disorders.

The Health Commissioner's Multivitamin Counseling and Distribution Program has distributed and educated childbearing-age women who seek services at local health departments have provided folic acid an education about the role of folic acid in the reduction of birth defects.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Educate providers on how to better serve low income women and link them to community resources including health insurance.		X		
2. Educate public on the importance of early prenatal care.			X	
3. Provide education and training to providers on topics that support adequate prenatal care.		X		
4. Provide funding to district health departments to support prenatal care.		X		
5. Through the FIMR and Maternal Death Review process, entry into prenatal care will be monitored, issues identified, and community-based recommendations implemented and evaluated for effectiveness.		X		
6. VHSI local sites continue outreach to programs and clinics that provide pregnancy-testing services to increase referrals early in pregnancy. Referral systems are established with Medicaid eligibility workers, Community Health Centers, health depart	X			
7. Review and make recommendations regarding proposed legislation or policies addressing access to care.				X
8.				
9.				
10.				

b. Current Activities

A pilot project has begun with emergency room (ER) departments within Virginia hospitals. All women diagnosed as pregnant during the ER visit will be provided with a completed Pregnancy Verification Form, which has been developed and approved by the Department of Medical Assistance Services for hospitals to revise and use as needed. Several hospitals are taking steps to integrate this form and this notification process into their electronic medical record.

VDH received funds to implement the Pregnancy Assistance Fund (PAF) grant. The initiative seeks to provide support to both male and female pregnant and parenting students age 18-29 enrolled in institutions of higher education. Primary program activities include the implementation of evidence informed peer counselor programs, the creation of Offices of Pregnant and Parenting Student Support (OPPSS) centers, and projects to identify and refer student-parents experiencing sexual assault, domestic violence and stalking issues.

Pregnancy and Parenting Information Connection is being implemented. The purpose of this grant is to increase the number of childbearing age women that access 2-1-1 VIRGINIA. A social

marketing campaign is aimed at increasing the awareness of 2-1-1 VIRGINIA. Number of calls and hits to the internet site will be monitored.

An attachment is included in this section. IVC_NPM18_Current Activities

c. Plan for the Coming Year

Folic Acid continues to be available for all women receiving any service at local health departments. All local health departments will offer pregnancy testing and, if positive, provide patient counseling and referral for prenatal care within two weeks.

Resource Mothers Program site selection will be determined by a competitive bidding process for FY 2013 and therefore, the number and location of these sites will possibly change.

The Healthy Baby Begins with You program will be offered to universities and colleges within central Virginia in hopes to schedule a training in the fall 2012. Preconception health messages support the identification and treatment of chronic disease prior to pregnancy. Other preconception messages regarding folic acid consumption, smoking cessation, drug and alcohol use, and healthy diet are included. Education is provided concerning early parenting decisions such as providing a safe sleep environment, lactation as the primary feeding method, and immunizations.

The Pregnancy Assistance Fund grant will continue. Through a competitive bid process 17 campuses are participating in the project and have begun developing Offices of Support for Pregnant and Parenting Students. Students regardless of income are connected by program staff and peer mentors to services that will help them stay in school and graduate. They are also linked with resource information and enrollment assistance for health, social and educational services on campus as well as within their communities. In the coming year, VDH intends to expand the program to include two Historically Black Colleges and Universities. Each of the participating campuses is required to coordinate and implement a campus-wide awareness campaign regarding sexual assault, domestic violence, and stalking. In addition, a media and marketing campaign consisting of an interactive website, television ads, and print materials will be completed and used to promote the support centers at each school.

The Maternal, Infant and Early Childhood Home Visiting (MIECHV) project will continue to fund local sites to improve early childhood systems of care including access to prenatal care. Expansion of home visiting services through this project will increase the number of families who are linked to services and resources in Virginia. The Home Visiting Consortium (HVC) continues to work with local Smart Beginnings Coalitions to identify and establish collaborative relationships to improve access to prenatal care and linkages to social, educational and health services. The HVC will continue to serve as the advisory and interagency leadership group for the Virginia MIECHV project.

RPCs' contracts to conduct the Virginia Fetal and Infant Mortality Review program will be critically examined to assess cost benefit, level of effectiveness and possible alternatives. The contracts will be renewed for a limited amount of time as this analysis is completed and recommendations made to management.

D. State Performance Measures

State Performance Measure 1: *Percent of infants born preterm (gestational age less than 37 weeks completed)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					8
Annual Indicator		10.5	10.2	10.0	9.5
Numerator		11211	10678	9907	9506
Denominator		106578	104979	98924	100392
Data Source		VA Birth Data	VA Birth Data	VA Birth Data	VA Provisional Birth Data
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	9.5	9.4	9.3	9.2	9.1

Notes - 2011

2011 provisional data.

Notes - 2010

2010 Birth data.

Notes - 2009

2009 final birth data.

a. Last Year's Accomplishments

The Virginia Healthy Start Initiative (VHSI) provided case management services to high risk pregnant women including risk assessment, care plan development, and education. In FY 2011, 12% of live births among VHSI participants were born at less than 37 weeks gestation.

The Perinatal Councils used the Fetal Infant Mortality Review process during FY 2010 and completed chart abstractions and maternal interviews on one hundred forty-five cases: 62 fetal and 87 infant deaths. The top three issues identified for the state report are low birth weight infants, maternal obesity, and multiple stressors. This information was used to prepare their FY 2011 work plan and supplement reports developed by VDH.

East Central Perinatal Council assessed the use of 17 alpha hydroxyprogesterone caproate (17P) by providers. Recommendations identified are the following:

- Increase provider education regarding insurance coverage of progesterone administration (both private and Medicaid insurance)
- Increase provider awareness of current research findings and evidence based recommendations
- Increase public awareness about the use of progesterone for women with a prior spontaneous preterm birth
- Promote interconception counseling about the use of progesterone for women with a prior spontaneous preterm birth

Virginia was a pilot site for the text4baby text messaging platform. Text4baby provides text informational messages with a public health focus during pregnancy and infancy. This project is accomplished in partnership with Healthy Mothers, Healthy Babies (HMHB), CDC, the White House, the Department of Defense, George Washington School of Public Health, and numerous public and private organizations in Virginia. The messages include information focused on maintaining pregnancy until over 37 weeks gestation. As of March 2012, over 12,000 Virginia women were enrolled in text4baby. Customized PSAs were developed by HMHB and have been distributed to local Virginia media. The partners have continued to promote the service as

previously.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Educate providers on how to better serve low income women and linked them to community resources including health insurance.		X		
2. Educate public on the importance of decreasing preterm births.			X	
3. Provide education and training to providers on topics that support decreasing preterm births		X		
4. Provide funding to district health departments to support prenatal care.		X		
5. Through the FIMR, Child Fatality Review and Maternal Death Review process, preterm births will be monitored, issues identified and community-based recommendations implemented and evaluated for effectiveness.		X		
6. VHSI local sites continue outreach to programs and clinics that provide pregnancy-testing services to increase referrals early in pregnancy.	X			
7.				
8.				
9.				
10.				

b. Current Activities

VHSI local sites provide case management services including screening and education to participants to increase access to prenatal care and community resources. Education is provided on the importance of delivering a full term infant and the signs and symptoms of preterm labor.

RPCs and Virginia Healthy Start sites both have FIMR case review teams and collaborate on activities. There are currently a total of 16 case review teams.

The RPC Program coordinated a telephone conference with the five perinatal councils and the Department of Medical Assistance Services (DMAS) Maternal and Child Health Division to discuss distribution of the DMAS memorandum to clarify coverage for 17P to providers. DMAS provided a webinar for the RPCs on 17P and DMAS's Maternal and Child Health programs and services.

An attachment is included in this section. IVD_SPM1_Current Activities

c. Plan for the Coming Year

VHSI local sites will continue risk assessment, care plan development, and case management services to reduce preterm births.

RPC and Virginia Healthy Start staff will continue to share ideas and outcomes during the Council meetings and work on issues identified by local case review teams. The Councils will continue to provide consultation to Community Action Teams in their region. FIMR data will be used to

prepare work plans and supplement reports developed by VDH.

Health districts that provide prenatal care will continue to educate women about signs and symptoms of preterm labor and refer patients to a perinatologist as needed. Telemedicine will continue to be explored and incorporated as service is available. Telemedicine is currently in practice in one health district.

OFHS will continue to support the efforts of the Virginia Chapter of the March of Dimes as a member of the Program Services Committee.

State Performance Measure 2: *Percent of women ages 18-44 who report good/very good/excellent health.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					95
Annual Indicator		90.5	88.3	91.9	88.4
Numerator		1309849	1283273	1328778	1328776
Denominator		1447091	1453097	1445533	1503939
Data Source		Virginia BRFSS	Virginia BRFSS	Virginia BRFSS	Virginia BRFSS
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	90	90	92	92	94

Notes - 2011

Self-rated health status obtained from the Virginia Behavioral Risk Factor Surveillance System (BRFSS), 2011.

Question: Would you say that in general your health is: excellent, very good, good, fair, or poor?

Notes - 2010

Self-rated health status obtained from the Virginia Behavioral Risk Factor Surveillance System (BRFSS), 2010.

Question: Would you say that in general your health is: excellent, very good, good, fair, or poor?

Notes - 2009

Self-rated health status obtained from the Virginia Behavioral Risk Factor Surveillance System (BRFSS), 2009.

Question: Would you say that in general your health is: excellent, very good, good, fair, or poor?

a. Last Year's Accomplishments

Pregnancy and Parenting Information Connection was created and funded. The purpose is to increase the number of childbearing age women accessing 211 VIRGINIA. By implementing a social marketing campaign aimed at increasing awareness of 211 VIRGINIA, calls and hits to the internet site will increase and appropriate services will be utilized. Under this umbrella, a partnership with Healthy Mothers, Healthy Babies was planned for expansion to create a nutrition

education module that will be provided by a text messaging platform. Both activities have the potential to improve the health and well-being of women and infants in Virginia.

VDH received a federal Pregnancy Assistance Fund (PAF) grant to support pregnant and parenting students at institutions of higher learning and strengthening the public's response to these challenges through increased knowledge and awareness. Strategies include the implementation of evidence informed peer counselor programs, the operation of offices of pregnant and parenting student services at targeted institutions of higher learning, and the development and implementation of a public awareness program.

The Healthy Baby Begins with You program was planned to be provided in Virginia. This national campaign, developed by the Office of Minority Health, U.S. Dept. of Health and Human Services, is dedicated to raising awareness about infant mortality with an emphasis on the African-American community through involving Historically Black Colleges and Universities. Preconception health messages support identification and treatment of chronic disease prior to pregnancy. Other preconception messages regarding folic acid consumption, smoking cessation, drug and alcohol use, and healthy diet are included. Education is provided concerning early parenting decisions, such as providing a safe sleep environment, lactation as the primary feeding method and immunizations

VHSI explored changing the approach to care to incorporate the life course model as a delivery of care model. Education, training, and documentation systems were explored and created.

Resource Mothers implemented the Florida State curriculum, including information concerning physical, emotional, and mental needs of women during the childbearing years. Anticipatory guidance was provided to all clients continuing to practice healthy behaviors and seeking additional support and knowledge about areas of health concern.

Because of the Governor's interest and efforts by the State Health Commissioner, the 2011 General Assembly appropriated funds to VDH to promote the Plan First, the state Medicaid family planning waiver in local health departments and the private sector. A full-time Plan First Coordinator position was established and hired.

The Every Woman's Life (EWL) program provided breast and cervical screening and follow-up services to 8,193 low-income, uninsured/underinsured Virginia women between ages 18-64. Services included screening mammograms, clinical breast exams, Pap tests, pelvic exams, follow-up procedures to reach a final diagnosis and case management services to ensure women received the recommended screening tests and procedures in a timely manner. In FY11, 158 cases of breast cancer, 52 cases of cervical dysplasia and 10 cases of invasive cervical cancer were diagnosed. Women diagnosed with breast and/or cervical cancer/pre-cancer by an authorized EWL provider are eligible for medical assistance under the Breast and Cervical Cancer Prevention and Treatment Act. In 2011, 249 women that were diagnosed were referred to Medicaid for treatment. EWL focuses on disparate populations including never/rarely screened women, women over age 50, minority women and women with an annual income less than 100% of the Federal Poverty Level.

WISEWOMAN program services, offered at 10 of 30 EWL provider sites, include additional blood pressure, cholesterol, glucose, and BMI (body mass index) screenings for EWL participants between ages 40-64. Participants receive risk reduction counseling where screening results are explained, clinical referrals made for abnormal or alert values, as well as heart disease and stroke risk, lifestyle behaviors (physical activity, nutrition, smoking) and readiness to change assessed. They are given stage-based materials, referrals to community/clinic programs, appointments for followup telephone counseling, and an annual rescreen. In FY11, WISEWOMAN served 1,220.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. By providing vaccines to the public and responding to outbreaks as appropriate, citizens will maintain or achieve protection from diseases.				X
2. By implementing the Pregnancy and Parenting Information Connection and the Pregnancy Support Fund grant, women will be referred to local, regional and/or state resources to assist citizens improve health status.		X		
3. In supporting the Healthy Baby Begins With You program, college age women will be educated about preconception health and life course wellness.		X	X	
4. The "Virginia is for Families" toolkit for employers will be implemented allowing employees will have information concerning the services of VDH and increase access to care.		X		X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Health districts promote women's health and wellness through maternity, family planning, flu vaccination, and general medical clinics. Responding to the Japan tragedy, VDH informed healthcare providers and citizens about radiologic safety and is monitoring the radiological situation. VDH provides tobacco cessation and obesity prevention services for women, including support for worksite lactation programs.

Through a public and private provider network, VDH provides over 7000 women with breast and cervical screening and referral. WISEWOMAN also provides these women with knowledge, skills, and opportunities to improve diet, physical activity, and lifestyle behaviors to prevent and control cardiovascular and other chronic diseases.

Activities related to the PAF grant continue. Strategies include evidence informed peer counselor programs, operation of offices of pregnant and parenting student services at targeted institutions of higher education, and development and implementation of a statewide public awareness campaign using social marketing tools and traditional media to inform the public and link parenting and pregnant students to needed services.

The Plan First coordinator is comprehensively working to educate and promote use of Plan First. Issues facing local health departments in increasing Plan First use are being assessed through focus groups and will guide future marketing plans. VDH is providing outreach to increase participation through state agencies and groups.

c. Plan for the Coming Year

The "Virginia is For Families" initiative will be implemented. This program encourage Virginia businesses to support health and wellness in their employees, with a particular emphasis on those that support family health (breastfeeding/adult immunization) and strengthen communication between public health and the business community. Recognition of business participation is planned.

The Pregnancy and Parenting Information Connection has been withdrawn for Year 3. Monitoring calls and internet site hits will continue along with the number of services and linkages added to

the 211 VIRGINIA system.

"Healthy Baby Begins with You" will be evaluated for integration into programs within institutions of higher learning, curriculum clarity and student interest. Changes will be made to learning exercises and preconception health messages regarding chronic disease as appropriate. Messages regarding folic acid consumption, smoking cessation, drug and alcohol use, and healthy diet will remain mandatory. Education will continue on early parenting decisions such as safe sleep environment, lactation as the primary feeding method, and immunizations.

The Maternal, Infant and Early Childhood Home Visiting Program will continue work to increase efficiency and effectiveness of early childhood home visiting interventions. Evidence-based models and operations in the existing early childhood program structure will be monitored. Home visiting programs will better match service intensity, frequency, duration, and visitor type to each family's particular needs.

The PAF grant strategies will be monitored and adapted to meet the needs of students, institutions of higher learning, and VDH. The statewide public awareness campaign will continue.

VDH will continue to promote, enroll and increase utilization of Plan First with DSS and DMAS. VDH will conduct a media campaign in three media markets with a high prevalence of low birth weight and non-marital births. The coordinator will provide outreach to potential providers and referral sources. VDH health districts will educate clients about Plan First and work closely with local DSS offices to improve application accuracy.

VDH will continue to provide breast and cervical screening services to low-income, uninsured/underinsured women between ages 18-64. New efforts will focus on implementing evidence-based strategies to raise awareness on routine screening and health systems change strategies (client reminder systems) to ensure appropriate and timely screenings and follow-up are received. WISEWOMAN will expand services to provide 1,375 screened women with the knowledge, skills, and opportunities to improve diet, physical activity and other behaviors to prevent and control cardiovascular and other chronic diseases.

Quitline services will continue with expanded enrollment via a web-based program. Obesity prevention programs targeting women of childbearing ages will continue, expanding in healthy community sites across Virginia.

State Performance Measure 3: *Percent of 9th-12th graders who have ever been bullied on school property during the past 12 months.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					15
Annual Indicator			22.0	22.0	22.0
Numerator			163	163	315
Denominator			741	741	1435
Data Source			Virginia Youth Survey	Virginia Youth Survey	Virginia Youth Survey
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	22	20	20	18	18

Notes - 2011

Data from the 2011 Virginia Youth Survey.

Notes - 2010

Data from the 2009 Virginia Youth Survey.

Question: During the past 12 months, have you ever been bullied on school property?

Survey response rate did not allow for weighted data.

Notes - 2009

Data from the 2009 Virginia Youth Survey.

Question: During the past 12 months, have you ever been bullied on school property?

a. Last Year's Accomplishments

The Division of Prevention & Health Promotion (DPHP) analyzed data from a statewide school bullying prevention project that the agency had implemented from 2006-2010 in over 90 schools. Among other results, the analysis demonstrated decreases in reported perpetration bullying in 78% of the middle schools and 64% of elementary schools; decreases in the reported experience of being bullied in 78% of the middle schools and 48% of the elementary schools; and increases in reported teacher intervention in 67% of the middle schools and 48% of the elementary schools. DPHP staff presented this data to CDC Violence Prevention program staff in Atlanta in August 2010 and at the Joint Annual Meeting of Safe States Alliance, SAVIR in Iowa in April 2011. Throughout the year, DPHP provided ongoing consultation and presentations on bullying prevention and intervention strategies and resources to parents, community groups, and school personnel. DPHP hired a full time bullying prevention coordinator to advance a statewide bullying prevention initiative. Resources were purchased to support 60 schools in implementing the evidence-based Olweus bullying prevention program.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote and provide training and resources to expand implementation of evidence based Olweus bullying prevention programs by schools and community groups.			X	X
2. Provide information and education on the public health impact of bullying and prevention and intervention strategies and resources.		X		X
3. Review and make recommendations regarding proposed policies related to bullying prevention.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Through a competitive application process, twenty schools and two school districts throughout Virginia were selected to receive support to implement and evaluate the Olweus bullying prevention program. This included all necessary materials and program resources, training of the

schools' Coordinating Committee and monthly consultations for 18 months by an Olweus Certified Trainer, technical assistance, site visits, and multiple opportunities to attend statewide networking and regional conferences. During 2012, DPHP will also support a state-wide conference on bullying prevention and positive school climate with expected attendance by over 500 school leaders and support professionals. DPHP plans to provide funding to 5 community organizations through a competitive application process to plan and implement a youth-led event that addresses positive youth development and youth violence prevention in their respective communities. Additional research and evidence-based training, technical assistance and public awareness activities and resources have also been provided to various organizations, schools, and community groups throughout Virginia. Current resources, information, and research have been distributed regularly through speaking events, website updates, and email list serve distribution.

c. Plan for the Coming Year

DPHP will continue to provide training and other support to elementary and middle schools in the Commonwealth that were selected to implement the evidence based Olweus bullying prevention program. DPHP will also continue to provide presentations on the public health impact of bullying as well as ongoing consultation to youth service providers, parents, and caregivers on strategies and resources for preventing and addressing bullying at home, at school, and in the community. DPHP plans to expand resource and training support for bullying prevention to focus on strengths-based approaches and incorporating other related topics such as dating violence prevention and suicide prevention. Activities would support schools and community groups to implement one of several different evidence-based, effective youth violence prevention program and curricula that match their resources and needs, supporting community organizations to implement youth-led events that address positive youth development, and hosting a series of regional information exchanges on strengths-based youth violence prevention followed by a statewide conference on the topic to include lessons learned from the regional information exchanges

State Performance Measure 4: *The rate of childhood unintentional injury hospitalizations per 100,000 children ages 0-19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					129
Annual Indicator		146.9	146.4	126.0	
Numerator		3005	3046	2625	
Denominator		2046241	2080026	2083685	
Data Source		VA Hospital Discharge Data	VA Hospital Discharge Data	VA Hospital Discharge Data	
Is the Data Provisional or Final?				Final	
	2012	2013	2014	2015	2016
Annual Performance Objective	122.5	122.5	120	120	120

Notes - 2011

Data for 2011 hospital discharges not yet available.

Notes - 2010

Data from 2010 hospital discharges

Notes - 2009

Data from Virginia Hospitalization Discharges, 2009.

a. Last Year's Accomplishments

The Division of Prevention and Health Promotion (DPHP) continued its coordination of an unintentional injury prevention program which focuses on the leading causes of injury morbidity and mortality among children and women of child-bearing age. DPHP fulfilled requests for almost half a million individual pieces of educational material (brochures, videos on a variety of childhood injury topics) through the Injury Prevention Resource Center. DPHP staff published an annual report on injury deaths and hospitalizations in Virginia and Virginia Injury Update Newsletters that featured data, prevention strategies, and resources on falls, abusive head trauma in children (Shaken Baby Syndrome), and distracted driving. DPHP updated 2009 injury hospitalization and death data into the Virginia Online Injury Reporting System (VOIRS) with allows the user to create customized injury data reports on various causes and intents of injury by geographic and demographic variables.

DPHP coordinated a statewide injury prevention network to promote the sharing of resources and information to a variety of professionals throughout Virginia through an email digest, workshops, and quarterly network meetings. DPHP coordinated a two day Injury Prevention Symposium in July for approximately 130 professionals statewide. The Symposium provided informational sessions on traumatic brain injury, poisoning, teen driving, water safety and safe sleep as well as professional development workshops. DPHP also coordinated five regional concussion workshops for approximately 380 professionals. The clinics highlighted Chris Nowinski from the Sports Legacy Institute who presented on sports concussions, current traumatic brain injury research and prevention strategies. Other information addressed included the importance of cognitive rest, the role of schools, best practices for medical professionals and best practices being implemented across the state.

Effective July 1, 2010, a new Virginia law requires student athletes suspected of sustaining an injury to be removed from play, properly diagnosed, and given adequate time to heal. To support schools with compliance to the new law, DPHP coordinated a targeted mailing to Virginia middle and high schools and sport recreation leagues to promote the CDC Heads Up series of traumatic brain injury (TBI) resources and to offer training and consultation. DPHP conducted a needs assessment among Virginia health care providers (emergency room physicians, pediatricians and family practice physicians) to determine current concussion evaluation and management techniques. This survey indicated that 86% of respondents incorrectly identified appropriate concussion management methods and 44% incorrectly identified the type of brain changes caused by a concussion. In addition, 39% of respondents reported not being comfortable clearing a player with a suspected concussion for return to play. Survey results are being used to inform current and FY 2013 TBI prevention activities.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinate state, community and school based activities relating to the prevention of unintentional injuries.			X	
2. Provide funding and support for health districts' unintentional injury projects.		X		
3. Develop and implement public awareness campaigns.			X	
4. Disseminate safety devices (e.g. child restraints, smoke alarms).	X			
5. Analyze data, and reviewed and make recommendations regarding proposed legislation or policies addressing				X

unintentional injury issues.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DPHP continued to host injury prevention content on its website, provide information on funding opportunities, new resources, and upcoming events through e-mail distribution lists, and coordinate three quarterly information sharing meetings for injury stakeholder groups. In June, DPHP will also host a prevention symposium with expected attendance by 200 injury professionals and advocates. DPHP is currently developing a state plan which will include an assessment of gaps in programming and capabilities among professionals and organizations working in injury prevention across the state. DPHP has also published advertisements promoting childhood injury prevention in six family magazines distributed across the state and aired radio PSAs for concussion prevention during March in support of Brain Injury Awareness Month. DPHP is working with Virginia's Home Visiting Consortium to incorporate a module on abusive head trauma (Shaken Baby Syndrome) within the training requirements for early childhood home visiting services. In recognition of Playground Safety Week, DPHP has partnered with the Department of Education to mail playground safety materials and resources to public and private elementary schools. Schools will be encouraged to assess the safety of their school playground and develop an improvement plan. This information will be used to select schools to receive funding during 2013 to improve playground signage and surfacing.

c. Plan for the Coming Year

DPHP will continue to coordinate statewide projects related to the prevention of high-priority childhood injury areas, to work with interagency and statewide committees on childhood injury prevention policy development, and to disseminate educational information and resources through its website, 1-800 number, e-mail distribution list servs, and workshops for injury prevention professionals.

DPHP also plans to expand its work in sports-related concussion prevention by coordinating three concussion awareness workshops targeting recreation league administrators, coaches, parents and athletes and developing targeted online concussion prevention training for parents, athletes, and coaches; school personnel; and medical providers. The online trainings will be professionally produced and narrated and feature evidence-based prevention, intervention, and treatment information tailored to each target audience. In addition, medical providers will be able to receive CMEs for completing the concussion prevention education.

DPHP will also partner with the Department of Education to develop a playground safety assessment video for schools. Schools completing the assessment and developing an improvement plan will be eligible to apply for playground improvement funding which is expected to be distributed to at least 10 schools across Virginia to improve surfacing material and signage. DPHP will also partner with local health departments to address the mutual risk factors for suffocation, Sudden Infant Death Syndrome, and abusive head trauma (Shaken Baby Syndrome). Resources will be targeted to new parents receiving services at local health departments in the Southern/Southwestern portion of Virginia where mortality rates for these conditions are particularly high.

State Performance Measure 5: *Percent of low income children (ages 0-5) with dental caries.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	12.4	12.3	12.2	12.1	12
Annual Indicator	21.3	21.1	17.8	19.4	18.4
Numerator	2761	2715	2327	2498	2094
Denominator	12938	12887	13091	12890	11407
Data Source		Head Start Data	Head Start Data	Head Start Data	Head Start Data
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	18	18	17.8	17.8	17.5

Notes - 2011

FY11 Head Start Data; State FY 7/1/10-6/30/11

Notes - 2010

FY10 Head Start Data; State FY 7/1/09-6/30/10

Notes - 2009

FY09 Head Start Data; State FY 7/1/08-6/30/09

a. Last Year's Accomplishments

The Dental Health Program (DHP) provided local health department dentists with assistance in recruiting and orienting new staff, collecting patient data, and workforce development. Additionally, Dental Health Program staff conducted quality assurance reviews for local health department dental clinics. Local health departments provided 34,949 dental visits for individuals and 135,621 clinical services valued at more than \$11.6 million during FY 2011. Approximately 65% of all dental visits were for school-aged children and 8,794 dental sealants were placed. More than 5,230 fluoride varnish applications and 3,910 dental visits were provided for children ages 0-4 years.

Bright Smiles for Babies (BSB), the fluoride varnish program for preschool children, grew in FY 2011 with funding from multiple grant sources including Title V, the Targeted Oral Health Service Systems Grant, Preventive Health and Health Services Block Grant, and the Oral Health Workforce Activities Grant. In FY 2011, screening, assessment, and fluoride varnish applications were provided for 9,002 children in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) programs and 760 children in Early Head Start (EHS) Programs. Individual risk-based information was also provided to 9,756 parents of WIC-enrolled children regarding daily oral hygiene, nutrition, feeding practices, fluoride, and the importance of primary teeth. A total of 5,021 children were referred to a dental home. New program sites included Central Virginia, Pittsylvania-Danville, and Rappahannock-Rapidan Health Districts.

Follow up data for the BSB program continued during FY 2011, with progress made in data entry and cleanup. Baseline data from child screenings and parent questionnaires collected in FY 2008-09 will be compared to new data to determine the overall program success. This phase of data collection will continue through FY 2012 and has approval from the VDH Institutional Review Board.

Staff continued to train early child, medical, and dental providers in public and private settings. Four trainings were held for Head Start/Early Head Start and Department of Social Services day care workers. Five private medical offices and one health district were trained to provide fluoride varnish via staff nurses. Between February and September 2011, five continuing education trainings were provided to 100 dentists, hygienists and auxiliary staff regarding the dental care of

children with special health care needs (CSHCN) and very young children. The hands-on portion of the training allowed providers to treat 109 CSHCN as part of the continuing education course. With the cooperation of Prevent Child Abuse Virginia, the dental home visiting program that provided training for home visiting staff in Lenowisco, Cumberland Plateau, and Southside Health Districts was expanded to include Rappahannock-Rapidan, Central Virginia, Pittsylvania-Danville, Central Shenandoah, and Lord Fairfax Health Districts. The dental home visiting training was provided to 41 dental home visitors, 9 general home visitors and 25 VDH dental staff. This training included an overview of oral health and age appropriate key messages for high-risk child populations, including CSHCN. Dental home visitors have provided oral health education to 740 clients. Partnerships with the Bristol Care Connection for Children allowed hygienists to provide oral screenings and/or fluoride varnish to 208 CSHCN, anticipatory guidance for 392 parents of CSHCN, and 45 dental referrals during pediatric specialty clinics. Staff also assisted with the 2011 Connections Resource Fair for families and professionals working with CSHCN and provided oral screenings and fluoride varnish for 71 CSHCN during the event.

VDH continues to work with the Department of Medical Assistance Services (DMAS) regarding fluoride varnish reimbursement issues and serves on the statewide Head Start and DMAS Advisory Committees.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide anticipatory guidance for parents.		X		
2. Provide fluoride varnish application for children.	X			
3. Maintain data collection efforts for evaluation of dental programs.				X
4. Provide training for dental providers.		X		
5. Collaborate with Medicaid regarding covered services.		X		X
6. Collaborate with partners (e.g., WIC, Early Head Start, Head Start) to provide anticipatory guidance and other oral health services.		X		
7. Oral health services are provided to children 0-5 in local health department dental clinics and Early Head Start Centers.	X			
8. Review and make recommendations regarding proposed legislation or policies addressing access to dental care.				X
9.				
10.				

b. Current Activities

In FY 2012, local health dental clinics provided 2,039 visits and 3,226 fluoride varnish applications for children less than four years of age. The BSB program provided assessments and fluoride varnish to 3,226 children in WIC and EHS programs. The program was implemented in two new health districts, Pittsylvania-Danville and Central Shenandoah. Follow-up data collection of participants is continuing in three districts using the Basic Screening Survey and parent questionnaires; and baseline surveys are ongoing in 8 districts. Two new education cards were developed regarding brushing and flossing. Billing Medicaid for fluoride varnish application continues to reach sustainability. Trainings have been provided for 77 providers including private physician offices, dental hygienists, dental hygiene students, and VDH public health nurses.

Through partnering with Care Connection for Children pediatric specialty clinics in three counties, VDH provided oral screenings and varnish for 22 CSHCN, dental referrals for 31 CSHCN and oral

health education for 78 parents. Staff provided oral screenings and fluoride varnish for CSHCN while participating in the Connections 2012 Resource Fair.

The dental home visiting program is continuing in all 8 districts until the grant ends. Dental home visitors have provided 687 oral health education visits. Oral health training has been provided to 82 persons including 52 in health districts not involved in the dental home visiting program.

c. Plan for the Coming Year

VDH will work to increase the current level of services provided through the BSB program to WIC and EHS children through all potential funding sources and program models. Of Virginia's 35 health districts, all but three districts have implemented the BSB program utilizing one or more models. We will continue to promote the value of the program and support efforts to improve implementation and sustainability. Through renewed partnerships with the Virginia Chapter of the American Academy of Pediatrics and the Virginia Healthcare Association, we will increase participation in the private and non-profit sectors. In FY13, VDH will analyze and report the data from the four-year evaluation of the BSB program. VDH will continue to collaborate with other providers of services to young children such as Head Start and EHS through serving on the state advisory committee and working with local programs. A DVD is being developed to provide education and anticipatory guidance for parents to be used in WIC waiting rooms in all areas of the state.

Dental home visiting programs will continue utilizing VDH dental assistants as the dental home visitors for children with extensive dental needs. VDH will provide ongoing consultation and training, as needed. Oral health training for home visitors, family support workers and health educators will continue throughout the state to ensure that information is disseminated to families served by the home visiting programs.

Through collaboration with the Virginia Dental Association Foundation (VDAF), plans are underway to expand the continuing education courses for dental professionals across the state. The goal is to provide three courses each year for the next two years to 90 dental providers.

The DHP will continue to partner and collaborate with Care Connection for Children, Child Development Clinics, hospitals, the Virginia Department of Education, and CSHCN parent/professional organizations to disseminate oral health education, increase application of fluoride varnish for these high risk children, and increase dental visits by age one. VDH will continue collaboration with Virginia Commonwealth University (VCU) School of Dentistry to increase opportunities for students and residents to work with CSHCN during their dental training. VCU has also agreed to include pediatric dental residents as assistant clinical instructors for the continuing education courses for dentists and hygienists planned with VDAF for the next two years.

State Performance Measure 6: *Percent of low income third grade children with dental caries.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					20
Annual Indicator			25.3	15.4	
Numerator			6649	1207	
Denominator			26315	7837	

Data Source			Virginia Free Lunch Program	Virginia Free Lunch Program	
Is the Data Provisional or Final?				Final	
	2012	2013	2014	2015	2016
Annual Performance Objective	15	15	14.5	14.5	14

Notes - 2011

Data for 2011 not yet available.

Notes - 2010

Data for 2010 from the VA Free and Reduced Lunch Program

Notes - 2009

Untreated tooth decay among children enrolled in the Free Lunch Program. Virginia Free Lunch Program data, 2009.

a. Last Year's Accomplishments

Local dental programs were assisted with recruitments, orientations, and technical assistance. Quality assurance visits were made to four local health department dental programs. Local health department dental clinics continued to provide services to clients, the majority of whom were children from five to thirteen years old.

More than six million citizens of all ages consumed water that has been optimally fluoridated, reducing dental decay up to 40%. The VDH dental program worked in conjunction with the VDH Office of Drinking Water, to monitor 144 systems for compliance with standards for water fluoridation levels from the Centers for Disease Control and Prevention (CDC). In FY 2011, the Community Water Fluoridation Program provided grant funding for communities to start or upgrade fluoridation equipment to maintain optimal fluoridation in 20 communities impacting nearly 155,000 citizens. This program has become increasingly important in the difficult economic times, particularly for small rural systems with limited budgets and aging water fluoridation equipment.

Education programs regarding oral hygiene, nutrition, and fluorides were conducted in FY11 for 8,039 school-aged children and 1,234 teachers and school nurses. Programs implemented in FY10 to improve the oral health of children with special health care needs (CSHCN) of all ages, including training for health professionals, lay health workers, and family members were continued in FY 2011.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Eight health districts utilize funding to provide comprehensive dental services for children and comprehensive oral health services are provided to children through local health department dental clinics.	X			
2. Provide education regarding oral health topics to school-aged children.			X	
3. Collect and analyze data on 3rd grade children regarding disease status.			X	
4. Provide access to population-based prevention programs (community water fluoridation and school fluoride rinse) for school-aged children, including CSHCN.			X	

5. Collaborate with partners (e.g., Department of Education) to provide oral health services.	X			
6. Provide training to school staff including nurses and teachers regarding oral health.			X	
7.				
8.				
9.				
10.				

b. Current Activities

Local dental programs were assisted with recruitments, orientations, and technical assistance. Quality assurance visits were made to programs in Chesterfield, Rappahannock-Rapidan, Norfolk, Mount Rogers and the hygiene program in Cumberland Plateau. As of December 2011, 17,184 patient visits had been made to local dental clinics; more than 70% of the visits were for children from five to thirteen years old. In this period, nearly 68,000 diagnostic, preventive, and treatment services were provided to this population at a value in excess of \$5.5 million.

In conjunction with the VDH Office of Drinking Water, the Dental Health Program monitored 143 water systems with more than six million people for compliance of CDC fluoridation standards. During FY12, the Community Water Fluoridation Program provided grant funding for 12 communities to purchase or upgrade fluoridation equipment to maintain optimal fluoridation impacting more than 131,100 people. In areas without access to community water fluoridation, the school topical fluoride rinse program was resumed with federal funding in seven districts targeted by the Oral Health Workforce Activities Grant. To date, more than 9,000 elementary school children are participating in the weekly rinse program. VDH has provided 4,795 school children and nearly 340 teachers and school nurses with education and training regarding oral health in FY 2012.

c. Plan for the Coming Year

The Dental Health Program will continue to focus on population-based activities including oral health education, fluoride rinse, and community water fluoridation to reduce the disease burden of tooth decay.

As follow up to the 2009 Public School Needs Assessment, an open-mouth Basic Screening Survey of third grade children is planned for 2012. Statistically sampled "sentinel" schools representing approximately 800 potential student participants from across the State will be screened to monitor oral health trends and progress toward VDH prevention goals. Processes and forms for this survey are currently under Institutional Review Board review. Data from this assessment will be analyzed and used in the development of a comprehensive oral health plan including objectives for reducing childhood decay. Oral health education programs will continue to operate in conjunction with other VDH programs to facilitate a coordinated school health program.

A Centers for Disease Control and Prevention "State Based Oral Disease Prevention Program" grant awarded in FY 2012 to establish, strengthen, and enhance the infrastructure and capacity of states to plan, implement, and evaluate population based oral disease prevention and promotion programs will continue to be implemented. These resources will be used synergistically with existing programs to maximize the targeted efforts aimed at reducing childhood decay.

State Performance Measure 7: Percent of women with a live birth who went to a dentist during pregnancy.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					50
Annual Indicator		39.9	40.0	48.8	
Numerator		40784	40109	47965	
Denominator		102342	100226	98389	
Data Source		PRAMS	VA PRAMS	VA PRAMS	
Is the Data Provisional or Final?				Final	
	2012	2013	2014	2015	2016
Annual Performance Objective	50	51	51	52	52

Notes - 2011

Weighted 2010 VA PRAMS data not yet available.

Notes - 2010

Weighted 2009 VA PRAMS Data

Notes - 2009

From 2008 Virginia Pregnancy Risk Assessment Monitoring System.

a. Last Year's Accomplishments

VDH education efforts that targeted pregnant women were two-fold. Dental Health Program staffs provided direct education services utilizing dental hygienists in the Bright Smiles for Babies Program (BSB) in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) clinics in local health departments. Additionally, oral health information was provided to other state partners who provide direct care and education to expecting mothers. In addition to the services for WIC-enrolled children, the BSB program also provided direct oral health education, oral health educational materials, a toothbrush, toothpaste, and dental referrals for pregnant women enrolled in WIC. In FY 2011, 9,756 caregivers, including 496 pregnant women, were provided with individual education sessions from a dental hygienist during the program.

Multiple oral health trainings were provided to 312 early child state partners, including Head Start, Early Head Start, and CHIP of Virginia staff. The Dental Health Program also provided extensive input and content for WIC's Health Bites modules related to pregnant women and early child oral health issues. Health Bites is an interactive online education tool for WIC participants. Oral health information for pregnant women was also provided to 41 dental home visitors, 9 general home visitors, and 25 VDH dental staff to enable the home visitors to provided one-on-one information to 85 high-risk pregnant women.

In FY 2010, the Dental Health Program partnered with the Women's and Infant's Health Program to implement a pilot project to educate women of childbearing age regarding oral health and the impact on overall health, pregnancy outcomes, and their children's oral health. This project continued in FY 2011 with the distribution of the educational card, "Fluoride, Flossing and Folic Acid", that contains information on dental health and folic acid and a sample of dental floss. The card was given to women attending WIC clinics, and to attendees of targeted oral health exhibits and trainings.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service
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	DHC	ES	PBS	IB
1. Provide education to WIC-enrolled pregnant and inter-conception women.		X		
2. Provide maternal oral health education to Healthy Start staff.		X		X
3. Provide maternal oral health education to Head Start staff.		X		X
4. Provide maternal oral health information to obstetrical and neonatal nurses.		X		X
5. Train home visitors to provide oral health education to pregnant women served by home visiting programs.		X		X
6. Provide technical assistance regarding oral health information to state partners developing useful resources.		X		X
7.				
8.				
9.				
10.				

b. Current Activities

Currently, VDH efforts to educate women regarding oral health are concentrated in WIC clinics through the BSB program, where 1,294 caregivers, including 297 pregnant women, have received oral health education this grant year. Multiple oral health trainings were held for 312 Head Start, Early Head Start, and CHIP of Virginia staff, covering maternal and early child oral health topics. Oral health information for pregnant women was also provided to 8 dental home visitors, 66 general home visitors, and 8 VDH dental staff to enable the home visitors to provide one-on-one information to 72 high-risk pregnant women. For the first time, the Dental Health Program will be collaborating with the VDH Reproductive Health Program on the "2-1-1 Virginia" initiative. This online tool will provide oral health information and resources for call center representatives responding to client requests for community resources.

VDH hygienists continue to offer the "Fluoride, Flossing and Folic Acid" educational card along with additional oral health information to women of childbearing age, including pregnant women. Support for WIC Health Bites message contents continue in FY 2012. Although Virginia WIC's Health Bites online modules are new, existing data indicates the potential of reaching 200 -- 300 clients per month.

c. Plan for the Coming Year

VDH will continue to maintain and expand direct and indirect education services. In addition to providing education to pregnant women through WIC clinics, Program staff will explore the expansion of the Bright Smiles for Babies Program to add oral screenings for pregnant women in targeted locations where feasible based on the availability of the hygienist. A brief survey regarding oral health knowledge and behaviors and specifically addressing dental visits during pregnancy will also be considered.

VDH will identify new partners that offer services for pregnant and inter-conception women in public and private programs. In addition, the DHP will collaborate with the Virginia Oral Health Coalition to participate in the 'Medical and Dental Collaboration Initiative', which is currently in the initial planning stages and has the potential to create new and valuable partnerships.

State Performance Measure 8: *Percent of children eligible for WIC that are enrolled in WIC, ages 0 to 5.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					80
Annual Indicator		70.3	69.3	75.8	74.6
Numerator		114233	115089	128661	126441
Denominator		162482	166189	169638	169394
Data Source		WIC Program	WIC Program	WIC Program Data	WIC Program Data
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	75	75	77.5	77.5	80

Notes - 2011

Data from the WIC "Annual Potential Eligible" projections report, 2011.

Notes - 2010

Data from the WIC "Annual Potential Eligible" projections report, 2010.

Notes - 2009

Data from the WIC "Annual Potential Eligible" projections report, 2009.

a. Last Year's Accomplishments

In FY 2011, the Virginia WIC Program served a monthly average of 156,085 participants statewide, an average of 78,887 per month were children. Thirty five local health districts provided direct services to WIC participants, and the Division of Community Nutrition (DCN) continued to work with other state partners to strengthen the program. These partners include the State WIC Advisory Committee, the Virginia Chapter of the American Academy of Pediatrics, the Virginia Breastfeeding Advisory Committee, the Commissioner's Workgroup on Obesity Prevention and Control, the Commissioner's Infant Mortality Workgroup, the Virginia Department of Medical Assistance Services, Virginia Cooperative Extension, and the United States Department of Agriculture.

Two research projects intended to reach populations of children not currently participating in the Virginia WIC Program targeted foster families and grandparents raising grandchildren. These projects began in FY 2010 and will inform WIC administrators on the most effective methods to access these populations and increase WIC participation rates. This will be done by methods such as statewide surveys and focus groups yielding qualitative and quantitative data to guide outreach efforts. Grandparent-Headed Families and Virginia WIC: An Examination of Service Awareness, Utilization, and Delivery began on August 1, 2010, and will conclude in 2012. The research initiative targeting foster families to ensure that all age-eligible foster children are enrolled in WIC was initiated in FY 2010, and ran from October 1, 2010-June 30, 2011.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide WIC services to children ages 1-5 enrolled in the program through local health departments.	X			
2. Review and make recommendations regarding proposed				X

legislation or policies affecting the Virginia WIC Program.				
3. Collaborate with partners to expand program access and promote program availability.		X		
4. Perform outreach to inform potentially eligible participations about the Virginia WIC Program.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DCN conducted a media and outreach campaign in FY 2011 designed to increase enrollment of eligible women and children in the Virginia WIC program. This multi-stage, multi-media campaign included the facilitation of focus groups, creation of outreach materials, bus boards, production of radio and television spots, and purchase of media airtime. An online outreach component was included to maximize the exposure of spots created for television, also being displayed on various websites and social networking sites. Through direct outreach efforts using media outlets, the Virginia WIC Program engaged a wider audience and reached more potentially eligible participants. Television, radio and internet spots ran from April through September 2011 with a goal of increasing WIC participation by three percent. In addition, DCN partnered with James Madison University to create and launch an on-line nutrition education program, HealthBites in November 2011. HealthBites is designed to increase the nutrition knowledge of WIC participants and the general public. Approximately 1,000 individuals have completed the entire HealthBites pathway.

Participation rates of children may also be affected by the Healthy, Hunger-Free Kids Act of 2010, which provides state agencies the option of certifying participant children for up to one year instead of six months. DCN is analyzing the impact this change in certification may have on rates and may modify current certification timeline.

c. Plan for the Coming Year

DCN is collaborating with the Child and Adult Care Food Program (CACFP) to increase WIC participation among children enrolled in Head Start. By working with Head Start programs participating in CACFP, WIC will have the opportunity to reach eligible children and families who may not currently be enrolled in the program. Through program outreach, education and potentially service integration, the enrollment rates for children in the Virginia WIC Program could increase. DCN houses both the WIC and CACFP which will facilitate communication and coordination between both programs.

A partnership with the Virginia Community Healthcare Association (VCHA) that began in FY 2011 is also anticipated to continue through FY 2013. The VCHA is the state association for Federally Qualified Health Centers (FQHCs); these health centers are located in medically underserved areas. By offering WIC clinical services within FQHCs, it is anticipated that the number of WIC participants, including children, will increase. Efforts to begin incorporating WIC clinical services into the health centers will be contingent upon availability of federal funding. The process would begin with DCN conducting a feasibility study, the results of which would guide the integration of services.

DCN will also plan to provide outreach support to local agencies by generating relationships with private and government agencies that provide services to potentially eligible WIC participants.

DCN plans to transition the Virginia WIC Program from the disbursement of paper food benefits to

electronic benefits. These benefits will be aggregated at the family level to integrate the mother-baby dyad for infant feeding and allows for tailoring of the food packages.

State Performance Measure 9: *Percent of eligible children in daycares that participate in the Child and Adult Care Food Program (CACFP).*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					25
Annual Indicator				16.5	25.7
Numerator				59196	69887
Denominator				358008	271422
Data Source				CACFP, VA Dept of Social Services	CACFP, VA Dept of Social Services
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	27.5	27.5	27.5	30	30

Notes - 2011

Numerator is the number of children ages 0-12 years in daycares that participated in the Child and Adult Care Food Program during 2011.

Denominator is the total licensed capacity for child daycare in Virginia during 2011. Data provided by the Virginia Department of Social Services.

Notes - 2010

Numerator is the number of children ages 0-12 years in daycares that participated in the Child and Adult Care Food Program during 2010.

Denominator is the total licensed capacity for child daycare in Virginia during 2010. Data provided by the Virginia Department of Social Services.

a. Last Year's Accomplishments

On October 1, 2010, the Virginia Department of Health became the program administrator for the Child and Adult Care Food Program (CACFP). This program was transitioned from the United States Department of Agriculture Mid Atlantic Regional Office to the Division of Community Nutrition (DCN) within VDH. CACFP provides year-round federal funding to eligible child care, family day care, Head Start, at-risk after school care, emergency shelter, and adult care centers to provide nutritious meals and snacks to lower income participants in these care programs.

Enrollment in the CACFP increased in 2011 with an average daily participation rate of 63,540. This compares to 59,196 for FY 2010 (7.33%). Applications were reviewed and approved for 13 Family Day Care Sponsors for 2569 Family Day Care Homes. Applications were approved for 395 Child Care Sponsors for 3895 sites. During the fiscal year DCN conducted reviews on 104 Day Care Sponsors and 74 day care sites and 7 Family Day Home Sponsors and 69 homes to ensure compliance with federal and state policies and regulations.

A significant challenge for FY 2011 was the President's signing of the Healthy and Hungry Free Kids Act in January, 2011. This allowed At Risk Centers to be reimbursed for meals, retroactive to October, 2010. DCN was able to accommodate these requests.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide meal and operational reimbursements and administrative oversight to daycares participating in CACFP.	X			
2. Review and make recommendations regarding proposed legislation or policies affecting the Virginia CACFP.				X
3. Collaborate with partners (DSS, Office of Early Childhood Development) to offer nutrition and physical activity guidance and technical assistance to participating CACFP daycare centers.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

As the CACFP program administrator, VDH and DCN are responsible for providing monitoring, training, and technical assistance to CACFP providers as well as policy development and implementation. Technical assistance is provided by the Special Nutrition Programs (SNP) team in DCN through telephone and written correspondence and on-site visits. Currently DCN has 13 Family Day Care Sponsors with 2,533 sites and 398 CACFP Sponsors with 3,940 sites. Approximately 130 reviews are scheduled for FY 2012. DCN will be developing and hosting training and reviews for newly approved institutions. In addition, there will be annual training developed for institutions currently participating in the program.

The Healthy, Hunger Free Kids Act of 2010 necessitated numerous policy and procedure changes which DCN has implemented and will continue to implement into FY 2012. Among those changes is the provision that at risk after school programs participating in the CACFP are now allowed to offer an additional meal to children.

DCN has also begun to establish relationships with many state partners including Virginia Department of Education, Virginia Department of Social Services, Office of Early Childhood Development, Virginia Department of Health's Obesity Prevention Team, Virginia Family Day Care Sponsor's Association, Virginia Head Start Association, Virginia Head Start Collaboration Office, Virginia Foundation for Healthy Youth, and Virginia School Nutrition Association.

c. Plan for the Coming Year

DCN will continue to administer the CACFP and strengthen relationships with internal and external partners. In an effort to strengthen the quality of child day care centers and homes participating in the program, DCN plans to work on developing nutrition and physical activity guidance for providers. This will be done in conjunction with state partners including the VDH Obesity Prevention Team, the Virginia Department of Social Services, and the Office of Early Childhood Development. DCN also has a goal of developing online training modules for

participating CACFP institutions to make training more accessible.

The development of a new online claim processing system for CACFP and the Summer Food Service Program will occur in FY 2013 simultaneously, as the two programs will share the system. A new claims processing system will increase program efficiencies both at the state and provider levels.

State Performance Measure 10: *Percent of eligible children participating in the Summer Food Service Program (SFSP).*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					15
Annual Indicator		12.2	11.4	10.8	11.8
Numerator		50870	51798	50767	57905
Denominator		418343	454310	469472	491946
Data Source		SFSP, VA Dept of Education	SFSP, VA Dept of Education	SFSP, VA Dept of Education	SFSP, VA Dept of Education
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	12	13	14	15	16

Notes - 2011

Numerator data from the 2011 Summer Food Service Program.

Denominator data provided by the Virginia Department of Education.

Notes - 2010

Numerator data from the 2010 Summer Food Service Program.

Denominator data provided by the Virginia Department of Education.

Notes - 2009

Numerator data from the 2009 Summer Food Service Program.

Denominator data provided by the Virginia Department of Education.

a. Last Year's Accomplishments

On October 1, 2010, the Virginia Department of Health became the program administrator for the Summer Food Service Program (SFSP). This program was transitioned from the United States Department of Agriculture Mid Atlantic Regional Office (MARO) to the Division of Community Nutrition (DCN) within VDH. SFSP provides federal funding to eligible sponsor organizations to provide meals and snacks to lower income children during the summer months when school is not in session. SFSP sponsor organizations can be a school, camp, governmental entity, private non-profit organization, or a college participating in the National Youth Sports Program.

Summer of 2011 was a learning experience for the SNP team. Processes and procedures are being developed to ensure that all regulations are met. The SNP team will revise the application for 2012, revise the site and sponsor review forms, and develop resources for the SFSP sponsors. VDH has a toll free number for sponsors, prospective sponsors and the public seeking information and/or technical assistance.

The number of sponsors increased from the previous year by 7, the number of sites by 113, and the average daily attendance for children receiving meals by 7,251.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide meal and operational reimbursements and administrative oversight to daycares participating in SFSP.	X			
2. Review and make recommendations regarding proposed legislation or policies affecting the Virginia SFSP.				X
3. Perform outreach with partners at DOE, DSS, VDACS, and the Virginia Cooperative Extension to inform the families of eligible children about program availability.			X	
4. Collaborate with partners to ensure that SFSP sites and sponsors participate in the program and offer meals in areas with highest unmet need.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The SNP team continues to strengthen their relationships with agency, state and community partners including: VDH Division of Environmental Health, Virginia Department of Education (DOE), Virginia Department of Social Services (DSS), Virginia Department of Agriculture and Consumer Services (VDACS), Virginia Cooperative Extension (VCE), The Virginia Food Banks, and Share our Strength.

In December 2011, VDH surveyed the 128 SFSP sponsors from Summer 2011 to determine who planned to return for Summer 2012. The majority responded that they will participate in 2012.

Data from school year 2011-12 was obtained from DOE regarding eligibility levels for free-and-reduced-price meals (FRPM) in all Virginia counties and cities. These areas were separated into Groups I and II. Group I represents the areas of greatest potential need with eligibility for free-and-reduced-price meals at 50 percent or higher and Group II represents the areas of potential need with eligibility for free-and-reduced-price meals in the 30 to 49.9 percent range.

The SNP team compared this list of high-need counties and cities with the list of expected returning sponsors for Summer 2012 to identify areas where both high levels of need and lack of SFSP meal service through known sponsors will likely occur. These identified counties and cities will be targets for outreach. Approximately 145 applications have been sent out for Summer 2012. Publication of the availability and location of SFSP meals will be done.

c. Plan for the Coming Year

DCN will continue to strengthen their partnership and communication with other VDH departments and outside agencies who will serve as partners for SFSP; this includes the VDH Office of Environmental Health, Virginia Department of Education, Virginia Department of Social Services, Virginia Department of Agriculture and Consumer Services, and Virginia Cooperative Extension.

Outreach efforts to reach areas with the highest levels of unmet need will continue for FY 2013; targeted areas will be defined in the FY 2013 Management and Administration Plan. These efforts will be directed toward reaching counties and cities with the highest percentages of eligibility for free-and-reduced-price meals and the highest unmet needs as evidenced by the level of SFSP participation. Publication of SFSP availability will occur through the Virginia Department of Social Services 2-1-1 system as well as WIC clinics, and by working with Virginia Department of Education to disseminate printed or electronic materials to families of school children prior to the end of the school year. We will ask SFSP sponsors to have their sponsors post signs showing meal location, dates and times at a location that is visible from the street. We will share with the sponsors SFSP practices that other states have found successful for increasing participation. We will also present information about SFSP at the Virginia Faith-Based & Neighborhood Partnership meeting in February. Share our Strength will also develop a website that will help parents and the community locate SFSP sites.

DCN staff will continue responding to inquiries, identifying and contacting prospective sponsors, and assisting current sponsors in efforts to expand their participation or number of sites.

The development of a new online claim processing system for SFSP and CACFP will occur in FY 2013 simultaneously, as the two programs will share the system. A new claims processing system will increase program efficiencies both at the state and provider levels.

E. Health Status Indicators

E. Health Status Indicators

The Office of Family Health Services (OFHS) has made a strong commitment to improve Maternal Child Health (MCH) surveillance capacity through the use of Title V, State Systems Development Initiative (SSDI), and other funding such as the Centers for Disease Control and Prevention (CDC) Assessment Initiative, the Pregnancy Risk Assessment Monitoring System (PRAMS) and the Virginia Youth Survey (State YRBS). With the development of an OFHS Data Mart and the agency Data Warehouse, staff have better access to vital records data, hospital discharge data and other health status indicators that are updated on a regular and timely basis. These enhancements to the state's surveillance capacity have been used to identify emerging trends, target program initiatives and evaluate programmatic efforts to determine the most effective use of resources within a framework of the life course perspective for women and children in Virginia. Virginia utilizes all Health Status Indicators (HSI) to inform the direction of programs. This report focuses on two indicators of high priority to MCH goals.

Virginia's Health Status Indicators (HSI) support two Title V Maternal Child Health Block Grant program priorities. The first MCH priority is to reduce infant mortality in the state. Virginia's overall infant mortality rate during 2010 was 6.8, falling short of meeting the Healthy People 2010 goal of 5.0 infant deaths per 1,000 live births. Despite improvements in reducing infant mortality in Virginia, disparities in health outcomes of infants continue to exist. The rate of infant death for Hispanic infants of any race (7.0 per 1,000 live births) did not meet the Healthy People goal of 5.0 infant deaths per 1,000 live births in 2010; White non-Hispanic infants did meet the goal with a

rate of 4.9 per 1,000 live births. However, non-Hispanic black infants were nearly three times more likely to die within the first year of life (14.6 per 1,000 live births).

Since birth weight is an important determinant of infant health and survival, Virginia utilizes four Health Status Indicators (HSI) to provide a basis for developing plans and resource allocation aimed at reducing the number of infants born weighing less than 2500 grams and infant mortality. These indicators are HSI01A, HSI01B, HSI02A, and HSI02B.

Singleton low and very low birth weight health status indicators (HSI02 and HSI02B) are perhaps Virginia's best indicators for progress in reducing the percent of infants born weighing less than 2,500 grams. As OFHS moves towards incorporating a life course perspective, data have been used to identify methods to improve preconception health behaviors, increase access and utilization of preconception health services, and help women identify and manage chronic conditions before pregnancy. Preconception health is a critical part of wellness for women as well as an important factor for improving pregnancy outcomes. The PRAMS survey is the primary source of data about the attitudes, behaviors, and experiences of women before they become pregnant.

The second set of HSIs support the Title V goal of reducing injuries, violence, and suicide among Title V populations. Injuries are the leading cause of death for Virginians ages 1-40 years. Sadly, one in five women in Virginia report having experienced intimate partner violence (IPV) at some point in the life. In 2009, over six million dollars was billed due to childhood motor vehicle crash hospitalizations. Indicators supporting surveillance of injuries in Virginia are HSI04A, HSI04B, and HSI04C.

Despite a slight decline in the percent of low birth weight (LBW) in recent years, trend analyses of HSI 01A shows a statistically significant increase in the percent of infants born weighing less than 2500 grams since 1999. In 2010, 8.1% of all Virginia births were low birth weight, down from 8.2% in 2009, and 8.3% in 2008. The racial/ethnic disparity in low birth weight infants continued in 2010. Of all black non-Hispanic infants, 12.5% were low birth weight. For white non-Hispanic infants, 6.9% were low birth weight. Historically the percent of Hispanic infants of any race had the lowest percent of low birth weight, however, in 2010, 8.1% of Hispanic infants of any race were born weighing less than 2,500 grams, up from 6.1% in 2009. Only white non-Hispanic infants met the Healthy People LBW goal of 7.8%.

A reduction in the number of singleton births would make a significant reduction in the percent of infants born with low birth weight in Virginia. Of all live singleton births in 2010, 6.3% of the infants weighed less than 2,500 grams, and the racial/ethnic disparities remained in 2010. The percent of black non-Hispanic LBW singleton births was twice that of white non-Hispanic LBW singleton births (11.0% vs. 5.0%), while the percent of Hispanic LBW singleton births was 5.1%.

In 2010, 1.4% of all live births were very low birth weight (VLBW) infants. Looking at the data from 1999 to 2010, it is unclear if there is any significant trend in the overall percent of VLBW infants. The racial disparity continued in 2010 with 3.0% of black non-Hispanic births resulting in a VLBW infant and 1.2% of white non-Hispanic births being VLBW. Hispanics of any race had higher percent of VLBW infants at 1.3%.

In 2010, 1.1% of all live singleton births were very low birth weight (VLBW) infants. The racial disparity continues with 2.4 percent of black non-Hispanic live births resulting in a VLBW infant and 0.8% of white non-Hispanic births being VLBW. Hispanic, any race had a percent very similar to the white non-Hispanic group (0.9% vs. 0.8%).

VDH's Injury and Violence Prevention Program has much to celebrate this year with several indicators showing significant declines. Virginia's death rates from unintentional injuries among children and adolescents from birth to age 19 have declined by 45 percent from 2000 to 2009. Virginia's rate surpasses the 30 percent decline seen nationally. Decreased deaths from motor

vehicle accidents represent the single biggest area of decline. In 2010 there were 4.6 unintentional injury deaths per 100,000 children aged 14 years and younger. From 1999 to 2009 there is a significant decreasing trend in the unintentional injury deaths in this population. In 2010, black non-Hispanic children 14 years and younger had the highest rate of death from unintentional injuries (6.3 deaths per 100,000), while white non-Hispanic rate was 3.8 per 100,000 and the Hispanic rate was higher in 2010 at 6.2 per 100,000 children under age 14 years compared to 3.3 in 2009.

A significant decreasing trend in the rate of unintentional injury deaths among children less than 14 due to motor vehicle crashes has occurred in the past ten years. In 2010, the rate was 0.7 per 100,000 children in this age range; in 1999 the rate was 2.6. The death rate for white non-Hispanic children and black non-Hispanic children was 0.88 and 0.87 respectively. The death rate for Hispanic children aged 14 and younger due to motor vehicle crashes is the lowest among all population groups (0.0 per 100,000).

In addition, a statistically significant decreasing trend has been observed in the rate of unintentional the death rate from motor vehicle crashes among youth aged 15 through 24 in Virginia. In 2010 the overall death rate for this measure was 13.0 and in 2009 the rate was 16.4 per 100,000 youth in this age group. In 2010 the death rate for black non-Hispanic was 11.14 and for white non-Hispanic and Hispanic the death rate was 14.71 and 12.77 respectively. The VDH Injury and Violence Prevention Program does not have projects or programs that directly impact this age group. However, the program does provide data and best practice and promising practice information to communities and organizations when requested. Program staff also participates on state level committees that are beginning to look more in depth at this age group and potential programs that may address this issue. Of the Virginia high school students responding to the 2011 Virginia Youth Survey, 7.3% said that they never or rarely wear a seat belt when riding in a car. In addition, 20.0% of the respondents indicated that they had ridden with a driver who had been drinking in the past 30 days. These responses show how the risk behavior of youth has a potential impact on the unintentional injuries and deaths from motor vehicle crashes.

Since 1999 the rate of nonfatal injuries in children aged 14 years and younger has significantly decreased from 225.7 per 100,000 children aged 14 years and younger to 149.7 in 2010. A change in Virginia's child restraint law in 2007 has contributed to the decrease in nonfatal injuries and motor vehicle deaths. In 2007 the age requirement for children to be secured in an approved safety seat while riding in a vehicle increased from five to eight years old. Hispanic children had the lowest rate of non-fatal injury at 109.0 and black non-Hispanic children had the highest rate at 164.2/ 100,000 compared to white non-Hispanic children at 147.2.

Since 1999 the rate of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger has significantly decreased. In 2010 the rate was 9.2 per 100,000 children in this age range. Black non-Hispanic children had the highest rate of nonfatal injuries (11.6) and Hispanic children had the lowest rate (4.5).

Since 1999, there has been a significant decreasing trend in the rate of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24. In 1999 the rate was 127/100,000 and in 2010 the rate had decreased to 76.0/100,000 in this age group. White non-Hispanic children ages 15-24 had the highest rate of non-fatal injuries due to motor vehicle crashes, followed by black non-Hispanic youth. Hispanic youth of any race had the lowest non-fatal injury rate at 36.4 per 100,000.

The Office of Family Health Services has completed a reorganization that included the creation of a new Division of Policy and Evaluation. One of the functions of the new division will be to assess the efficacy of the state's current efforts towards the desired outcome of improved maternal and infant health including monitoring of HSIs.

To evaluate screening and referral strategies, an analysis of PRAMS data was conducted. This analysis began with the assumption that the health of women and infants may be adversely affected by emotional problems, alcohol use, tobacco, and violence. Additionally, women are often afraid to discuss problems of this nature with their health care providers because of stigma and shame, especially around the time of pregnancy. VA PRAMS data revealed that women who report symptoms of post partum depression (26%) were also more likely to have co-existing behavioral risks such as smoking (12%), intimate partner violence (15%) and binge drink during the last three months of pregnancy (2%). VA PRAMS data also shows these same women interact with a variety of health care providers, providing an excellent opportunity for screening and appropriate referral.

To improve screening and referral processes and assist health providers in their screening efforts, maternal child health staff across several state agencies identified an appropriate screening tool, which is non-threatening, very effective, and easy to administer. Medicaid reimbursement became available November 29, 2010 for screening, increasing the opportunity to get the support and resources needed to address behavioral risk factors that negatively impact maternal, infant and family health outcomes in Virginia. PRAMS data provided the evidence to support the use of a multi-risk screening tool for pregnant women and women of childbearing age in Virginia.

An evaluation of linked birth data to examine intergenerational effects and their contribution to persistent racial disparities in birth outcomes has been conducted. This study compared the birth weights of 67,696 infants whose mothers had normal birth weights (NBW) to 5,267 infants whose mothers were born low birth weight (LBW). Overall, 16% of infants born to LBW mothers were also born LBW compared to 8% among NBW mothers. Although race modified the effect, both black (OR=1.6 [95% CI: 1.45, 1.80]) and white (OR= 2.0 [95% CI: 1.76, 2.24]) infants were significantly more likely to be born LBW if their mother was born LBW, even after adjustment for maternal socio-demographic factors.

This analysis provides evidence of an independent effect of maternal birth weight on infant birth weight. Even after adjusting for known maternal risk markers in the current pregnancy, infants born to LBW mothers remained at increased risk of LBW. This finding is important to public health because it shows a mother's early life experiences can impact the health of her children and suggests healthcare delivery systems should adopt a life-course framework as a step toward preventing adverse birth outcomes.

Other analyses include a comparison study of women eligible but not enrolled in a home visiting program or the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) contributing to understanding potential program impacts on low birth weight. Using PRAMS data, an analysis of multiple outcomes, breastfeeding, completed well child visits, completed post partum visits, adequacy of prenatal care and infant birth weight were examined. Results showed that women who participated in home visiting were 87.5% less likely to have a low birth weight infant.

The Division of Policy and Evaluation will have trained epidemiologists, evaluators and policy analysts available to provide data support for Title V program planning, policy development, and decision-making. Virginia has identified overarching themes that will guide data and program activities over the next several years. These themes are improving the health of women across the lifespan, addressing the social determinants of health, and targeting social determinants to reduce health inequities.

As OFHS moves towards incorporating a life course perspective, data has been used to identify methods to improve preconception health behaviors, increase access and utilization of preconception health services, and help women identify and manage chronic conditions before pregnancy. While individual health behaviors, genetics and access to health care are important factors in improving the health of maternal and child health populations, it is also critical to

address the social determinants of health to make sustained improvements in health across the lifespan and reduce health inequities. VDH supports a variety of initiatives for both population and systems based approaches to improve preconception health behaviors, increase access and utilization of preconception health services, and help women identify and manage chronic conditions before pregnancy. While individual health behaviors, genetics and access to health care are important factors in improving the health of maternal and child health populations, it is also important to address social determinants of health in order to make sustained improvements in health across the lifespan and reduce health inequities.

At the highest level, the State Health Commissioner has led an Infant Mortality Work Group (IMWG) for the past four years. This workgroup includes medical and health professionals as well as community and civic leaders who meet regularly to review data and collaborate to promote statewide initiatives and general awareness about the importance of reducing infant mortality. The IMWG has partnered with Healthy Mothers, Healthy Babies (HMHB), CDC, the White House, the Department of Defense, George Washington School of Public Health, and numerous public and private organizations in Virginia to implement the text4baby campaign. Women enroll into the service and receive three free text messages per week. These messages are timed to the due date or baby's date of birth and cover such topics as birth defects prevention, immunization, nutrition, mental health, oral health, and safe sleep. The messages also connect women to prenatal and infant care services and other resources. As of March 2012, over 12,000 Virginia women were enrolled in text4baby. Customized PSAs were developed by HMHB and have been distributed to local Virginia media.

The Silent Epidemic, is a power point presentation created as a way to provide a consistent message pertaining to infant mortality reduction strategies, including the need for the mother to receive early and adequate prenatal care. The Silent Epidemic has two components one designed to use with community leaders and one to use with professionals. Over the last two years it has been used for over 16 sessions including over 500 community and professional partners.

VDH has numerous other efforts to help reduce the disparities observed in low birth weight, adequate prenatal care, and infant deaths between the Medicaid and non-Medicaid populations. Approximately 3.5 million Title V dollars are allocated to 35 health districts to support services to improve maternal and infant health. In FY 11, 29 of the 35 health districts used Title V funds to provide prenatal services including pregnancy testing, referral to private prenatal care providers, direct prenatal care, and case management services.

VDH continues to lead the state Home Visiting Consortium and directly administer ongoing programs such as the Virginia Healthy Start Initiative (VHSI) and Resource Mothers Programs. VHSI and Resource Mothers have implemented strategies to increase the number of pregnant women who enter prenatal care in the first trimester and keep their prenatal appointments which will increase those receiving adequate care. Program data show that 79% of program participants entered care in the first trimester. The Maternal, Infant and Early Childhood Home Visiting project will continue to fund local sites to improve early childhood systems of care including access to prenatal care. Virginia was recently awarded an additional \$6.2 million to increase funds for this project. Expansion of home visiting services through this project will increase the number of families who are linked to services and resources in Virginia.

"A Healthy Baby Begins with You" preconception program was offered in January 2011. This national campaign, developed by the Office of Minority Health of the U.S. Department of Health and Human Services, is dedicated to raising awareness about infant mortality with an emphasis on the African-American community through the involvement of Historically Black Colleges and Universities. Forty-two peer educators were trained in January 2011 and have since developed several college projects. The preconception health messages support the identification and treatment of chronic disease prior to pregnancy. Other preconception messages regarding folic acid consumption, cessation of smoking, drug and alcohol use, and healthy diet are included.

Education is also provided concerning early parenting decisions such as the importance of providing a safe sleep environment, lactation as the primary feeding method, and immunizations.

Guiding Virginia efforts to continuously assess its health systems capacity and relationship to perinatal outcomes, Virginia has administered the Pregnancy Risk Assessment Monitoring System (PRAMS) for the past four years. PRAMS obtains information regarding pregnancy experience and outcomes from a sample of new mothers. Low weight births are oversampled in Virginia in order to gain more insight on issues that may be faced in this population. These data are analyzed and presented annually to groups such as the Infant Mortality Work Group in order to keep abreast of system issues.

The VDH Injury and Violence Prevention Program prevents injuries to children through public information, training, community education and events, and support for community coalitions. The unintentional injury prevention program focuses on the prevention of the leading causes of fatal and non-fatal unintentional injuries in Virginia by examining injury patterns and by identifying groups at high risk and potentially modifiable factors. The program focuses available resources on the prevention of unintentional injuries determined to be the leading causes based on available Virginia injury data. Resources are also focused on those causes that have an enormous impact on audiences that can be effectively targeted with information and countermeasures that will result in the desired behavior change. The program utilizes prevention strategies and related activities at both the state and local levels to support the accomplishment of goals in the areas of child passenger safety, traumatic brain injury, fire and burn prevention and general injury prevention outreach, education and policy. These strategies include raising awareness of the scope of the injury problem through sharing of data, information and resources, presentations, trainings and exhibits, and collaborative projects; increasing the number of state and local agencies, organizations and groups committed to and working on injury prevention through consultation and technical assistance, leadership of a state injury planning group, coordination of local prevention projects and dissemination of proven safety devices and partnerships; and policy development.

The DPHP coordinates a child passenger safety program that promotes proper safety seat restraint use for children from birth until they transition to the vehicle safety belt; increases risk perception and correct usage of child restraints among parents and care givers through outreach and education; provides proper installation education through community safety seat check stations and events; and addresses financial barriers that prohibit access to safety seats through the Low Income Safety Seat Distribution and Education Program (LISSDEP). The child passenger safety program is funded through Highway Safety Funds, Traffic Revenues and the MCH Block grant. In 2011, DPHP distributed approximately 16,000 child safety seats to families in need, inspected over 600 seats through safety seat check events, and distributed over 165,000 pieces of education resource materials. In addition, the health care provider-focused First Ride Safe Ride Program which promotes the safe transportation of newborns from the first ride home continued to expand during 2011 with 20% of maternity hospitals in Virginia receiving staff training.

OFHS will continue to monitor relevant health status indicators and assess factors which program and policy changes may impact to improve overall health and well-being of maternal child health populations in Virginia.

An attachment is included in this section. IVE - Health Status Indicators

F. Other Program Activities

VDH is leading a multidisciplinary effort, which includes the Departments of Education and Health Professions, to update school health guidelines for schools to implement mandatory policies in place for possession and administration of stock epinephrine as result of 2012 legislation. This

will enable trained school personnel to better respond to anaphylactic reactions and reduce potential mortality.

Project RADAR is a provider-focused initiative to promote the identification, assessment, treatment, and referral of victims of intimate partner violence (IPV) in the health care setting. In 2010, over 1,400 health care professionals across the Commonwealth were trained using Project RADAR curriculum. This number includes more than 135 professionals certified as instructors through train-the-trainer sessions, those that completed an online version of the course, and more than 1,200 that attended workshops and in-service training sessions.

In conjunction with Project RADAR, VDH published the results of a 2009 survey of healthcare providers to assess knowledge, attitudes, and screening practices of Virginia healthcare providers related to domestic violence, more specifically violence between intimate partners. A total of 4,481 survey responses were received from dentists, dental hygienists, licensed clinical social workers, and medical doctors who identified themselves with specialties in obstetrics/gynecology, family/general practice, pediatrics, emergency medicine, and psychiatry. Survey data was also collected from community health centers, free clinics, campus health centers, and family planning clinics at local health departments.

VDH was selected as one of 10 sites nationally to launch Project Connect, an initiative to develop comprehensive public health prevention and intervention models to improve health and safety for victims of domestic violence and their children. Virginia's project is focusing on family planning and home visiting settings. A Leadership Team was established, curricula for home visitors and family planning providers were developed and a train-the-trainer event with 75 participants was held to launch the campaign. Over 1,400 home visitors and family planning nurses have been trained and "pilot communities" have been established to create shelter-based health services programs and develop policies and cooperative agreements to improve the identification of health care needs in advocacy programs and formalize cross-referral processes and collaboration between domestic violence programs, family planning clinics and home visiting programs.

Virginia's State Child Fatality Review Team (CFRT), located in the Office of the Chief Medical Examiner (OCME), is a statutorily mandated activity to support the public health and safety of Virginia's children. The Team examines specific circumstances of child death to make recommendations for prevention and intervention of child injury and violence and suggest improvements in child death investigation techniques.

Beginning in 2011, the CFRT is reviewing all 2009 infant deaths that were likely related to unsafe sleep environments. The Team expects to complete its review of 121 cases in 2013 and use the information to develop recommendations for prevention and intervention. The information will be shared with the Fetal and Infant Mortality Review teams in each of the five Regional Perinatal Councils to use as the basis for their unsafe sleep prevention activities.

Early in its review, CFRT members identified problems of standardization with the OCME's death scene investigations of these potentially sleep-related deaths. The CFRT identified the need for better scene photography and, whenever possible, re-enactments of the child's placement in the sleep environment with dolls and the cooperation of parents or other caregivers. The Chief Medical Examiner and Chair of the Team worked with the Virginia Association of Chiefs of Police and the Virginia Sheriffs' Association to train law enforcement leadership on the need for these types of investigations and the importance of their assistance to the OCME in getting the re-enactments scheduled and completed. The OCME plans to provide regional law enforcement training in the future.

Also in this review, the State CFRT identified the need for training of Emergency Medical Services (EMS) Personnel on managing infant death scenes. EMS plays a unique role in death scenes: caring for the patient, assisting the grieving and shocked caregivers, but also assisting the death investigation with the preservation of evidence. As first responders, their eyes and

ears are often critical to understanding red flags associated with how a child was injured and died. Through the EMS for Children Committee, the Team is sponsoring a one-hour training for EMS personnel on "When A Child Dies."

The State CFRT Team Coordinator also assisted the Joint Commission on Health Care with information on "shaken baby syndrome" or abusive/inflicted head trauma that resulted in deaths.

Local and regional child fatality review teams are permitted, but not required, in Virginia health statutes. Prior to 2011, Virginia had one active regional team. With colleagues from the Virginia Department of Social Services (VDSS) and at the request of the Virginia Governor's Advisory Board on Child Abuse and Neglect, regional teams are now required in each of the five VDSS Regions in Virginia. Beginning with FY11 deaths, these teams will review all child fatalities taken for investigation for a complaint of child abuse and neglect. Each team will provide an annual report of key findings and recommendations, which will be combined into one report and presented to the Board for discussion and action. These teams are coordinated by VDSS and the OCME provides trainings and technical assistance.

Virginia's Maternal Mortality Review Team (MMRT) continues to review all cases of death occurring to a pregnant or recently pregnant Virginia resident regardless of the cause of death or outcome of the pregnancy (termed pregnancy-associated death). This multidisciplinary team meets six times per year to review deidentified case summaries and determine system factors contributing to the death. To date, the MMRT has identified several major risk factors for pregnancy-associated death and made recommendations to address them. These include: motor vehicle accidents, substance abuse, mental illness, domestic violence, obesity, chronic diseases, obstetric emergency management, and diseases and conditions of the heart.

Most recently, the MMRT focused on pregnancy-associated deaths due to heart conditions. Over half of these deaths were directly related to the pregnancy. There were 10.1 deaths for every 100,000 live births in Virginia. The rate of heart disease deaths among recently pregnant Black women was 3.7 times higher than the rate for White women. Review of the circumstances surrounding these deaths indicates that the most vulnerable women were single mothers with less than a high school education living in areas with lower levels of household income. Overall, factors associated with death among these women included late entry into prenatal care, lack of health insurance, and the presence of pre-existing conditions such as chronic hypertension and obesity. Recommendations included the need for continuous disease management before and after pregnancy along with provider assessment of economic status and the provision of necessary assistance to access primary and preventive health services.

In late 2011, the OCME added the Pregnancy-Associated Mortality Surveillance System (PAMSS) system to its maternal death review efforts. Each year, maternal death certificates along with matched infant birth or fetal death certificates are provided to PAMSS and relevant data abstracted. This surveillance system allows for the epidemiologic study of patterns and trends related to these deaths.

G. Technical Assistance

The Office of Family Health Services (OFHS) will have a new director once recruitment is completed. As OFHS has completed its reorganization and is ready to address the MCH priorities under its new structure, it would be beneficial to have an outside consultant or experienced Title V director/staff from another state to orient the new OFHS/Title V Director. Technical assistance would be beneficial as the office engages in strategic planning around the Title V priorities. The Virginia Title V program is particularly interested in training on incorporating the life course model into planning and programming. As part of the life course perspective, specific areas of interest include preconception care and related quality improvement and performance measures. The VDH Title V program would also seek to dedicate part of this planning to better integrate chronic disease prevention into maternal and child health services.

Resources, training, and other state initiatives that have been successfully utilized would be helpful.

Recent national developments changing health care systems will continue to impact MCH populations and delivery of Title V services. Two related yet distinct areas of interest for technical assistance and expertise are health care reform and health information technology. As the Affordable Care Act continues to be implemented, the opportunity to have access to technical assistance where detailed discussions and assistance in anticipating where changes may need to be made in delivery of Title V and population-based services would be beneficial. In addition, developments related to national and state health information exchange and electronic medical records would be helpful. With multiple information technology initiatives at state and national levels, an expert to assist Title V programs assure that they are fully utilizing available information would be appreciated.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation <i>(Line1, Form 2)</i>	12345316	12268838	12369389		12369389	
2. Unobligated Balance <i>(Line2, Form 2)</i>	0	0	0		0	
3. State Funds <i>(Line3, Form 2)</i>	9313133	10096819	9277042		9470031	
4. Local MCH Funds <i>(Line4, Form 2)</i>	0	0	0		0	
5. Other Funds <i>(Line5, Form 2)</i>	0	0	0		0	
6. Program Income <i>(Line6, Form 2)</i>	1500000	121178	510813		500000	
7. Subtotal	23158449	22486835	22157244		22339420	
8. Other Federal Funds <i>(Line10, Form 2)</i>	130632139	156485606	156485606		156035618	
9. Total <i>(Line11, Form 2)</i>	153790588	178972441	178642850		178375038	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	2218013	3818586	2917141		3792803	
b. Infants < 1 year old	3349020	750769	765926		745700	

c. Children 1 to 22 years old	7162334	7590243	5871066		7538994	
d. Children with Special Healthcare Needs	7500000	10185310	7931713		9086923	
e. Others	1694551	0	3302979		0	
f. Administration	1234531	141927	1368419		1175000	
g. SUBTOTAL	23158449	22486835	22157244		22339420	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	93713		97260		65357	
c. CISS	132000		132000		150000	
d. Abstinence Education	0		889973		828000	
e. Healthy Start	1050000		1050000		1050000	
f. EMSC	0		0		0	
g. WIC	114690471		134589737		134589737	
h. AIDS	0		0		0	
i. CDC	7811979		8738114		6574445	
j. Education	0		0		0	
k. Home Visiting	0		0		0	
k. Other						
DMAS	447500		447500		447500	
Family Planning	4797671		4797671		4499174	
MCHB	1108805		5243351		7351405	
SAMSHA	0		0		480000	
SAMSHA	0		500000		0	
SAMSHA Youth Suicide	500000		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services	13980096	9504644	9778934		9443824	
II. Enabling Services	2218013	6515376	4932287		6473684	
III. Population-Based Services	3738985	525693	1475476		518807	
IV. Infrastructure Building Services	3221355	5941122	5970547		5903105	
V. Federal-State Title V Block Grant Partnership Total	23158449	22486835	22157244		22339420	

A. Expenditures

Form 3: For FY 2011, Virginia's Maternal and Child Health program was funded at a total level of \$21,923,435 with matching expenditures totaling \$9,654,597. Of the match, \$121,178 was generated from Program Income and expended on Children with Special Health Care Needs. 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 match of \$9,654,597, Virginia has exceeded this requirement.

Form 3: In FY 2011, there was a considerable increase in the expenditures for (8.), Other Federal Funds. In October 2010, the Virginia Department of Health acquired the Special Nutrition Program from the US Department of Agriculture. This new program, which was previously administered by USDA in New Jersey, increased Virginia's Federal funding levels.

Form 4: For FY 2011, expenditure data was captured and grouped into categories of people served (Pregnant Women, Infants < 1 year old, and others as required). Administrative expenditures and budget are primarily included into the categories of people served. This created variances of budget to expenditures, of more than 10%, in most categories of people served and Administration.

Form 5: For FY 2011, the total expenditures data was captured and grouped by types of expenditures. The types of expenditures were grouped into the categories required on Form 5 (Direct Health Care Services, Enabling Services, Population based services and Infrastructure). Direct Health Care Services contain expenditures for Child Development Clinics, Genetics Field Services, District Obesity, District Dental Health, Pharmacy, and Southwest Virginia Care Connection for Children. Enabling Services contain expenditures for Resource Mothers, Children with Special Health Care Needs Field Services and Hemophilia. Population Based Services contain expenditures for the Hearing Registry, MCH Injury, and Information on Fetal Development. Infrastructure Services contain expenditures for Injury Prevention, Dental, Regional Perinatal Council, Sickle Cell and Child Development Services Program Support.

B. Budget

The Title V block grant budget provides funds for Maternal and Child Health (MCH) Services, primary care for children and adolescents, and preventive and maintenance services to Children with Special Health Care Needs (CSHCN). Preventive and primary care services include policy and procedural oversight, nutrition services, Local Health Department (LHD) agreements, pharmacy and laboratory testing, Regional Perinatal Councils (RPCs), Fetal/Infant Mortality Review, Newborn screening/follow up, and reducing health problems and risk factors. Other services provided are promotion of health and provision of comprehensive health services, assessment, management of secondary and tertiary care, injury prevention, Child Care Nurse Consultant, Resource Mothers (RM), primary care, school health, family planning (under age 22), teen pregnancy prevention, maternal health (under age 22), laboratory testing, pharmacy, sickle cell services, and dental health.

Population services include policy and procedural oversight concerning women's services, agreements with LHD for family planning services, laboratory testing and pharmacy services.

Services for CSHCN include family-centered, community-based coordinated care for persons from birth through age 20 who have or are at risk for disabilities, handicapping conditions, chronic illnesses and conditions or health related educational or behavioral problems, and development of community-based systems of care for such children and families.

Virginia budgets 30% or more of MCH Federal funding for preventive and primary care services for children. At least 30% of Federal funding is budgeted for CSHCN. Less than 10% of Federal

Funding is for Administration. The remaining funds will be used for infants, children, pregnant women, mothers, and non-pregnant women over 21 years. Please see details below:

Groups Served: Budget % of Federal Budget

Pregnant Women: \$2,102,796 17%

Infants < 1 Year: \$368,082 3%

Children 1 to 22: \$4,205,592 34%

CSHCN: \$4,517,919 37%

Administration: \$1,175,000 9%

Total Federal Funding: \$12,369,389 100%

In addition, Virginia budgets for match on a 4 to 3 ratio of Federal to State, keeping in mind the Maintenance of Effort (MOE). Sec. 505 (a)(4) requires that states maintain the level of funds provided (match) solely by the state for MCH health programs at a level at least equal to the level provided by the state in fiscal year 1989. Virginia's MOE is \$8,718,003. The Fiscal Year 2013 Budget meets the match and MOE amount as follows:

FY 2013 Budget amount:

Federal amount: \$12,369,389

State Match amount: \$9,470,031

Program Income amount: \$500,000

Administration: VDH's definition of Administrative costs includes management and policy direction, accounting and budgeting services, personnel services and support services.

Additional Federal Funds: The largest Federal Funding comes from the US Department of Agriculture for the Women Infant and Children program and the Special Nutrition program with a Budget of \$134,589,737 for FY 2012. On October 1, 2010, the Virginia Department of Health acquired the Special Nutrition Program from USDA which accounts for increased funding for the FY 2013 Budget .

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.