



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

**State Narrative for
Vermont**

**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

The required assurances and certifications are maintained on file in the Vermont Department of Health's central administrative offices. The information can be accessed by contacting Sally Kerschner, Vermont Department of Health, Division of Maternal and Child Health, 108 Cherry St, Burlington, VT. 05401, 802-652-4179.

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

Ongoing public input for Title V programs takes a variety of forms that allows direct Title V input and also input into general MCH programs of the VDH. The public budget process is one opportunity, as the VDH budget is publicly available (on request and via publications on the website.) An annual legislative committee session is purposely advertised for public attendance to allow for input into Title V and other federal grant applications. Focus groups and surveys for the WIC and EPSDT programs are conducted to assess satisfaction with services and to solicit input for suggested improvements as well as additional services. The Office of Dental Health has conducted focus groups with low income consumers about access, satisfaction and awareness of oral health care services. The VDH/VCHIP Program for Opioid-exposed Newborns uses mothers who have experienced addiction as advisors for their program. The ECCS/Building Bright Futures planning processes both statewide and regionally have included parents of young children on the planning committees. The VDH Newborn Screening Advisory Committee has several parents of children with metabolic conditions as members. CSHN partners with parents (including parents of CSHCN who are not served or are not eligible for CSHN programs) through Vermont Family Network and its facilitated focus groups, surveys and interviews. In addition, several CSHN staff members are parents or close relatives of CSHCN. Title V grant application is reviewed annually by several VDH partners and the comments have been incorporated into the grant narrative and are considered for improvement in case management and clinical services. In Vermont, the VDH Title V partners comprise a large group of state and community leaders who advise and collaborate regularly on MCH public health and service delivery issues. These partners participated in five year needs assessment process and are regular members of VDH advisory committees and collaborative efforts (School Health, Birth Registry, Early Childhood Comprehensive Systems, Department of Children and Families, Newborn Screening, Comprehensive Integrated Services, Department of Education, Department of Mental Health, etc) See attached Public Input Table, individual program descriptions, and Sec 111E for further information. In addition, current efforts are underway for the Agency of Human Services to improve communication between external stakeholders (e.g. Vermont Family Network, Vermont Federation for Families, American Academy of Pediatrics -- Vermont Chapter, Vermont Academy

of Family Physicians, and various early childhood service providers) and the Agency's departments and offices involved with the integration of services for children generally referred to Children's Integrated Services (CIS). Continued stakeholder involvement with CIS will be encouraged. The leadership of Vermont Family Network has provided specific content, data, and editorial guidance to this year's document. The Title V coordinator has begun to attend quarterly meetings of the District Office MCH Coordinators to hear updates on Title V services and community organization needs for the MCH population. In 2010, fiscal restructuring passed by the VT legislature and called Challenges for Change has initiated a period of rapid planning and structural redesign of services for children and families, including MCH services. The AHS leadership consistently invites large numbers of stakeholders and "consumers" to provide input. Most recently the invitation has gone out to have input into the redesign of "Enhanced Family Services. //2013/ ***In 2012, VDH is conducting a family planning needs assessment - data gathering activities include conducting focus group of low income young mothers. The participants are providing information their understanding of family planning and local access to OB/GYN and family planning clinical services. In addition, A VFN staff member will be co-located at CSHN offices to provide consultation to CSHN staff on families' needs in programming and support. As CSHN implements changes to its financial assistance program/payor of last resort role, key stakeholders and constituents will have the opportunity to comment on the changes through a services of community meetings held across the state. //2013//***
An attachment is included in this section. IE - Public 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

Section II C Needs Assessment Summary Vermont Title V July 2012

The overall guidance for the Title V Strengths and Needs Assessment was provided by the MCH Leadership Team with representation from Local Health Services, EPSDT, WIC, School Health, Family Planning, Injury Prevention, and Title V. Examples of participating partners within state government are the Department for Children and Families, Medicaid, the Department of Mental Health, and the Department of Education. Community and statewide groups are VCHIP, University of Vermont, Fletcher Allen Health Care and community based birth hospitals, the Farm Health Task Force, the Child Fatality Review Team, the Domestic Violence Fatality Review Team, Parent Child Centers, Community Health Clinics, Home Health Agencies, Prevent Child Abuse Vermont, Vermont Chapters of AAP and AAFP, Planned Parenthood of Northern New England, Safe Kids Vermont, and Vermont Family Network.

The MCH strength and needs assessment will inform several planning efforts at VDH and also will be useful to VDH partners both in state government and in non-state and local community organizations. For example, VDH is preparing the 2010 Injury Prevention Plan - action steps in this plan will reflect population injury prevention issues as detailed in the Title V assessment. In addition, several 2010 Affordable Care Act grant applications are presently being prepared and will use the findings of the Title V assessment for program planning and serving special populations. The assessment will provide information on program, staff, and other organizational capacity which will be useful to these grant planning efforts in addition to over all strategic planning for both MCH and other VDH departments. Capacity for action will be determined by such factors as the information contained in this assessment, existing programs and their funding and effectiveness, programs and initiatives managed by other stakeholders (so as to complement efforts and not duplicate) and an examination of emerging health issues.

In 2010, the MCH Leadership Team chose to continue with the 10 Priority Goals as used in the 2005 TV SNA. The Team felt that these Goals are still applicable to Vermont in 2010 and for planning into the next five years. The goals are broadly worded and reflect the vision of a healthy MCH population for Vermont. In addition, they allow flexibility for planning within each goals. These goals were first created in 2002 via a goal-setting process facilitated by the planning unit of the Vermont Agency of Human Services. At that time, VDH began using the concept of goal setting and asset promotion for Title V planning. These goals continue to be useful for Vermont state government. For example, they are included in the recent Challenge for Change state legislation that was created to streamline systems in state government. Use of these goals when streamlining programs to decrease program "silos" will be useful to maintain overall goals for both AHS, our partners at DCF and Mental Health, and also for MCH planning.

The measures are worded to reflect a combination of both the traditional approach of program evaluation or "deficit" wording and also the newer approach of strengths-based wording. Measures were chosen to reflect the existing work of VDH programs or to begin measurement of initiatives that are in the beginning stages of implementation. It was desirable to include measures that reflected the broad scope of MCH public health -- hence the array of VDH programs such as environmental, CSHCN, exercise and the built community, etc. Six measures were determined to be still relevant and are continued into the next five years planning period. A

new measure, that of using YRBS data to assess the percent of youth who wear bicycle helmets, was added. This measure has a focus on injury prevention, safe communities, and physical activity promotion. In the coming year, the MCH Leadership Team will consider three additional measure dealing with: 1) measurement of CSHN access to a medical home, 2) a measure from the ACA funded home visiting program assessing families that are stable and support children, and 3) measurement of developmental screening practices by primary care clinicians to address the issues around emotionally healthy children. /2012/ Attached is a summary of the VDH related services/programs that would support women with high risk pregnancies -- this status assessment being performed for the Act 35 report on programs and scope of services available to pregnant women identified as high risk. Also included is 2012 Needs Assessment and Inventory of selected communities and home visiting services as submitted to HRSA for the Maternal Infant Early Child Home Visiting program grant application. Two new measures have been added. For the Priority Goal of Children live in stable and unsupported families, the new measure is defined as the rate per 1,000 of substantiated cases of child abuse and neglect for the population of children ages 0-17. The measure is also being used for Healthy Vermonters 2020 and as measuring the MIECHV benchmark of "Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits, Construct: Reported substantiated maltreatment for children in the program. The second measure is related to the Priority Goal of all children, including CSHN, receive continuous and comprehensive health care within a medical home. The measure is worded as the length of time between referral from a pediatric primary care provider to the first Child Development Clinic kept appointment for children identified as having a potential developmental delay or ASD. This is a Vermont CSHN SIG related grant objective and will be monitored using CSHN program data //2012//***2013/This year the Division of MCH created a strategic plan (2011-2013), intentionally crafted to not only guide MCH and Title V related activities but also to complement the VDH strategic plan (2010-2013.) The plan (included as attachment) reflects the specific actions that the MCH staff has chosen to be of high priority for the years 2011- 2013. The activities reflect the wide variety of programs and projects that are administered out of the Division of Maternal and Child Health, such as WIC, Children with Special Health Needs, child injury prevention, family planning, School Health, EPSDT, and nurse home visiting. This document is meant to be used in conjunction with other significant planning opportunities that have emerged to guide MCH public health professionals in recent years. The plan, as part of the VDH Strategic Plan, is congruent with Healthy Vermonters 2020, Healthy People 2020 and the HHS National Prevention Strategy. It is also to be used to specifically assist in promoting success in other key planning documents, such as the WIC state plan and the Title V MCH Performance Measures. Thematically, the plan reflects the holistic approaches of such frameworks as the Social Determinants of Health, the findings of the Adverse Childhood Experiences study, and the Lifecourse Health Development model. In addition, Dr. Breena Holmes, as MCH Division Director, lead the MCH leadership staff in a year long review of the Title V state performance measures to assess the measurability and appropriateness of each measure in relation to the ten priority goals. The review found that SPM#3, "Increase percent women of childbearing age who report eating at least five or more servings of fruits and vegetables daily," was being monitored by Health Promotion and Disease Prevention (HPDP) obesity programming. MCH is planning to focus on preconception health and wellness and thus chose a measure more reflective of this initiative - "Increase the percent of women giving birth to a live infant who had a preconception BMI between 18.5-24.9." Worded in this fashion, the measure addresses the issue of both over- and under- weight preconception status. Other MCH planning around preconception health involves gathering information via the Family Planning Needs Assessment (to be completed August, 2012 in conjunction with MCH's Title X Family Planning program) and increased coordination with other VDH programs who work with women's health. For example, regular meetings are now being scheduled between Ladies First, Wise Woman, and the Infertility Prevention Program to coordinate community grants and programs to support an increased VDH infrastructure in Women's Health. Also, MCH is researching the "One Key Question" from the Oregon Foundation for Reproductive Health. This program works with primary care providers to ask women patients the***

screening question of "Would you like to become pregnant in the coming year" and them offering appropriate counseling for contraception, preconception health, and folic acid. Another initiative in Vermont is the Genuine Progress Indicator which is being organized via the Gund Institute for Ecological Economics at the University of Vermont. The GPI monitors measures of societal well being (a broader approach than the traditional GNP.) Vermont legislation was passed in spring, 2012, directing UVM and state government to establish and test GPI measures that will assist state government in budgetary decision-making relative to supporting the health and wellness of Vermonters. In 2010 and 2012, Vermont's BRFSS included the CDC module on Adverse Child Experiences -- data indicates that nearly a quarter of adults reported one ACE (23%) and another quarter said they experienced two or three adverse events during childhood (12% had two and 9% had three). Thirteen percent of Vermont adults had four or more ACE. Adults with at least four ACE generally experienced higher rates of chronic disease and risk behaviors than the entire Vermont population.//2013//

An attachment is included in this section. IIC - Needs Assessment Summary

III. State Overview

A. Overview

III A. OVERVIEW (See also Sections III B, III D, IV A, IV B)

Vermont is a scenic and mountainous state, located in New England, sharing its northern border with Quebec, Canada. It is a rural state with the 2009 revised census showing a population of 621,760. Chittenden County has the largest population concentration with about 150,000 residents, almost ¼ of the state's population. Burlington, in Chittenden County, is the core of the state's only Metropolitan Statistical Area, which extends into parts of Franklin and Grand Isle Counties. Addison County also has strong connections to the MSA. The fringes of this region still have strong ties to Vermont's agricultural industry, which sometimes causes conflict over land use planning and policies. The estimated population of this MSA is 166,126, representing approximately 27% of the state's population. Of the 255 towns and cities in Vermont, nine have total populations that exceed 10,000. These nine sites account for 25.2% of the state's population. Vermont has 14 counties.

In 1990, Vermont's racial and ethnic minority populations were estimated to be about 2% of the total population. By 2007, that figure had doubled to 4%, representing about 24,000 Vermonters. While these numbers are still proportionately small compared to the rest of the US, Vermont racial and ethnic populations are growing at a much faster rate than the population overall. Aging of Vermont's population is similar to the changes nationally, the median age for Vermont was 39.3 years with a significant increase in the proportion of the population aged 55-64, as the "baby boom" generation ages. A declining birth rate is now considered a main reason for the decrease in school enrollment: 1995 enrollment of 98,361; 2006 enrollment of 96,363.

Household composition is changing - the number of Vermonters living alone increased by 28% in the past decade, to 63,112. There is an increase in the number of unmarried partners living together -- 18,079 (47%). The number of households with married couples living together fell to 52.5% of all Vermont households. Married couples with children younger than 18 (the traditional nuclear family) make up 23.2% of the households in Vermont. On July 1, 2000, a new Vermont law went into effect granting same-sex couples in Vermont all the benefits, protections, and responsibilities under law as are granted to spouses in a marriage. In addition, the marriage equality act, effective September 1, 2009 which allows same-sex couples to marry in Vermont, discontinued the need for the separate status of "civil unions". /2012/ Over 1,700 same sex marriages have taken place since the law passed //2012//

Vermont's governmental structure consists of state government and town/city government, with essentially no county governmental structures, except for certain key services such as the court system. The bicameral legislature is considered a citizen legislature that is in session during January through May each year. Vermont has no county health departments, but is divided into 12 Agency of Human Services districts, each with a district office of the Vermont Department of Health headed by a District Director (Vermont's equivalent to a local health official).

Vermont is the home to many long established businesses such as IBM, but the economy is diversified with industries in manufacturing, tourism, small businesses, and services. Agriculture is still a vital part of the economy, but its prevalence has diminished over the past several decades. Vermont's rural nature and areas of poverty presents the issue of sparse populations having ready access to resources and services. Residents living in isolated areas of the state may have special difficulties accessing services and medical care (particularly in the harsh winter months) due to their remote locations and the less than optimal road conditions.

A sizeable proportion of Vermonters are living either in poverty or are living very near the poverty level. In Vermont, for 2005-2007, the median income per person was \$26,223 and the median household income was \$49,382. For these same years, 7% of all families and 13% of families with children under age 5 reported their past year's income to be below the poverty level. In

Vermont, low income people are more likely to be young (18-34,) less educated, unemployed or unable to work, female, or of an ethnic/racial minority. Vermont's minimum wage is \$8.06/hour (\$15,974/year,) which is higher than the federal minimum (\$7.25/hr) but still much lower than a livable wage (\$27,188/year.) As of June, 2010, the state's unemployment rate is 6.2%.

In 2011, there are 7.6% or about 47,000 Vermonters who are uninsured, a significant decrease from 2005, when 9.8% or about 61,000 were uninsured. In 2008, 22% or 18-24 year olds were uninsured, the highest percentage of any age group. For children under age 18, 2.9% have no insurance, the lowest percentage of any age group. For all Vermonters, 60% have private insurance as their primary coverage, while 14% are covered by Medicare and 2.4% by military plans. For those enrolled in publicly funded health insurance programs, coverage can be precarious - in an average month, up to 70% of CSHCN lose Medicaid coverage at least temporarily. The highest percentage of Vermonters with no medical home are among those younger than 35, those earning less than 250% of poverty level, and those with a HS diploma or less. Chittenden County, home to the state's largest medical facility, has the highest ratio of FTE primary care physicians at 94.4/100,000, compared to Grand Isle at 14.9. Similar disparities are found with dental care, with Chittenden County having 83 of Vermont's 282 primary care dentists.

Vermont ranks 1st nationally in the ratio of students to teachers in the public schools: 11.7 pupils to one teacher vs. a national ratio of 15.9. Nearly 90% of Vermont adults have a high school education or more, compared to 84% nationally and 33% hold a bachelor's or more, compared to 27% US.

Since 1980, the Refugee Resettlement Program has relocated well over 5,700 refugees to Vermont, increasing the cultural and linguistic diversity of the population being served by the health care and social service system of the state. Initially, resettled refugees arrived primarily from Vietnam, Cambodia, the Balkans, and sub-Saharan Africa; more recently resettled refugees are mostly Nepali from Bhutan and Burma. The health needs of migrant farm workers are becoming evident as this population is rapidly growing in Vermont. Estimates show there are about 2,500 migrant farm workers from Mexico and Central America, with the workers being concentrated in Franklin, Grand Isle, and Addison Counties.

Vermont Health Care System of Publicly Funded Insurance:

In July, 1995, Vermont's Medicaid 1115 Research and Demonstration Waiver application to create and implement the Vermont Health Access Plan (VHAP) was approved. The waiver allowed for a basic package of insurance coverage for previously uninsured adults with incomes up to 150 percent of the federal poverty level (FPL). In February, 1999, eligibility for previously uninsured adults was expanded to include parents and caretaker relatives of Medicaid-eligible children up to 185% FPL. In October 1998, the children's Medicaid program, Dr. Dynasaur, expanded eligibility for children birth to 18 years to include those with incomes up to 300% FPL, further reducing the percentage of Vermont children who are uninsured. (Vermont had been covering children with incomes up to 225% FPL since the early 1990's.)

In the Fall 2005, Vermont secured approval for Section 1115 Medicaid waiver, the "Global Commitment waiver," that allows Vermont to fundamentally restructure its Medicaid program. The waiver imposes a cap on the amount of federal Medicaid funding available to Vermont for nearly all Medicaid expenditures except for SCHIP and Nursing Homes. It also includes all Medicaid administrative expenses. In combination with a second, long-term care waiver, the Global Commitment waiver makes Vermont the first state in the nation agreeing to a fixed dollar limit on the amount of federal funding available for its Medicaid program. In exchange for taking on the risk of operating under a capped funding arrangement, the waiver allows Vermont to use federal Medicaid funds to refinance a broad array of its own, non-Medicaid health programs, and a greater level of program flexibility. Such flexibility includes changes in cost sharing, plan design, and possible caps on enrollment for "non-mandatory" Medicaid beneficiaries. There are 4 key elements: 1) Imposes a global cap that limits the state to drawing down federal Medicaid matching funds on no more than a total of \$4.7 billion in Medicaid spending for acute care

services over a 5 year period. If, however, Vermont reaches the \$4.7 billion cap, it will not receive any additional assistance from the federal government for Medicaid costs. This is a marked contrast to the regular Medicaid financing structure, which provides states with guaranteed federal matching Medicaid funds for all Medicaid services provided to Medicaid beneficiaries with no set limits. 2) Allows the state to establish itself as a managed care company -- allowing Vermont to pay itself a premium for each beneficiary that it serves. If the state can deliver care for less than the premium revenue, it can use the "excess" revenue for a broad array of purposes. Within limits, the state controls the amount it pays itself, which means it can ensure that "excess" premium revenue arises by paying (with the assistance of matching federal funds) more than needed to operate its Medicaid program. 3) Provides new flexibility to use federal Medicaid funds for non-Medicaid health programs. Through the "excess" premium revenue, Vermont can replace some of its own spending on various state-funded health care initiatives. Some 50 initiatives have been identified, such as tobacco cessation, domestic violence, and the state's medical school and public laboratory. Estimates are that Vermont may be able to secure up to \$335 million in new federal Medicaid matching funds under the waiver that it does not need to use in providing care to Medicaid beneficiaries. Instead, it can use the "extra" federal funds for fiscal relief or to expand non-Medicaid health initiatives. 4) New flexibility to reduce benefits, increase cost-sharing, and limit enrollment or set up waiting lists for most of the "optional" and "expansion" populations (groups that the state covers at its option with the assistance of federal Medicaid funds.) These populations include many children and parents in low-income working families and all other adults who are not disabled or elderly covered by the Vermont Medicaid program. Under the Global Commitment waiver, the federal government has given the state significant authority to decide if and when it will impose reductions or cost sharing increases. In the Spring, 2008 new regulations adds many significant elements to original Health Care Reform legislation. Examples: requires inventories of school nutrition and physical activity programs with recommendations on how to improve and build on these programs and how to organize grant funding for future programs based on best practices, updates on recommendations for nutritious foods available in schools and school nutrition policies, review of best practices in primary care settings for treatment and prevention of overweight in children and recommendations for insurance policies that reimburse those practices, review of practices to encourage the availability of healthy foods (esp local foods) to communities, review of best policy practices encouraging worksite wellness. In development of these reviews and recommendations, much coordination will be required between public/private health groups such as insurers, Medicaid, VDH, Depts of Education, Agriculture, and the Banking, Insurance, Securities, and Health Care Administration. In 2010, Vermont legislature passed S.88 intended to develop health care options giving universal access to care, one option being a single payer system.

/2012/ Act 48 passed which creates Green Mountain Care (GMC), a publicly financed health care program designed to contain costs and to provide comprehensive, affordable, high-quality health care coverage for all Vermont residents. The act sets out 14 principles as a framework for reforming health care in Vermont and expands the list of Vermont's ongoing health care reform efforts. It requires the creation of a strategic plan for health care reform, a proposal on medical malpractice reform, a work plan for the newly created GMC board, and several other reports and proposals to be submitted to the general assembly. The act creates an independent, five-member GMC board to improve the health of Vermonters, reduce the rate of growth in health care expenditures, enhance the patient and health care professional experience of care, recruit and retain high-quality health care professionals, and achieve administrative simplification. The act requires the state health care ombudsman to monitor the GMC board's activities. The act creates the Vermont Health Benefit Exchange (the "Exchange") in DVHA to provide qualified individuals and qualified employers with qualified health benefit plans as required by the federal Patient Protection and Affordable Care Act. GMC, a publicly financed universal health care program, can be implemented after (1) Vermont receives a waiver from the federal Exchange requirement; (2) the general assembly enacts a law to finance the program; (3) the GMC board approves the initial benefit package; (4) the general assembly passes the appropriations for the initial benefit package; and (5) the GMC board makes specific determinations about the program's impacts. All Vermont residents are eligible for Green Mountain Care, which must include at least the same

covered services as are available in Catamount Health. The act states the intent of the general assembly that all Green Mountain Care enrollees will have a primary health care professional involved with the Blueprint for Health within five years following GMC's implementation. //2012// **2013/ Legislation passed to set requirements for the health benefits exchange and requires all individual and small group insurance plans to be sold through the exchange. GMC Board members are appointed and assume responsibility for reviewing and approving insurance rates, approve first insurance rate request form BC/BS. GMC Board approved first pilot program to test different ways to pay physicians in order to improve care and efficiency and reduce cost. This 3 year pilot involves cancer care in St Johnsbury region //2013//**

The MCH Director, the CSHN Medical Director, and other key MCH staff continue to be involved in the administration of the Medicaid program. For example, through EPSDT, the MCH Director, the Director of the Office of Local Health, and other key program managers continue to assure that children and youth have access to quality health care through the dissemination and updating of the Vermont-specific pediatric periodicity schedule and the provider toolkit that accompanies it. The VDH managers work very effectively and collaboratively with Vermont American Academy of Pediatrics and American Academy of Family Physicians to continuously review, develop, and distribute best practices for pediatric care. Also, the EPSDT program has enhanced its system of regular contact with Medicaid families to inform them of their child's health needs within the pediatric periodicity schedule. In 2008, recommendations for best practice were updated to reflect the revised Bright Futures, Guidelines for Health Supervision. As of Jan 2009, OVHA is allowing providers to bill for the well child visit and the developmental screening on the same day when a standardized screening instrument is used. Any standardized screening instrument in AAP policy statement is accepted. Providers must document the screening and the instrument used in the patient record. VDH/OVHA working with VCHIP to promote full implementation. Also, DCF working with CIS teams to implement referral, intake, triage system to assist families in accessing services to promote healthy development. Although Medicaid allows PCPs to bill for developmental screening in addition to the well child visit, the provider agreements which many PCPs have with commercial insurers pose a barrier to billing Medicaid, since commercially insured patients must also be billed and their insurance often does not cover the separate screening charge. /2012/ VDH collaborated with VCHIP to provide training and TA to VT primary care pediatric practices on developmental screening, tools, periodicity, and billing. The first phase of this training was direct practice improvement process utilizing PDSA cycles and mentoring. The second phase expansion, supported in the coming year through MCHB Autism SIG, will reach more practices through a "detailing" process //2012// **2013/ In September 2012, EPSDT Program Director, Dr. Wendy Davis, and parents from AAP and VHCIP, will hold at least 8 community meetings similar to the 2008 Building Bright Futures format. New connections will be made to support Blueprint and health care reform efforts, community health teams, and strengthened links to Children's Integrated Services and Home Visitation (MIECHV)//2013//**

In Vermont, individuals with disability-based SSI are also eligible for Medicaid. A study group examined strategies for enrolling SSI recipients in the managed care plans. After a brief pilot in two counties, it was determined that the best form of managed care for these individuals would not be a pre-paid HMO model, but rather a primary care/case management model (PCCM). This PCCM program, called Primary Care (PC) Plus, began in October, 1999. However, the impact of prospective, monthly premiums on enrollments for Dr. Dynasaur continues to be of some concern. Medicaid tracks the disenrollments, and the CSHN program monitors the Medicaid disenrollment of CSHN clients monthly and notifies CSHN staff. In FY 2008 however, the Dr. Dynasaur premiums were reduced by half and then to rise again in SFY09; CSHN efforts to help families maintain continuity of coverage will need to intensify. CSHN continues to meet with Medicaid leadership to understand and improve collaboration with the new Medicaid case management initiatives, which, although targeted to adults with certain chronic conditions, do include some CYSHCN, especially those with respiratory illnesses. A significant percentage of CSHN have both private and Medicaid insurance. CSHN noting difficulties in coordination of benefits when families have both public/private insurance, leading families to drop private

coverage. CSHN SIG includes focus on health care financing analysis to help understand and advocate for policy improvements. CSHN has successfully blended its accounts payable process with that used by Medicaid and Part C. A single fiscal contractor (HP, formerly EDS) enrolls all providers, applies established fee agreements, sequences payers, and processes payments. In addition, CSHN and Medicaid have aligned their determination of medical necessity. CSHN's and Medicaid's physical therapist consultants work side by side to review authorization requests, to achieve a consistency irrespective of health care coverage //2012/ DVHA has initiated new working groups on coordination of benefits, including private coverage, Medicaid, and Medicare. CSHN representatives sit on these workgroups. In addition, through the SIG, CSHN is examining its POLR role and has proposed an administrative rule to tailor financial assistance and respite to the most vulnerable families and ensure that the State does not step in front of other coverage. CSHN financial assistance will also be limited to the birth-21 population, families below 500% FPL, and will require a Medicaid application. As part of SIG, CSHN will also be contracting with a financial technical assistance consultant to support families in selecting the most appropriate health insurance plans, navigating payor systems, and identifying alternative payors //2012// ***//2013/ As part of the final year of the CSHN SIG, CSHN contracted with a financial technical consultant to support CSHN families in navigating the complexity of the health insurance/payor system. As such, CSHN has successfully transitioned a number of patients with CSHN-subsidized private health insurance to public health insurance (to Vermont's Catamount Health, Working People with Disabilities, and VHAP programs) as well as enrolled a few patients with high prescription costs into pharmacy assistance programs. In the coming year, CSHN will enhance its provision of financial technical assistance to CSHN families through a grant to the Vermont Family Network //2013//***

Current Priorities:

The Vermont Blueprint for Health is a vision, a plan and a statewide partnership to improve health and the health care system for Vermonters. The Blueprint provides the information, tools and support that Vermonters with chronic conditions need to manage their own health -- and that doctors need to keep their patients healthy. The Blueprint is working to change health care to a system focused on preventing illness and complications, rather than reacting to health emergencies. The Blueprint is based on the Chronic Care Model. The goals are 1) To implement a statewide system of care that enables Vermonters with, and at risk of, chronic disease to lead healthier lives. 2) To develop a system of care that is financially sustainable, and 3) To forge a public-private partnership to develop and sustain the new system of care. The Model envisions an informed activated patient interacting with a prepared, proactive practice team, resulting in high quality encounters and improved health outcomes. Six components: community, health system, decision support, delivery system design, self management education and clinical information systems. Intense planning for implementing the Blue print began in 2004 and in 2007 state legislation was passed to codify Blueprint as part of health care reform and enable its provisions to be in line with the Medicaid Global Commitment. Pilot areas are working on specific aspects of Blueprint such as hospital systems, quality improvement, community care coordination, and electronic medical information systems. There are plans to coordinate BP with other Agency programs such as mental health services, elderly services, etc. In addition, planning for coordination BP concepts with pediatric medical home is taking place. //2012/ In 2010, the legislature passed Act 128 to expand the Blueprint to all hospital service areas. Each hospital service area is charged with forming planning teams. With this expansion, practice involvement will expand from internal and family medicine to pediatrics. In the expansion communities, there are currently 2 main components of clinical planning and information technology currently being developed. Blueprint for Health is being piloted in 3 pediatric practices in Vermont in winter 2011-2012. Each community will have its own decision making process for moving forward, forming teams and ensuring high quality care for children and families.//2012//***2013/ Two practices in each Health Service Area (HSA) have transitioned to the Blueprint model. Expansion is continuing, working towards involving all willing providers statewide by October 2013 in compliance with Act 128. Efforts over the past year encompassed all aspects of the Blueprint model, including: Preparing for and facilitating the transition of traditional primary care practices to become Patient-Centered Medical Homes in accordance with National Committee for Quality Assurance standards; Planning for and developing core***

CHTs in each HAS; Expanding the number of CHT "extenders" across the state; Increasing self management programs and decision-making support for patients, including new chronic pain Healthier Living Workshops and enhanced tobacco cessation support and counseling; Implementing payment reforms that involve all major insurers; Connecting practices' information systems with the Blueprint's centralized data systems, and expanding the Blueprint's health information architecture to each HAS; Enhancing and growing the Blueprint's evaluation program, allowing for highly structured reporting that can guide the activities of a Learning Health System -- a system that uses data and experience to fuel continuous improvement. //2013//

In 2008, Vermont has been awarded a CSHCN State Improvement Grant which will support an inclusive, comprehensive process for examining needs, refocusing priorities, and, above all, integrating the several complementary and overlapping redesign efforts for children and families being undertaken by the Agency of Human Services--in effect, integrating the integration. Two of these efforts--the blending of three early childhood programs (Part C, Healthy Babies, and Early Childhood Mental Health--now called Children's Integrated Services), and a new initiative to redesign services for children with disabilities, headed by the MCH director and a special assistant to the AHS Secretary--have particular affinity for CSHN redesign. The overarching goal of the initiative is to transform the existing system of care for CYSHCN into one that: serves the true population of CYSHCN, assures services that reflects evidenced based and culturally effective practice, supports delivery system in which primary care services, including early and continuous developmental screening, are provided in accordance with Bright Futures 3rd edition in medical homes with appropriate and effective linkages to the system of specialty care, assures best opportunities for access to adequate health care financing, operates within community based, coordinated, integrated systems of care, supports youth as they transition to adulthood.

//2012/ CSHN has been awarded a no-cost extension to complete the important work of the SIG. Significant headway has been made in the last year in integrating systems of care for CYSHCN through coordination between CSHN and the Department for Disabilities, Aging, and Independent Living (DAIL), under a new umbrella called Children's Health and Support Services. Further collaboration between CSHN and CIS has also taken place. Through the SIG, CSHN is poised to transition the management, staffing and operations of the majority of historically-CSHN-managed direct care services out of VDH to the tertiary health systems, redefine the role of CSHN care coordinators, to align with Medical Homes and families, implement and monitor practice improvements at the Child Development Clinic, partner in the development of a university-based Autism Center, integrate information technology with other systems of care, build capacity of medical homes and specialty care to serve CYSHCN by collocating care coordinators in practices and clinics, and retool CSHN financial assistance (as described above) //2012// ***//2013/ As of May 2012, CSHN has completed the HRSA SIG grant for CYSHCN. Major improvements were made to the operations of the Child Development Clinic resulting in significant reductions in waiting time between referral to CDC and an appointment. CDC capacity has been expanded to new locations in Vermont (Morrisville and Springfield), paperwork requirements have been reduced, and the program has moved to an electronic system which better tracks patient activity and records. A new CDC brochure and enhanced outreach to medical homes will be distributed by the end of July 2012. In FY12, for the first time, CSHN funded a pilot Autism Diagnostic Center in the Child Psychiatry Division at the University of Vermont. The Center has been successful in expanding our accessibility of diagnosis to families with children with possible ASD. It will continue to be funded next year with greater capacity. Additionally, specialty clinics that CSHN has historically subsidized and managed have successfully been transitioned to the Vermont Children's Hospital, including the Metabolic, Orthopedic, Physiatry, and Neurology clinics. CSHN continues to maintain a strong relationship with these clinicians and patients and families in order to assure quality and coordinated care for children and youth with special health needs across the state. The SIG also supported significant enhancements to CSHN's model of Care Coordination, by developing new systems, eliminating patient paperwork requirements, and transitioning to a proactive relationship with patients. Eventually, CSHN aims to expand Care Coordination to more areas of the state. CSHN continues to plan for***

an amendment to the Administrative Rule that governs its financial assistance program. As of January 1, 2013 CSHN will no longer provide financial assistance to patients over age 21, nor to the highest income families with children under the age of 21, but will transition to a system of technical assistance to support families in navigating the health insurance/payor system (currently covered families will have a 1 year grace period of coverage). As of January 1, 2014, CSHN financial assistance to families will be limited to Respite funding. Funds historically devoted to financial assistance will be reinvested into care coordination, financial technical assistance, increased respite allocations, systems development, and additional non-monetary supports for the CSHN expanded population.

//2013//Central to an agency-wide transformation of services to Vermont children and their families, CSHN was awarded management of two programs previously overseen by the Department of Aging and Independent Living (DAIL). Children's Personal Care Services and Pediatric Hi-Tech Nursing Services moved to CSHN, effective January 1, 2012. The move of these two programs, serving nearly 2,500 children, means that for the first time children may receive their Personal Care, skilled Nursing, Care Coordination, and other services through one department in an environment that focuses first and foremost on the health of children and their families. In addition, CSHN and the Department of Vermont Health Access (DVHA -- the state's Medicaid office) are collaborating on Vermont's Palliative Care initiative. Because of the high degree of overlap of children receiving both CSHN and Palliative Care services, this collaboration makes total sense. As a result, CSHN is a key player in the lives of children and youth with special health care needs across the span of birth to age twenty-one.***//2013//***

/2012/ HRSA/MCHB awarded (beginning 09/2010) VT CSHN a 3-year state improvement grant for children with autism and related developmental disabilities. Goals and activities include: (1) Partnerships between professionals and families of children and youth with ASD/DD, in the project and in all aspects of the system of care, with at least 50% parent/individual members on the Advisory Council, and support of parent participation with incentives .for time and travel. (2) Children and youth with ASD/DD have access to high quality medical homes which will use an algorithm the grant will develop, to guide children from positive screen, to diagnosis, to early intervention, and will use health care management checklists, also developed through the grant, for ASD and other DD, and will collaborate with community-based teams for children with ASD/DD. (3) Children and youth with ASD/DD have access to adequate health insurance and financing of services needed. The VT legislature recently passed an insurance funding initiative for young children with ASD, the implementation of which remains to be worked out. (4) Early and continuous screening for ASD/DD by Medical Homes will expand, leading to timely evaluation, diagnosis and appropriate treatment, through reaching all medical homes with a developmental screening practice improvement project; also, through adaptation of screening tools for children who are English Language Learners; and, through training and mentoring ,staff and parents are trained in evidence-based interventions for children < 6. (5) Community-based services are organized for easy use by families, by supporting Autism awareness activities statewide, creation of ASD resource website and phone support based at Vermont Family Network. (6) Transition to adult health care, work, by improving medical homes' capacity to provide care for young adults, and by creating and disseminating Best practice guidelines for transition are developed by and for youth and providers. The grant is implemented through in-kind program directorship from the AHS Autism Specialist, subgrants to UVM VCHIP, UVM I-LEHP (the UVM LEND program), the VT AAP chapter, VFN (Vermont Family Network), and competitively awarded subcontracts to autism service providers who are providing the training and mentorship components.

In this reporting year, CSHN completed the final years of two newborn hearing screening grants, an MCHB EHDI grant, and a CDC EHDI cooperative agreement, and applied for new funding cycles (note: both were awarded as of this writing). Major accomplishments of the VT EHDI system include: universal in-hospital newborn hearing screening; universal outpatient follow-up through the hospitals for babies were missed or need a repeat screen; accessible, in-state non-sedated ABR for diagnosis of infants by the age of 3

months, placement of and training in the use of OAE screening instruments in Medical Homes expressing an interest; placement of and training in the use of OAE screening instruments in lay mid-wife practices delivering most of the about 200 VT babies born at home who, hitherto, did not receive screening; mutual cross-border collaboration with EHDl programs in neighboring states; thorough individual case management to assure screening and diagnosis; integration with Newborn Bloodspot Screening through co-location in CSHN and data integration through the Child Health Profile, accessible to Medical Homes. In the coming years, funding will support similarly seamless integration with early intervention for children with hearing loss as well as data and quality improvements //2012// /2013/ The annual progress report for the Autism SIG grant (ASIG, Autism-SIG) has just been submitted to HRSA. The report details (1) the expanded family/consumer membership on the Advisory Council, (2) the completion of the Algorithm to guide medical homes from the developmental/autism screening of all children at standard ages, through the referral to diagnostic and early intervention services, as well as guidance for the ongoing provision of medical home care to children with ASD; (3)the stepwise operationalization of the new state legislation requiring health insurance coverage of ASD services; (4)renewed and expanded outreach to individual medical homes to promote developmental/autism screening, utilization of ASD protocols and online training modules, with a focus on the developmental screening and early intervention for young Vermonters who are part of VT's growing refugee population and other non-English speaking families, culminating in May 2012 with a two-day conference attended by nearly 200 professionals in health care and early intervention; and intensive inservices in ASD early intervention for Vermont EI providers; (5) substantial implementation and growth in the VFN Autism website for families and providers; and (6) completion of the Transition Guidance manual. We enter our third (and final) ASIG year in September 2012. With respect to the EHDl grants, among the significant achievements of this year, with the support of HRSA and CDC funding, is the implementation of hearing screening by lay midwives, using shared OAE equipment and under the training of the VT-EHDl team, resulting in the screening of homebirthed babies to an impressive degree. In addition, an expanding number of medical homes are now providing in-office OAE, with training and provided by the EHDl team. As these providers screen babies and children, the screening results are recorded in the statewide Child Health Profile, along with the data from birth hospitals. Diagnostic ABR is now available without sedation for Vermont babies, when appropriate. //2013//

Initiatives for mental health needs of children and families: see Section III E.

Healthy Babies Kids and Families and ECCS: See Section III E.

VDH in coordination with providers, schools, insurers, and others, has developed a model Health Screening Recommendations for Children and Adolescents, also known as the Vermont Periodicity Schedule (historically funded by CISS grants.) Although the federal law requires that the VDH EPSDT program determine the scope of services for children using Medicaid, Vermont developed this well child screening instrument for all children, regardless of insurance payor. A clinical providers' tool kit is available on-line at the VDH website and intended for ready access during the clinical visit.

Concern about Vermont's teens high rates of marijuana and alcohol and a growing concern about the use of illegal drugs such as heroin and cocaine has focused new planning and community based efforts. In 2003, a methadone clinic opened at Fletcher Allen Health Care in collaboration with Howard Mental Health Services. Mobile methadone clinics were introduced in Newport and St Johnsbury in 2005 and are expanding statewide. See SPM #2.

The VDH (MCH, Office of Local Health, Alcohol and Drug Abuse Programs) are responding to a growing maternal child health concern regarding high risk chemically addicted pregnant and parenting women. Identified women are referred to FAHC/UVM Comprehensive Obstetrical

Service (COS) for specialized prenatal care. Creating statewide system of care for mothers and children including mental health, child welfare, birth hospitals, home health agencies, pediatric and obstetrical practices, corrections and substance abuse providers. VDH/Vermont Child Health Improvement Program (VCHIP) and Vt Regional Perinatal Health Project coordinate with birth hospitals on transport procedures and protocols for opioid exposed mothers and newborns.

/2012/ Maternal Mortality Review Panel establish by legislation May 2011 to conduct a comprehensive, multidisciplinary review of maternal deaths in Vermont for the purposes of identifying factors associated with the deaths and making recommendations for systems changes. 2011 Vermont legislation requiring report from VDH and DVHA on high risk pregnancy - existing programs, scope of services including case management and women as identified as high-risk //2012//**2013/ Data reported to legislature on the 98 home births for CY2011. MM Review Panel is chaired by Dr Holmes, MCH Director. Rule making must occur in order to continue with the intent of Act 35. //2013/**New initiatives are being planned to combat obesity, promote physical fitness in all ages, and increase food security for children and their families. In 2003, the Dept of Ed and VDH created the Fit and Healthy Kids initiative. Funding support for Run Girl Run program designed to give middle school girls the information, training, confidence and support to make healthy lifestyle choices and expand the Fit WIC program to include non-WIC families. 2004: Vermont received CDC funding for Nutrition and Physical Activity Programs for Prevention and Control of Obesity and Related Chronic Diseases. 2005: Obesity Burden Document. 2007: Fit and Healthy Vermonters Obesity Prevention Plan. Statewide Hunger Task Force to address issues of hunger and food insecurity. Produced the provider practice resource Promoting Healthier Weight in pediatrics. Blueprint and physical activity and walking programs statewide. Developed practitioner toolkit "Promoting Healthier Weight in Pediatrics." Farm to School grants increase locally produced foods to be used in school food service programs.

Women's health's programs focus on outreach, screening and lifestyle counseling via community health providers such as FQHC and Planned Parenthood of Northern New England. The Ladies First program works to improve access to preventative health screening services, including reimbursement for breast and cervical cancer screening and heart health screening for lower income, uninsured, or underinsured women. Over 1,300 health care providers participate in Ladies First. See IVB.

In the Tobacco Control Work Plan (first issued June, 2001, latest version 2010-2011), the VDH outlines action steps for preventing youth smoking, helping smokers to quit, and reducing secondhand smoke exposure. Related policy/environmental efforts are to assist communities to work for changes in local policies, work with local programs of Vermont Kids Against Tobacco (middle school age) and Our Voices Exposed (high school age) and work with Department of Education to develop a comprehensive policy toolkit for schools to use for alcohol, tobacco, and other drugs. See NPM 15 for smoking in pregnancy.

Environmental health issues that are of special concern for children's health continue to be a focus of attention for assessment and planning. /2012/ Child Lead Poisoning Screening and Prevention: See Section IVB and SPM#6. Newly created VDH Radiological and Toxicological Sciences Program will assess radiological and toxicological human health risk from exposure to chemical toxins, radiation, electromagnetic fields, sound and other physical phenomena. This new alignment is expected to create new partnerships and to continue to serve the needs of VDH department in the areas of toxicology and radiology. VDH has applied for CDC Healthy Homes grant funding. Strategic Planning, including MCH and Injury representation in the advisory board is underway. In 2013, MCH participating in strategic planning for Vermont Healthy Homes three year strategic planning.

Vermont receives CDC funding to upgrade state and local jurisdictions' preparedness for and response to bioterrorism, other outbreaks of infectious disease, and other public health threats and emergencies. As a small state, there is a close relationship between VDH Central, the local offices, and other state and local agencies, professional and voluntary organizations, hospitals,

and the National Guard. Vermont is also developing cross border collaborations with neighboring states and Canada.

Infant mortality reduction and improving birth outcomes continues to be a high priority for the Health Department. The infant mortality rate in Vermont for 2008 is 4.6/1,000 live births. Although a low rate, our MCH surveillance reports indicate that the rates overall, tend to not be significantly different year to year. However, surveillance continues to monitor these rates that, although low, may be slightly increasing and the two leading indicators related to infant mortality, low birthweight and preterm delivery, are increasing. VDH continues to focus on the prevention of preterm deliveries and identification of psychosocial risk factors that put women at risk for preterm delivery. In 2002, the legislatively mandated Birth Information Council (BIC) was formed under the direction of the Commissioner of Health. The broad based membership of the committee recommended the creation of a Birth Information System to enhance Vermont's ability to identify and refer to services appropriate newborns with special medical conditions. CDC and state funding is being used to support the position of a Birth Information System Coordinator to implement the system. VDH grant to Vermont Child Health Improvement Program (VCHIP) for a variety of deliverables on improving birth outcomes, including training for neonatal health care providers, QI assistance for birth hospitals, and a web-based data registry (OBNet) collecting information on maternal-fetal risk factors, interventions and outcomes. In addition, VDH has implemented a Folic Acid marketing campaign, and distributing multivitamins non-pregnant WIC clients. /2012/ The VDH implemented the Birth Information Network (BIN) with the 2006 birth year. The BIN includes infants with special health conditions such as birth defects, hearing loss, metabolic and endocrine conditions and infants born at very low birthweight. When the legislation authorizing the collection of data for the BIN was passed, the wording inadvertently precluded the ability to add new conditions. This winter the VDH successfully introduced an amendment that added two birth defects to the list of conditions included in the BIN, and a process to allow the VDH to amend the list of medical conditions through rule-making//2012// ***/2013/ CSHN continues to work closely with VDH Health Surveillance in support of BIN. Families whose newborns have been identified as having been born with health or developmental challenges are referred to CSHN for services. The CSHN Social Work Supervisor, a master's prepared medical social worker, ensures that there is a contact made to each family. Families are provided information about CSHN and VFN and CSHN maintains a log of all contacts in its client database. //2013//***

In 2002, VDH and the Department of Education received a CDC infrastructure and expanded school health coordination grant. At both the DOE and VDH there is a designated coordinator whose purpose is to work with community schools on the CDC coordinated school health model of coordinated school health services, programs, and policies in schools under the broad definition of school health. Each participating school or school district is encouraged to create a School Health Action Committee that plans individual school responses to the nine components of the School Health Model (such as enhancing clinical services, supporting healthy nutrition, promoting staff wellness, etc.) Goals of the program include increasing communication and collaboration between DOE and VDH on all levels, especially at the state planning level and within individual schools. The School Health Coordinating Council (DOE, VDH, School Principals' Association, Vermont School Boards' Association, and Vermont School Superintendents' Association) meets monthly to coordinate statewide health related activities and policies for school aged children. In 2009, VDH did not receive grant renewal for the Coordinated School Health Grant from CDC. Efforts were made to maintain the gains made during the 7 years of the grant-funded programs utilizing existing resources. A major success has been that the EPSDT school data system now allows for ready access to school nurse reporting on various elements from school nurse survey. For example, in the school year 2007-08, 80% of students reported having some sort of health insurance, 55% reported having a well child exam in the last year, and 62% reported being seen by a dentist for a dental checkup. In 2009, work with AAP, AAFP, School Nurse Association, Principals/Superintendents/School Boards Assns/VCHIP/DOE resulted in a plan for wellness exams designed to combine school-required school sports physical and traditional annual exams using Bright Futures standards. One result being that students needing a "sports physical" will receive compete BF wellness exam. Also, in 2009, VDH created

a newly created position of state school nurse consultant: duties are to maintain/update school nurse standards of practice and provide TA to school nurses/VDH staff. In 2009, a newly signed MOU between VDH and DOE will jointly approve standards in School Nurse Standards of Practice Manual. Newly established Joint Committee to research and make recommendations to Commissioners on issues such as school nurse ratios, training, telemedicine, coordination with medical homes, etc. In 2009 an update to Vt Title 16 aligns school vision/hearing screening to AAP Bright Futures Guidelines, thus avoiding the duplicating of screening activities. In 2010, there are plans to create an on line new School Nurse Orientation program. This is a required component for DOE school Nurse certification. This course is a collaborative effort between VDH and DOE and will include clinical practice guidelines as well as program recommendations such as CDC's Coordinated School Health Model. The improved access to this on line format will enable new school nurses to become certified by DOE through out the year as opposed to once yearly during a summer course which historically has been difficult to attend by new nurses. The Standards of Practice; School Health Services manual has been completely up- dated in 2010, and will be reviewed each year by a sub-committee to the Joint School health Committee to assure it remains current with evidence based practice.

In 2000, the Vermont legislature passed Act 125, which directed the Departments of Health, Education, and Buildings with the implementation of interventions to create safe and healthy school buildings. An Act 125 Task Force was created, with representation from many organizations addressing asthma in particular. The work of the Task Force led to the development of the Envision Program at the Health Department. The Envision Program provides grant funding to schools to participate in a model school environmental health program that is based, in part, on EPA's Tools for Schools. Technical assistance provided includes information about implementing measures like safe cleaning practices, regularly scheduled heating and ventilation maintenance, and alternatives to pesticides to reduce asthma triggers. All of the schools participating in the Envision program are at different stages of incorporating the best practices to reduce exposure to environmental triggers. IN Spring, 2012, passage of Act 68, requiring use of safe cleaning products in schools to improve indoor air quality and environmental conditions.

After the AHS reorganization in 2005, the CSHN director is now a participant in the interagency/consumer committee reviewing home care programs now clustered in the new Department of Disabilities, Aging, and Independent Living; these include Medicaid Personal Care Services, High-tech program, and the Medicaid Home and Community Based Services Waiver for Developmental Services (all of these programs are Medicaid-funded). The focus is on improving the PCS application process for children and maintaining supports in a year of severe budget cuts in Medicaid. CSHN is also exploring assuming the responsibility for clinical determinations of Katie Beckett Option (TEFRA option; in VT also known as the "Disabled Children's Home Care Program"--DCHC) eligibility. CSHN is also represented on the VT Developmental Disabilities Council; the DOE Regional Autism Centers Initiative; the Autism Task Force; the TBI board; the ICC for Part C. In 2008, CSHN spearheaded an interdepartmental committee to reassign responsibilities for Katie Beckett (KB) determinations. The Disability Determination Unit within the Department for Children and Families, which already determines SSI eligibility and also the first step towards KB eligibility, began, in November 2006, to complete the institutional level of care determinations for KB as well. The CSHN program feels this change has been working very well. The Regional Autism Center discussion prompted a new legislative directive, S. 121, creating a statewide, inclusive study process, to result in a report and a plan-for-a-plan. CSHN also participates in the re-design process for the Hi-tech home care program for children (Medicaid-funded, within the Department of Aging and Independent Living). UVM's VCHIP program added a new focus on chronic disease in children; the CSHN medical director is the liaison to VCHIP for these projects. The CSHN medical director joined the VT Developmental Disabilities Council in June, 2008, replacing her membership on the ICC for Part C. In 2010, CSHN Medical Director becomes a member of newly formed Autism Advisory Committee and the Pervasive Developmental Disorders Diagnosis Committee. CSHN continues on the Consumer Advisory Board for UVM's UAP, grant to the UVM LEND program, Vt Interdisciplinary Leadership

Education for Health Professionals /2012/ Through the CHASS initiative, families will benefit from a streamlined and more coordinated intake and initial assessment process that will, once fully implemented, ensure that there is "no wrong door" into CSHN, Children's Hi-Tech, Children's Personal Care Services, Children's Palliative Care Services, or Care Coordination. Additionally, CHASS intake and assessment will identify families for whom Enhanced Family Services (EFS) may be indicated. EFS represents state services geared toward children and families confronting behavioral and mental health concerns, perhaps in addition to physical and developmental complications //2012//

/2012/ Federal ACA funds have created many opportunities for furthering MCH and public health services and systems infrastructure for Vermont: Personal Responsibility in Education (PREP) received from ACF. This joint VDH-DOE project will implement evidenced-based curricula on comprehensive sex education to high risk youth, including youth in foster care, runaway and homeless youth, and incarcerated/adjudicated youth. ACA Pregnant and Parenting Teens/Women funds were granted to DCF to support the Learning Together Program, which was developed in VT in the 1980's. Provides comprehensive supports to pregnant and parenting teens and young women in all VT Parent Child Centers with focus to learn parenting and job skills, complete their high school education, and gain confidence in life skills. ACA Maternal Infant Early Child Home Visiting funding supports the implementation of evidenced based home visiting programs to at-risk communities and their vulnerable families who are low income young parents. Vermont instituted a process of home visiting needs assessment and evaluation of counties using the criteria as required in the grant guidance. The home visiting model selected is the Nurse Family Partnership that will be first implemented in the communities/counties of Franklin, North East Kingdom, Rutland, and Bennington. The nurse home visiting model was selected due to its well researched effectiveness, significant technical assistance, and ability to complement other existing community resources. A statewide program coordinator will begin July, 2011 with the first two communities being enrolled fall, 2011. The MIECHV program will be closely coordinated with the CIS system of care//2012// **/2013/ MIECHV NFP model has begun to enroll families in northern Vermont and planning for central Vermont has begun. Implementing this program involved significance community collaboration for referral systems with service providers, creation of contracts with home health agencies, recruitment and hiring of nurses through home health agencies, and attendance at NFP trainings in Colorado. Pew Trust has supported statewide home visitation workgroup to assess home visitation programs and create opportunities to strengthen their scope and evidence base. In 2012, Vermont ACA/PREP funds were distributed through grants to 8 community-based agencies serving high-risk youth across the state. The program addresses pregnancy and STI prevention through contraception and abstinence, as well as three adult preparation topics; Vermont has selected healthy life skills, healthy relationships, and adolescent development. Vermont is using the evidence-based curriculum: Reducing the Risk curriculum, which is also used in many middle and high schools across the State. Approximately 400 youth will be served each year through the PREP program. //2013//**

Vermont Department of Health Planning Initiatives (See also III B Agency Capacity and III E State Agency Coordination) VDH is working to improve health outcomes using the framework of social determinants and also the Lifecourse approach to public health interventions. Several trainings for VDH staff have been held on both approaches over the past several years, some trainings organized by the Boston University School of Public Health via MCHB grants. The recently released "Health Disparities of Vermonters" examines health disparities via the framework of social, educational, and economic parameters in addition to racial/ethnic status. This report is influencing VDH strategic planning and will also inform MCH strategic planning.

/2012/ 2011 began a major MCH strategic planning process which is aligned with VDH strategic plan. MCH strategies identified that are congruent with VDH goals -- at present activities are being determined that will align with PH need, program capacity and funding. Healthy Vermonters 2020 planning is finalizing the selection and prioritization of Vermont-specific objectives as related

to Healthy People 2020. The selected objectives and related strategies will be coordinated with the planning efforts described in Title V and the VDH strategic planning. VDH MCH Director working to align these planning initiatives with AHS Planning and 10 AHS Outcomes (from which the Title V Ten Priority Goals are modeled.) Other examples of other ongoing major planning initiatives: Oral Health Plan, Obesity Strategic Plan, Injury Prevention, Prenatal Smoking Cessation, Domestic Violence Prevention (via AHS), Blueprint for Health, Suicide Prevention, Cancer Prevention, Asthma Prevention. Major planning in 2011 included needs assessment and planning for the MIECHV ACA funded home visiting program, model selected is Nurse Family Partnership. The CDC funded National Public Health Improvement Initiative is funding a staff person to improve the capacity and performance of Vermont's public health systems. VT is using the technique of "Public Health Stats" in which information on all data, capacity, and issues relating to a specific public health issue is organized and key players meet to assess and develop intense structured action plans for a public health response. The first PH STAT, held June, 2011, was on Immunizations. Second PH Stat will address Injury Prevention. Efforts continue to incorporate Life Course Health Development into planning and program implementation. Presentation by Boston University staff on LCHD to VDH staff November 2010. PH Grand rounds on LCHD to CVDH staff on March, 2011. SSDI Goal 4 to develop life course performance metrics by use of National Survey Children's Health/BRFS data. SSDI supported planning also includes preconception health report, analyses of PRAMS and BRFS on adverse child events. //2012// See IVB for state planning. 2012-2013 PH STAT priority areas are: obesity, tobacco, youth and young adult substance abuse prevention, and immunization.

An attachment is included in this section. IIIA - Overview

B. Agency Capacity

Preventive and Primary Care Services for Pregnant Women, Mothers, and Infants:
Prenatal and Postnatal Program: The Healthy Babies, Kids and Families System of Care has become incorporated into the Children's Integrated Services along with the programs of Part C and children's mental health services. See III E.

Family Planning Program provides medical services: physical exams, screening for cancer and sexually transmitted diseases, contraceptive methods and pregnancy testing; education and counseling about reproductive health, breast self-exam, STD/HIV risk reduction, pregnancy and infertility; and community education programs. Services are provided via funds contracted to Planned Parenthood of Northern New England (PPNNE), and are offered at PPNNE sites statewide. All services are available via sliding fee schedule for those with incomes up to 250% FPL; no one is turned away because of inability to pay. SPM #1. ***/2013/ VDH/Medicaid grant funding to PPNNE via ACA provisions allowing PPNNE to be reimbursed for clinical services to patients with incomes under 200% FPL. //2013//***

Pediatric Genetic Services are provided via VDH contract with FAHC Children's Health Care Services which operates the Vermont Regional Genetics Center. Services include genetic counseling to families, evaluation, diagnosis, and treatment of genetic conditions; public information programs about teratogens, a pregnancy risk information toll-free hotline; and TA to VDH (NBS/metabolic.) The pediatric geneticist participates in the CSHN Metabolic Clinic and Newborn Screening Program, and the CSHN Craniofacial program. Newborn Screening Program provides for the genetic screening of occurrent births via legislation adopted in 1996. In 2005, legislation upgraded the NBS panel to include 14 additional conditions. Thus, of the 29 ACMG recommended conditions, Vermont screens for 28 in all birth hospitals. Vermont uses the New England Newborn Screening Laboratory at UMass for processing specimens. Organizationally, NBS is a program within CSHN and includes both "heelstick" and hearing screening components. The NBS Advisory Committee recommended adding cystic fibrosis to the screening panel. Thus CSHN has developed a new fee structure to support both heelstick and hearing lab and follow-up components./2012/ As part of CSHN's initiative to provide less direct health care services in

isolation, clinics will be migrated to their tertiary medical center locations and, as of September 2011, the Metabolic Clinic will be housed at the FAHC offices of the pediatric geneticist and pediatric ambulatory care center. CHSN will continue to provide grant funding to support the program and will fund a part time nutritionist to help coordinate the program and provide nutritional follow up and guidance. Travel clinics will continue to be held by the pediatric geneticist and her team //2012// **/2013/ This transition occurred. The CSHN nutritionist is located at the Genetics office half time and coordinates Metabolic Clinic //2013//**

Vermont Regional Perinatal Health Project at UVM/VCHIP (partially funded by Title V) provides professional education, transport conferences, and statistical analysis for individual hospitals and providers who treat medically high-risk pregnant women and neonates. Close collaboration with many statewide initiatives, such as the Birth Information Council, and QI efforts with birth hospitals. A 2009 March of Dimes grant allows statewide research project to assess adherence to obstetrical standards for low risk elective inductions and elective Caesarean sections and pediatric standards of care for late preterm infant with goal to reduce the rising rates of late preterm births. See NPM 17. /2012/ VRPHP will provide technical assistance and will participate in the advisory committee of the newly created Mortality Review Panel as established this year in 18 VSA, chapter 30 //2012//

The Special Supplemental Nutrition Program for Women, Infants and Children, a VDH program, provides individualized nutrition counseling, breastfeeding promotion and support, health screening & referral and specific nutrient dense foods to income eligible pregnant, postpartum and breastfeeding women and infants and children who are under age 5. Four of 12 districts have breastfeeding peer counselor programs for enhanced breastfeeding support. Vermont home delivers most WIC foods through contracts with local vendors, and provides a small fruit & vegetable cash value benefit through an electronic benefits transfer card that can be used at participating retail grocers. The card uses the 3SquaresVT/SNAP infrastructure. WIC also partners with DCF to provide Farm to Family coupons for produce purchases at selected farmers' markets. The DCF partnership also includes automatic referrals from DCF to WIC, based on new enrollments and recertifications in the Medicaid and 3SquaresVT programs, and screening and enrollment assistance for DCF programs by WIC staff.

WIC integrates or coordinates with other programs including but not limited to EPSDT, Lead Poisoning Prevention, Immunizations, Children's Integrated Services, family planning and birth defects prevention. WIC manages a comprehensive and innovative breastfeeding education and support program in all districts, see NPM #11.

/2012/ VDH/WIC partnered with Healthy Mothers Healthy Babies Coalition to offer expectant mothers and new moms health information to their mobile phones via text4baby program/2012//**/2013/ Much WIC programming designed to increase breastfeeding rates such as developing and implementing trainings for WIC staff and health care providers. WIC received a USDA performance bonus for breastfeeding peer counselor programs. Using these funds, WIC created a QI project with VCHIP and UVM OB Faculty to do comprehensive training at Vermont's community hospitals for breastfeeding support after delivery. See NPM 11. //2013//**

Preventive and Primary Care Services for Children:

See also IIIC

Immunization Program: See NPM 7. Vaccine Purchase and Distribution Program purchases vaccines, conducts assessment of immunization coverage, conducts surveillance of vaccine preventable disease, assists in outbreak control, provides education and TA for clinical providers and the public, and develops policies and plans that support immunization strategies and evaluate effectiveness and QA activities. The vaccines purchased by this program are provided without charge to physicians who participate in the Vaccines for Children program. Vermont has a system of universal vaccine accessibility for children. /2012/ Increasing childhood immunization rates remains priority - issues of complicated administration schedules and restrictions on certain vaccine availability. Planning for expansion of immunization payment system with insurers. Plans for statewide comprehensive social marketing campaign targeted to parents who have

reservations on giving their children immunizations and to providers who see these parents in their practices. 2008: VDH Immunization Regulations for kindergarten entry were changed to address new recommendations of the ACIP. Students entering kindergarten must provide documentation of the following vaccines: 5 doses of DTaP, 4 doses of polio, 2 doses of MMR, 3 doses of hepatitis B, and 2 doses of varicella. VT has experienced recent increases of the use of provisional status and philosophical exemptions by parents for school entry. VDH to increase public awareness and acceptance of immunizations and support to practitioners to encourage parents to immunize their children. New immunization simplified schedule format on VDH website http://healthvermont.gov/hc/imm/documents/vt_schedule_kids.pdf **//2013/ *Continued work to educate and support practices to fully immunize their patients. Act 157 passed requirements for schools and child care centers to make publically available the aggregated immunization rates of the student body for each vaccine necessary to attend a school or child care facility. Allows a philosophical or religious exemption for immunization. The proposals in this legislation stimulated significant public attention and discussion. VDH/MCH Act 157 follow up: VDH to receive reports from schools and child care of aggregated immunization rates for the student body for each vaccine; VDH to update exemption forms and identify or create evidence-based educational materials; VDH to collect data for 1st and 8th grade students on number of each type of exemption filed for each vaccine and number of provisional admittance students; VDH to convene work group with DoE to study how to protect immunocompromised students and students with special health needs and report. MCH director will be convening a work group this fall. //2013//***

Childhood Immunization Registry records immunizations and tracks eligibility for the VFC. Birth data is entered automatically within 10 days via the Vital Births data system. The Newborn Screening data and the Hearing Outreach data are presently being connected to the Immunization registry via secure web interface within the VDH SPHINX database so as to be available to clinical providers.

Early Periodic Screening, Diagnosis and Treatment (EPSDT) coordinates closely under an interagency agreement with DCF and the state Medicaid agency. Services for children (families making up to 300% FPL) include: education on preventive health care/age-appropriate health screening; assistance with scheduling medical/dental/ health-related appointments; assistance in locating medical/dental providers; information/referral on health and community services, and targeted follow up. **//2013/ *Annual grant to Vermont chapter of the American Academy of Pediatrics and the Vermont Academy of Family Physicians to improve population-based health outcomes for Medicaid-eligible children and their families (required by federal mandate); current areas of focus include: increase access to health care, health maintenance and preventive care, screenings (especially early/continuous developmental screening per national guidelines,) improving immunization coverage rates in children, improving blood lead screening rates in children. Annual grant to the Vermont Child Health Improvement Program (VCHIP) to improve health outcomes for Medicaid-eligible children/families: Perinatal data collection; outreach for training and technical assistance to obstetrical providers to improve perinatal health care; quality improvement in children's health care provider offices; child mental health systems improvement; integration of preventive behavioral health care in provider offices and community settings; advancing Vermont's "Blueprint for Health" in children's health care provider practices; quality improvement with pediatric specialists (to improve systems of care for Children and Youth with Special Health Care Needs. School Health: Administration of the (federal) Medicaid Administrative Claiming (MAC) program. Provides access to federal funding for school health-related initiatives, with emphasis on utilization of Health Department School Nurse Report and Youth Risk Behavior Survey data. Current spending priorities include: School Health Services; Guidance Counselors; Implementation of the CDC Coordinated School Health Model; Support Student Assistance Professionals; Tooth Tutor (connecting students to "dental homes") and fluoride rinse programs; Development/promotion of school wellness teams and policies (focus on physical activity and healthy nutrition); Support youth tobacco prevention and cessation programs; Purchase/effective utilization***

of electronic student health records. School-based Immunization Improvement Project: quality improvement initiative involving Health Department District Office-based school liaison personnel and school nurses as a connection to parents and children's health care provider practices in order to improve immunization coverage rates among school-aged children. Epidemiology/Laboratory Capacity Grant: Funding to assist school nurses in acquiring software for electronic student health records (EHRs). EHRs are then used by school nurses to report school-based disease surveillance information and to improve compliance with Vermont immunization regulations. //2013//

Nutrition Services Program (Non WIC and Non CSHN) Integrating nutrition into the Department of Education's Comprehensive School Health Guidelines. Providing training curriculum for teachers and health education staff. Activities related to reducing obesity as contained in Fit and Healthy Vermonters, the state obesity prevention plan -- key elements of community support, early childhood, empowering parents, access to healthy food in schools, access to healthy and affordable food, increasing physical activity. Participation on the Governor's Hunger Task Forces, working with community coalitions to promote nutrition and physical activity interventions, and identifying policies and best practices for environmental changes to support health behaviors. Community success stories around work with farmers markets, increasing physical activity opportunities, school wellness awards. See SPM #3. ***//2013/ Planning for new focus on worksite wellness and use of provider toolkits for pediatrics and adult. Working with child care facilities for increasing nutritional content of meals served at the site or brought in by parents. PH STAT for obesity in July, 2012 //2013//***

Office of Oral Health: See HSCI IIIF.

System of Care for Children with Special Health Care Needs:

PYRAMID LEVEL: DIRECT SERVICES:

CSHN continues to manage and subsidize a statewide network of multidisciplinary services: Clinics/Programs which are directly staffed and managed by CSHN include: Orthopedics (including also Hand and Myelomeningocele); Child Development Clinic, Metabolic, Craniofacial, and Feeding Clinics, and Seating, Nutrition, and Hearing (Hearing Outreach Program and Hearing Aid Purchase) Programs. Clinics/Programs which are supported through contracts, and which CSHN staff (nursing and/or social work) attend are: Cystic Fibrosis, Juvenile Rheumatoid Arthritis, and Neurology/Epilepsy. Clinics/Programs which we support through contract: Dartmouth Child Development Program (CSHN and Dartmouth co-fund the clinic coordinator), Hemophilia, FAHC NICU medical follow-up (providing the developmental screening component) and Vermont's LEND clinic. CSHN has become a direct provider of "Therapy Clinic" services under Medicaid, through which community based PT, OT and SLP are enrolled as credentialed providers, contractor-employees of CSHN, which, in turn, is able to bill Medicaid. The "Clinic" delivers therapy services directly to children in their homes. CSHN continues its intensive review of the Child Development Clinic, redefining its proper niche as a provider. CSHN is expanding contracts with Dartmouth, and continuing contracts with UVM for this purpose. The St. Albans CDC site has been active for about a year, with the lowest no-show rate in the state and much positive feedback from providers and families. A pediatric urologist arrived in April 2007. We have added a pediatric physiatrist (physical medicine and rehab), contractor, part-time, as a part of our orthopedic program. A full-time pediatric neurosurgeon began her practice at FAHC/UVM in Spring, 2008 and participates CSHN Myelomeningocele program. Recent reductions in the number of state government positions have affected all areas, including direct services in CSHN and elsewhere. CSHN has not been able to fill most of the year's nursing and social work retirements/resignations at this time. As of 2010, The NFI grant aims to refocus efforts towards specialized care coordination in partnership with primary care, and to expand Child Development Clinic resources in connection with AHS Integrated Family Services. This year, three regional orthopedic clinics were ended, with staff supporting families towards the care of tertiary specialists. CSHN has increased access to physiatry services through an itinerant clinic team model not available at tertiary care, thus reaching a broader population of children with physical disabilities (beyond those who might have needed orthopedic surgery at a point in time) and

addresses adaptive and mobility needs, as well as including adolescents.

/2012/CSHN no longer directly manages/houses the majority of children's specialty clinics, including those identified above. As of September 2011, CSHN will no longer manage the metabolic clinic. January 2012: CSHN will no longer manage the Physiatry or Orthopedics clinics. The management, staffing, and operations of these clinics will be transferred to services at FAHC and DHMC, the two regional hospitals with specialty services for children. The Feeding Team will likely be transferred in June 2012. CSHN will provide liaison support (RNs and Social Workers) through this transition period. All patients will be eligible for care coordination, as described below. CSHN will continue to coordinate and host the Child Development Clinic and the CranioFacial clinics. CSHN has been working on targeted practice improvements at CDC, to increase the number of referrals to CDC, unburdening the paperwork requirements, improving the timeliness in seeing patients, and the turnaround of comprehensive diagnostic reports, all with attention to best practices. July 2011: CSHN is partnering with and funding a university-based Autism Center pilot; the Center will see 40 Medicaid patients in its first year of programming //2012// ***/2013/ Specialty clinics that CSHN has historically managed have successfully been transitioned to the Vermont Children's Hospital, including the Metabolic, Orthopedic, Physiatry, and Neurology clinics. CSHN continues to maintain a strong relationship with these clinicians and patients in order to assure quality and coordinated care for children and youth with special health needs across the state. CSHN continues to operate the Child Development and Craniofacial clinics. Significant practice improvements and quality assurance systems were implemented at the Child Development Clinic, to decrease the waiting time between referral, appointment, and diagnostic report, as well as expand services in some parts of the state, limit the paperwork burden on families, and outreach to the primary care provider population across the state. //2013//***

PYRAMID LEVEL: ENABLING SERVICES

CSHN Financial Assistance Program: CSHN continues to provide after-insurance funding of medical services when these services have been pre-authorized by CSHN clinical staff and when they fall within the range of services permitted by CSHN guidelines. Changes (largely reductions) in Medicaid accessibility (increased premiums; tighter interpretations of medical necessity) have resulted unavoidably in some costs shifts to CSHN, but more importantly, loss of coverage of other services for CSHCN, such as primary care. CSHN staff work diligently to help families apply for and maintain their children's Medicaid coverage. In 2008, all three of the independent PT/OT/ST agencies providing services to children have experienced major setbacks this year. One has closed; one is no longer willing to bill Medicaid, which will result in a cost shift to CSHN for services CSHN prescribes; and one has decided not to enter any agreements to bill insurance (and has never accepted Medicaid). Other regional therapist shortages have also complicated service coordination and access for families with CYSHCN. However, as of 2009, all therapists in private practice are now eligible to enroll as Medicaid providers (institutions and clinics have been eligible for many years.) CSHN, therefore, is requiring, as of 12/31/09, that therapists complete enrollment in Medicaid in order to serve CYSHCN who use Medical. The fee differential between CSHN payment and Medicaid payment for PT/OT is minimal and CSHN will assist therapists in the logistics of enrollment. Speech therapy remains a funding challenge and may not be subject to the Dec date. ***/2013/ CSHN continues to plan for an amendment to the Administrative Rule that governs its financial assistance program. As of January 1, 2013 CSHN will no longer provide financial assistance to families, but will transition to a system of technical assistance to support families in navigating the health insurance/payor system (currently covered families will have a 1 year grace period of coverage). These funds will be reinvested into care coordination, financial technical assistance, and additional supports for the CSHN expanded population //2013//***

Special Services Program: CSHN continues to provide medical care coordination, through regional social work and/or nursing, and financial access to specialized services, for VT children who have a condition that CSHN covers but for which no established clinic exists. CSHN pediatric nurses and medical social workers are based in regional offices and are involved in care

coordination. Families are referred to CSHN from hospitals, Medicaid high-tech program, and others; CSHN MSW's are also members of the regional Part C Core teams (direct service teams); this role has continued, even though the Part C program has been transferred to the new Department for Children and Families in the AHS reorganization. The 2009 state position cutbacks have strained our capacity to cover all FITP regions.

CSHN has successfully blended its accounts payable process with that used by Medicaid and Part C. A single fiscal contractor (HP, formerly EDS) enrolls all providers, applies established fee agreements, sequences payers, and processes payments. In addition, CSHN and Medicaid have aligned their determination of medical necessity. CSHN's and Medicaid's physical therapist consultants work side by side to review authorization requests, to achieve a consistency irrespective of health care coverage. The NFI grant continues to support an examination of the future role of CSHN as a health care payer.

In response to the Challenges for Change mandates, CSHN is discussing, with programs serving overlapping populations of children, how best to integrate our approaches to eligibility and care coordination. The programs are part of the Department of Disabilities, Aging and Independent Living (DAIL), Division of Developmental Services, and include the Children's Personal Care Services program, the Bridge Program (regional DS case management, through community-based non-profits), and the Children's Hi-Tech program (in-home nursing for children assisted by technology). Both the cross departmental planning and the DAIL use of non-profits are particular "challenges" for "change."

Respite Care Program: Families receive annual grants or reimbursements to defray the cost of hiring respite care providers. Allocations are based on the skill level of the care needed; eligibility is based on enrollment in CSHN, income and ineligibility for respite care from other programs. For 2010-2011, in the CSHN budget, eligibility criteria, and allocation amounts remain unchanged at \$295,000. Enrollment is projected at 520 families, including 15 who receive a \$150 one-time allocation, while waiting for respite from the Division of Developmental Services. ***//2013/ CSHN continues to manage a robust respite system for families, and provides funding to the Vermont Family Network to provide a statewide system of family support, through a support line, informational/ educational materials, and support groups. //2013//***

In-Home Support Program: Medicaid funds Personal Care Services (PCS) for in-home support for children with severe disabilities. CSHN serves as one of several access points providing referral to PCS. As of 2010, CSHN MSW's continue to perform PCS renewal applications for a small number of long-term patients. Home health agencies providing direct services, and Developmental Service agencies which have received new case management staff are providing many new and renewal applications for families. Some FITP regions also perform this service for their families. VFN has also received permission from Medicaid to perform assessments/applications.

Nutrition Services: CSHN/Part C-IDEA and a state-level pediatric nutritionist who is developing and expanding the capacity of community-based nutritionists to provide local consultation to CSHCN. The state CSHN nutritionist reviews each client evaluation, assists in the development of the plan of care, and provides technical assistance in the treatment. CSHN also manages a nutritional formula program for children needing special formulas or "nutriceutical" treatment of their chronic condition. CSHN developed agreements with the major insurers and Medicaid to function as a clearinghouse for medical foods for children. In a small state with few nutritionists, it is often a struggle to maintain staff continuity in each of the 12 AHS regions. The CSHN nutrition consultant fills in, as she is able, while recruiting local dieticians to join the network. As of 2010, the CSHN nutritionist has recruited and trained 3 new regional nutritionists for the state. Only one region remains without regional coverage; the CSHN nutritionist continues to serve the region directly in the interim.

Family, Infant and, Toddler Project (FITP) is the statewide early intervention system of care for infants and toddlers with developmental disabilities, funded by Vermont's federal Part C-IDEA

grant, now transferred to AHS DCF - each of the 12 AHS districts has established its own regional planning team, designated host agency and developed programs that comply with Part C rules. CSHN regional social workers are members of FITP regional interdisciplinary service teams.

/2012/ CSHN is also making significant system improvements related to "enabling services". Firstly, CSHN is redefining and reemphasizing the role of care coordination. As CSHN moves away from direct health care clinic-based services, nurses and social workers will move into a role of providing care coordination across varying levels of service, to include: resource and referral, assistance in completing applications for Medicaid, Katie Beckett, Children's Personal Care, etc., consultation to early intervention teams, support around transition and other critical developmental periods, hi-tech nursing, medical and educational care conferences, liaison with medical homes and specialty care, and psychosocial support. As such, CSHN will expand its definition of CYSHCN to include populations that were not traditionally served by the program, including children with cancer, diabetes, and asthma. CSHN has planned a major overhaul of its financial assistance program. A pending Administrative Rule would alter the "entitlement" that current exists and transform CSHN financial assistance to its intended role of POLR. New limitations will be imposed: restricted to the birth to 21 population (currently service adults with CF and women with PKU), a cap at 500% of FPL, and the mandate that families first apply for Medicaid and other state-sponsored health insurance programs. In place of the current system, a supplemental assistance program will be developed which will require that all other payors be exhausted, an application, and a review by CSHN staff or its designees. CSHN will also review its respite program and eligibility. CSHN will be contracting with a financial technical assistance consultant to work individually with families in selecting the most appropriate health insurance plans, navigating payor systems, and identifying alternative payors. CSHN is examining its nutrition network and identifying ways to partner with VT's Blueprint for Health to provide community-based nutrition services to CYSHCN statewide, through a coordinated system that is covered by private and public health insurance. Up until now, Title V and Part C have been the only willing payors for pediatric nutrition services delivered in community-based and family home settings. CSHN provides ongoing support to the Vermont Family Network to provide a statewide system of family support, through a support line, informational/ educational materials, and support groups. VFN also offers ongoing training and education opportunities for families CYSHCN, as well as professionals and paraprofessionals working with this population. Support to VFN has expanded through the HRSA VT SIG autism grant which is funding a staffed resource center and website for autism information for families and providers. CSHN is also supporting the Vermont Family Network to develop educational materials on the "Six Ways" to access Medicaid and a guide on transition for CYSHN into the adult medical and educational systems. Please refer, also, to description of the infrastructure activities of the VT SIG autism project, under State Agency Coordination //2012//**2013/ CSHN has made significant enhancements to CSHN's model of Care Coordination, by developing new systems, eliminating patient paperwork requirements, and transitioning to a proactive relationship with patients. Eventually, CSHN aims to expand Care Coordination to more areas of the state. CSHN has not been able to expand the definition of children it serves this year, but aims to do this in the coming year. This year, CSHN has also initiated a Medical Home pilot project, in which a CSHN medical social worker has worked one day a week in a pediatric Medical Home, both to help the practice problem-solve around connecting children and families to community resources, and to help the practice develop its own care coordination processes. The pilot has also served to document the scope of the need for Medical Home care coordination and to develop a role definition for a Care Coordinator within a Medical Home. The pilot has expanded to a second practice, and will multiply with the addition of another MSW in another region of the state. (See also Infrastructure, below.) //2013//**

PYRAMID LEVEL: POPULATION-BASED SERVICES

Newborn Screening Follow-up: See NPM 1. Vermont has strong newborn screening programs, assuring that well over 90% of all newborns are screened in a timely way and receive timely

followup. Since July 2003, all VT birth hospitals have screened all newborns for congenital hearing loss. CSHN is responsible for the assurance and follow-up, overseen by a full time pediatric audiologist (through a grant to UVM), and largely implemented through the direct service of the Hearing Outreach Program, also by pediatric audiologists. Vt is charged with sustaining these population-based efforts through fees, rather than grants. The VT legislature has passed the Birth Information Network statute, and the CDC has funded its initial development and implementation, with the goal of earliest possible identification of certain congenital conditions and the assurance that identified babies have access to needed early intervention and health services. CSHN also participates in population-based screening (by referral) through HOP for older children up to age three, or those of any age who are difficult to screen by other methods.

In 2007, the CDC funded a new cooperative agreement with CSHN/VDH to integrate the screening and tracking information currently housed in MS Access databases into the emerging VDH "SPHINX" information system. NBS/UNHS will join ERBS and the immunization registry in a child health status integrated database, with web-based inputs and outputs. Statewide CF screening, implemented on March 1, 2008 - preparation included protocol development with three tertiary care centers who will provide follow-up sweat testing and counseling for positive screens, outreach education to PCPs, and cross-state-border discussions. In 2010, the implementation of the newborn hearing screening data system has begun, so PCPs can access their patients' results through the web-based Child Health Profile.

/2012/ CSHN continues its strong programming in newborn screening (hearing, metabolic and other conditions) as well as fully opening access to this information to Medical Homes, through the Child Health Profile. Newborn hearing screening has been taking place in every VT birth hospital for many years. However, until this reporting year, babies who missed their inpatient screenings were not always able to return there for a timely screen. With support of the HRSA EHDI grant to VT, all hospitals and/or their outpatient audiology providers, now perform missed or repeat screens, and report their findings/data to the CSHN EHDI program, which continues to provide necessary case management to assure all babies are screened and diagnosed. In addition, VT EHDI has been successful in establishing access to non-sedated ABR diagnostic testing at FAHC for babies needing diagnosis. This accomplishment is critically instrumental in assuring that babies receive their diagnosis by 3 months. Before this accomplishment, quality non-sedated ABR was not available in Vermont //2012//**2013/ Among the significant achievements of this year, with the support of HRSA and CDC funding, is the implementation of hearing screening by lay midwives, using shared OAE equipment and under the training of the VT-EHDI team, resulting in the screening of homebirthed babies to an impressive degree. In addition, an expanding number of medical homes are now providing in-office OAE, with training and provided by the EHDI team. As these providers screen babies and children, the screening results are recorded in the statewide Child Health Profile, along with the data from birth hospitals. Diagnostic ABR is now available without sedation for Vermont babies, when appropriate. In Bloodspot Screening, the capacity has increased by the hiring of an administrative assistant shared between EHDI and Bloodspot. Vermont has continued to participate in a leadership role in the New England-wide consortium of newborn screening programs, and maintains its zero lost to follow-up in bloodspot screening. //2013//**

PYRAMID LEVEL: INFRASTRUCTURE-SYSTEM BUILDING ACTIVITIES

"Children receive regular ongoing care within the medical home" See NPM 3, P Need 1.

"Families have adequate insurance to pay for needed services" See NPM 4.

With the expansion of Dr. Dynasaur (Medicaid and CHIP) to 300%FPL, Vermont continues to improve the percentage of children who have a source of adequate health care coverage. As a payer of last resort for many medical services, CSHN has developed and strengthened its internal financial processes to help families apply for Medicaid, understand their own private health insurances, and pursue benefits to which they are entitled. Medicaid has delegated to the CSHN director the responsibility for determination of the medical necessity and authorization of

continuation of services for OT, PT, and speech services for children after they have received them for a year. Through its Seating Clinic, CSHN also reviews and facilitates the ordering of wheelchairs and other seating and positioning equipment, as well as the coordination of insurance and Medicaid coverage for the equipment. At the same time, the collaboration with Medicaid in the prior authorization of individual services also is the basis for systems-level solutions to coverage issues that arise with individual children. In 2006, Medicaid resumed the direct responsibility for PA for therapies last year. Productive discussions and advocacy with Medicaid have resulted in (1) a less-frequent renewal necessary for children with chronic therapy needs; (2) independent Medicaid medical necessity determinations for children whose primary private insurance has denied coverage for an essential service and all appeals have been exhausted; (3) advocacy for coverage of previously uncovered items and services. CSHN continues to note the impact of CSHN families' need to pay monthly premiums prospectively as a source of dis-enrollment from Medicaid. As described elsewhere, CSHN reviews all 4-5,000 enrolled children's Medicaid status monthly, notes whose Medicaid coverage has lapsed or is about to lapse, notifies the families' CSHN clinical contact person, and attempts to support families with maintaining continuity. We have received staff training/information on the complex options available to young adults to transition to adult forms of health insurance (VHAP, Catamount, COBRA, etc.) In 2010, CSHN has seen some families move successfully onto Catamount coverage in this past year. Because we support and advocate for families in accessing their benefits, we are able to see trends in coverage. This year we have noted particular difficulties in coordination of benefits for families who have both private insurance and Medicaid; some families have chosen to drop their private coverage. Obtaining and maintaining Medicaid coverage is a complex process for families with CSHCN. Prospective monthly premiums whose omission causes a month without health coverage, transition from Dr. Dynasaur to other forms of public insurance at age 18--at the same moment that a newly-minted adult has to navigate the eligibility process on his own, coordination of benefits when a family also has commercial insurance, all conspire to create discontinuities in coverage.

/2012/ For infrastructure building, CSHN is working with the children's specialty center at the regional health systems to strengthen their clinical services to CYSCHN, through grant making, training, and care coordination support. CSHN is working with primary care practices/medical homes to expand their services to CYSCHN, through initiatives such as training for developmental screening, co-locating social workers in a primary care practice, and acting in consultation around specific patients and systems issues. VFN funded by CSHN to monitor the statewide system of care CYSCHN. VDH/CSHN serves jointly serves on a workgroup to address issues with coordination of benefits between private insurance, Medicaid, and Medicare//2012//

/2013/ In 2012, CSHN launched a medical home pilot. CSHN social worker was embedded one day a week in Chittenden Co. which serves a high number of patients with special health needs. The social worker training providers on financial coverage issues, linking health care to educational needs, facilitating care conferences.

See Section IIIA for the ASIG grant infrastructure/system building efforts. Focus on strengthening of Medical Home to provide developmental screening and continuing care for children with ASD/DD. Strategies of direct outreach to individual practices and web-based training modules. CSHN and CDC collaborative with the early intervention programs statewide, including sharing medical social work staff in all regions of the state. CSHN providing support to the UVM child psychiatry effort in ASD diagnosis to enable its integration into the network. In FY12, CSHN funded a pilot Autism Diagnostic Center at UVM, served 40 Medicaid patients through a comprehensive multi-disciplinary evaluation. Continued funding next year for 60 patients. CSHN works very closely with the children's specialty center at the regional health systems via grants, training, and care coordination.

Vermont is expanding in its multicultural identity, particularly in the northwest part of the state. ASIG grant funded 2 day conference, 200 attendees, on improving the ability of medical homes, early intervention, screening, diagnosis and continuing care, to care for

children from culturally/linguistically diverse families.

The CSHN Operations Director serves as a member of the AHS Integrated family Services (IFS) Implementation Team. IFS goal is development of a system of care that includes Health, Mental Health, and Developmental Services in a seamless system, allowing families a "no wrong door" approach to AHS services. //2013//

C. Organizational Structure

See also Sections IIIA and IIIB. The Agency of Human Services is the largest of the agencies of state government, and is headed by the Secretary of Human Services, who reports to Vermont's governor. The Vermont Department of Health (VDH), within the Agency of Human Services (AHS), administers the Maternal and Child Health (MCH) Block Grant, also known as Title V. Most Title V related activities occur through two divisions of the Vermont Department of Health: the Office of Local Health and the Division of Maternal and Child Health. MCH includes the programs of Children with Special Health Needs which are overseen by a medical director and operations director. CSHN contains the programs of Newborn Metabolic Screening and also Newborn Hearing Screening. MCH also includes the WIC program, EPSDT, injury prevention, family planning, and school health services. The MCH Director has the responsibility for the implementation of the entire Title V grant. As part of the oversight of the grant, the MCH Director meets regularly with the appropriate partners within VDH, with outside contractors receiving funds from Title V, and with state and community partners involved in MCH related activities.

Emergency Medical Services for Children is sited in the Division of Health Protection. The STD/AIDS program is in Health Surveillance. The Office of Local Health has oversight of the VDH services as administered out of the twelve VDH district offices. As a result of the 2005 state government reorganization, the oversight of Healthy Babies Kids and Families is shared with the Department of Children and Families (also under the Agency of Human Services.) The Department of Children and Families also manages the Family, Infant, Toddler Program (FITP) and Children's UPstream Services (CUPS). These three programs are being coordinated into one program of Children's Integrated Service (CIS.) VDH also oversees the state's Substance Abuse Services.

The Agency of Human Services consists of several departments responsible for services for children and families, such as the Department of Health, the Department for Children and Families, the Department of Disabilities, Aging and Independent Living, the Department of Corrections, and the Office of Vermont Health Access. AHS has 12 field offices that coordinate closely with the VDH's twelve District Offices. 12 AHS Field Service Directors oversee services in each AHS district and coordinate among the state's departmental offices. The VDH District Offices serve as local health departments and cover the entire state. VDH local DO's work closely on case management and service coordination with the local state and community offices that provide social, health and welfare services -- also with the community health centers and AHEC districts. At the state level, the community health centers are part of the Primary Care and Rural Health programs. Within VDH, collaboration are between MCH, Health Promotion and Disease Prevention, Office of Local Health, Protection, Alcohol/Drug Abuse and also with the Department

of Mental Health and the Department of Education. In addition, a close relationship exists between operations and program planning and the data and research office of the VDH. The collaboration has been critical in the preparation of the Title V grants and needs assessments and also with the preparation of federal ACA grants of 2010.

The Vermont Primary Care Collaborative (PCC): Purpose is to coordinate state primary care activities that promote the development of innovative and progressive primary care health care services for the underserved. The Vermont PCC provides opportunities for community-based providers of primary and specialty care (as well as behavioral and oral health care providers) to work together on state and regional issues and promotes the support and involvement of state agencies in primary care. The PCC representation: VT AHS (VDH: Minority Health and Mental Health), Department of Children and Families, Medicaid); the University of Vermont (College of Medicine, School of Nursing, Department of Dental Hygiene); Bi-State Primary Care Association; Dental Society; Health Care Authority; Coalition of Clinics for the Uninsured; VT Association of Hospitals and Health Systems; Medical Society; Nurses Association; Northern Counties Health Care; VT Long Term Care Coalition; and AHEC. Focused initiatives have been for oral health service needs, workforce development, rural health, veteran's health services, and the health needs of migrant farm worker and their families.

Division of Mental Health: The Child, Adolescent and Family Unit (CAFU) oversees aspects of the mental health system which serves child and their families and the 10 community based designated agencies (DA) and 1 specialized agency (SA) DMH is responsible for the oversight in these agencies, oversees and monitors the children's home and community based mental health waiver for children identified as having a serious emotional disturbance and are at risk of hospitalization - children can receive intensive services designed to keep them in home/community and out of psychiatric inpatient. CAFU is working with CPH and VCHIP to develop a depression screening tool to be used for youth when seen for well child checks in primary care settings - as of 2010, this initiative has reached 30 practices.

Office of Alcohol and Drug Abuse Programs: See SPM # 2. Major initiatives to increase child and adolescent treatment capacity and quality. Collaboration on systems of care for opioid addicted pregnant women and mothers.

Vermont continues to prioritize the strengthening of community based and statewide systems to support families' access to quality and affordable health care, including those with children with special health care needs. Vermont is considered exemplary in its successes in providing health insurance for its citizens. However, an area in need of attention is the utilization of health care among school-age children and adolescents; the School EPSDT Health Access Program is engaged in efforts to address this issue, along with coordination efforts with the Department of Education. Dental health care access is a longstanding problem for Vermonters and one that the Department of Health is addressing through the activities of the Office of Oral Health Unit, MCH, and the Office of Primary Health Care. The Office of Oral Health has just submitted a CDC grant for oral health planning.

Coordination of Health and Public Health Components of Early Childhood Systems: Community and State-Based Systems: MCH and the Office of Local Health have strong liaisons with Head Start, Early Head Start, and other early childhood programs. Staff from the Immunization Program in the Division of Health Surveillance and staff from Local Health work collaboratively with the DCF Child Care Services to increase the percent of children in child care who are fully immunized. VDH participates in the statewide Early Childhood Workgroup, which was established to coordinate efforts between a variety of state agencies and private, not-for-profit community organizations. VDH also participates in the ECCS grant activities, Building Bright Futures.

State wide organizing and collaborative groups deal with many public health and MCH issues. The VDH and MCH has representation on many of these groups, such as Injury Prevention Advisory Group, the Child Fatality Review Team, The Domestic Violence Fatality Team, the

School Health Coordinating Committee, the CIS planning committee, those committees dealing with physical activity and nutrition, Medicaid planning and reimbursement, CSHN coordination and clinical services, oral health coordination, coordination with AAP and Family Practice, and breastfeeding coordination. These groups and their work are discussed also in the various section of this grant application.

VDH/CSHN has a longstanding, strong and critically important relationship with the Vermont Family Network. Rather than hiring individuals to serve as program staff, VT has chosen to provide infrastructure support to VFN, to enable it to assess need and provide information and strategic support to a broader range of families than those who seek care from CSHN programs. The partnership allows CSHN, as a funding source, to have input into the priorities of VFN, without disrupting its mission and process, and, in return, provides CSHN with immensely useful information about family strengths, preferences, and needs. CSHN SIG has allowed for expanded support of website development and database integration at VFN. Website improvements are aimed to provide easier access to service information. Database integration at VFN will provide accurate reporting for the definition of gaps in services and act in support of defining future planning needs. The CSHN SIG also supported a VFN staff member to co-locate at CSHN to provide consultation to CSHN staff and to families participating in CSHN clinics and programs. ***//2013/ While this pilot has not been continued, CSHN and VFN will collaborate to provide ongoing financial TA to families, including one day per week assignment of VFN staff person at CSHN. VFN is funded as both a family to family organization and a Parent Information Center. In that dual capacity, VFN is in a key position to be aware of and advocate in support of family needs. //2013//***

MCH has a strong partnership with the VT chapters of the AAP and AAFP. Monthly meetings, as well as task forces, help to identify health care and systems issues affecting CYSHCN including children who have mental health conditions. VCHIP plays a role in hosting these efforts and providing guidance in the improvement strategies resulting from identification of problem areas. Vermont has received a 3 year CYSHCN State Implementation Grant - focus on outcomes in Medical Home, Health Care Financing, and Integrated Community Services, and will include family partnerships throughout. Also, the SIG will develop system complementary to other systems building initiatives at VDH, such as Oral Health and the Blueprint for Health (concentrating on chronic disease in adults.) The SIG collaboration with AHS/CIS, blending Part C, MCH home visiting (Healthy Babies, Kids, Families) and early childhood mental health (CUPS) July 2009 implementation of regional CIS Teams will begin using regional phased in approach. Regional teams will provided intake, assessment, and a single plan of care for children 0 -- 6 years old. Vital links with CSHN have been considered in the CIS design of local, community based, streamlined and easily accessible systems of care. Dr. Davis and Dr. Holmes have been spearheading VDH contribution to CIS along with SIG project coordinator in state team and workgroup efforts -- thus CYSHCN/MCH perspective has been included wherever possible throughout the multiple integration efforts that are taking place across AHS services and programs. These programs of CIS are to be involved with the planning and implementation of the upcoming home visiting program as funded by the 2010 ARA legislation.

Centralized planning at the AHS has increased in momentum as a result of the passage of Challenges for Change. Steve Brooks, CSHN director of operations/MCH administrator, is part of the core leadership of the Children's Integrated Services/Integrated Family Services planning and implementation process, an essential voice in the balance of health perspectives in the evolving system. Breena Holmes, MD, has also joined the process as the VDH MCH director. Her experience as a primary care pediatrician, a practice director, a health education teacher at the high school level, and past vice president of the VT chapter of the AAP, gives a breadth and depth of practical understanding . The planning entered a more concrete phase, with discussion of a common intake, a single electronic record, and a first round of piloting an RFP process for a single budget for 0-6 year olds at the regional level.

/2012/ With the award of the HRSA SIG autism grant to Vermont in September, 2010, the collaboration within AHS agencies on developing the system of care for children with ASD has intensified. See above. The project director for the grant is the DAIL Autism Specialist, working with the grant principal investigator, the CSHN medical director //2012//

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

Commissioner of Health

Harry L. Chen, M.D. earned his medical degree and completed his residency in emergency medicine at the Oregon Health Sciences University School of Medicine, where he served as chief resident. From 1983-1988, he was a faculty member at George Washington University Medical Center's Department of Emergency Medicine. In Vermont, Dr. Chen has been an emergency physician at Rutland Regional Medical Center for over 20 years, and medical director from 1998-2004. He is also on the clinical faculty at the University of Vermont College of Medicine. From 2004-2008, he served in the Vermont House of Representatives, and during his final term he was vice chair of the Health Care Committee. In 2008, Dr. Chen received the Vermont State Medical Society's Physician Award for Community Service. He has served on numerous statewide boards addressing healthcare and medical issues, including vice chair of the Vermont Board of Medical Practice. From June to September 2010, he served as Interim executive director of the Vermont Program on Quality in Health Care, and has been a board member since 2006. Dr. Chen has spoken on the issue of health care reform nationally and regionally, including presentations to the U.S. Senate Health, Education, Labor and Pension Committee, the New Mexico legislature's Health Committee, and the New England Medical Society Leadership Conference.

Director of the Division of Maternal and Child Health

Dr. Breena Holmes was appointed the Director of Maternal and Child Health at the Vermont Department of Health in February, 2010. She holds a teaching position at the University of Vermont School of Medicine where she is Clinical Associate Professor of Pediatrics. Dr. Holmes has a passionate interest school health and provides leadership for the Vermont Committee on School Health and serves on the American Academy of Pediatrics Council on School Health. In a previous role, she served as the school physician for Middle Union High School where she revised and taught the school health curriculum. In addition, she was a pediatric practitioner at Middlebury Pediatric and Adolescent Medicine and also Chair of the Department of Pediatrics at Porter Medical Center in Middlebury, Vermont. Dr. Holmes graduated from the University of Massachusetts Medical School and completed her residency at the Seattle Children's Hospital and Medical Center.

EPSDT Program Chief

Dr. Wendy Davis graduated from the University of Virginia College of Medicine, completed her pediatric residency at Case Western Reserve University and general pediatrics fellowship at Yale University. In January, 2007, Dr. Davis began work as the Director of Maternal and Child Health at the Vermont Department of Health, where she concentrated on initiatives related to child health promotion and disease prevention. From 2008 - 2010 Dr. Davis served as Vermont's Commissioner of Health and at present she is the VDH EPSDT Program Chief. Dr. Davis is a Professor of Pediatrics at the University of Vermont College of Medicine and serves as a senior advisor to the Vermont Child Health Improvement Program, an organization dedicated to improving the health of children in Vermont and nationally. She has served as president of the medical staff and as a member of the Board of Trustees at Fletcher Allen Health Care. Dr. Davis

is past president of the Vermont Chapter of the American Academy of Pediatrics. Key accomplishments during her presidency included helping to formalize a partnership with the Vermont Department of Health and providing consultation in a number of areas related to improving pediatric preventive health service delivery. In 2002, she received the Chapter's Green Mountain Pediatrician Award. She is a member of the team that is developing a toolkit to accompany the 3rd edition of Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.

Medical Director of Children with Special Health Needs Programs

Dr. Carol Hassler graduated from Radcliffe College in 1972 and earned a MD from the University of Pennsylvania in 1976. Her residency in Pediatrics took place (in 1976-1978) at the University of Virginia, and Dr. Hassler held a fellowship in Child Psychiatry at the University of Virginia (1978-1980), where she also served as Chief Resident from 1979 to 1980. She has served as the Director of the Division of Children with Special Health Needs at the Vermont Department of Health from 1990-1995, Director of the CSHN Unit within MCH from 1995-2008 and Director of Handicapped Children's Services at VDH from 1985-1990. She is Board-certified in pediatrics and is a Fellow of the AAP. Dr. Hassler also serves as Clinical Associate Professor of Pediatrics at the University of Vermont College of Medicine and as an Attending Physician at the Fletcher Allen Health Care Hospital. In the 2008 reorganization of the Vermont Department of Health and the Division of MCH, Dr. Hassler became the medical director for the CSHN Unit and the Director for the Child Development Clinic. In addition, she has become board certified in Neurodevelopmental Disabilities through the American Board of Pediatrics./2010/ Dr. Hassler earned her special certification in Developmental and Behavioral Pediatrics in 2009. She spends a significant portion of her time in patient care supervision in the Child Development Clinic./2010//

Director of Operations for Maternal and Child Health

Stephen Brooks graduated from Castleton State College, Vermont, and did graduate studies at Middlebury College, Vermont. He has worked with the Vermont Department of Health's program for Children with Special Health Needs since 1989 and is currently the CSHN Operations Director. Areas of particular interest are Systems Development, Quality Improvement, Practice Management, and developments in Family Centered care. Mr. Brooks participated in the Children with Special Health Care Needs Continuing Education Institute, in Columbus, Ohio and has a certificate in Physician Practice Management from the New England Healthcare Assembly. He has represented the Vermont Department of Health on a number of New England-wide workgroups sponsored by New England SERVE. The products of these workgroups included the publications Enhancing Quality; Paying the Bills, a Guide for Parents; and Ensuring Access. In addition to his work with CYSHCN, he has also been the state coordinator for the Preventive Health Services Block Grant for the past several years. Mr. Brooks has served on the Board of Directors of Parent to Parent of Vermont, the state's Family Voices program and is active with Vermont CARES, a statewide HIV/AIDS service organization.

Director of the Office of Dental Health

Dr. J. Steve Arthur graduated from West Virginia University School of Dentistry in 1968 and entered the US Navy as a Navy dentist. After 3 years of service, he moved to Vermont and was in private practice in Castleton and Fair Haven, Vermont from 1971-79. Dr. Arthur reentered the Navy in November 1979. In 1984, he entered the Masters of Public Health (MPH) program in Bethesda, MD, followed by a one year Dental Public Health residency at the National Institutes of Dental Research, National Institutes of Health, Bethesda, MD. In 1988, he became Board certified in Dental Public Health. He retired from the Navy on January 1, 2000. In May, 2005, Dr. Arthur accepted the position of Director of Dental Health and worked until October 2008. Three and a half years later, in January, 2012, Dr. Arthur returned once again to the Department of Health, as Director, Office of Oral Health.

Nutrition and Physical Activity Chief

Susan Coburn MPH, RD was appointed the Nutrition and Physical Activity Chief for the Vermont

Department of Health in 2006. She is a registered dietitian and has a Masters of Public Health in Leadership from the University of North Carolina at Chapel Hill. She came to the Department of Health in 2002 where she started in the Ladies First program to design and implement the nutrition and physical activity program to reduce cardiovascular disease among limited income women over 40. Prior to working at VDH she was employed by the Vermont Campaign to End Childhood Hunger where she coordinated Cooking for Life, a statewide cooking and nutrition program for limited income parents. She currently oversees several planning and program initiatives designed to reduce obesity that are implemented at the community level.

MCH Planning Specialist

Sally Kerschner holds a Masters of Science in Nursing from the University of Vermont and has over thirty years of experience in maternal and child health and community health nursing. She has worked at the Vermont Department of Health since 1983 in several positions (staff nurse, supervisory, management) and with a variety of public health issues (injury prevention, MCH, family planning.)

CSHN/Vermont Family Network (VFN)

CSHN provides significant funding to The Vermont Family Network (the merged entity, previously Parent to Parent of Vermont and the Vermont Parent Information Center). This funding supports VFN Community Resource Parents who provide outreach and assistance to families, statewide, whose children have special health care needs and/or encounter difficulties navigating the education system. In addition, VFN staff support families to attain and retain SSI and Medicaid coverage, in addition to accessing coverage through the several Vermont public health plans.

CSHN support of VFN is best described as infrastructure support. VFN performs a wide range of family support and system-informing functions which are provided most effectively by parent-professionals. VDH's on-going commitment to VFN is mutually beneficial, extending the organization's breadth and depth while affording CSHN with invaluable information through reports drawn from VFN intake and registration data as well as feedback from VFN families as to how CSHN's own services are perceived.

In 2010 and 2011, VFN was a solid partner with CSHN for implementation of the NFI SIG for CYSHCN. While funding to VFN through that grant has come to an end, VDH is assured of VFN's on-going support of the VDH continuous quality-improvement work. CSHN and VFN management teams have met and will continue to meet regularly to ensure not only good communications but also diligent oversight of their work in support of our grants to them. VDH/CSHN will continue to provide infrastructure support to VFN going forward. In 2012 the grants are fully outcome-based, reflecting best practices in that regard. In 2012, grants continue to be fully outcome based and reflecting the new direction at VDH for outcome based/evidenced based grants and contracts.

An attachment is included in this section. IIID - Other MCH Capacity

E. State Agency Coordination

Children's Integrated Services (CIS): As a result of the 2004 AHS reorganization, planning began for a system of services to AHS clients that is holistic, integrated and seamless in order to support pregnant/postpartum women, infants and children age birth to 6. Three programs became co-located at the state level: Healthy Babies, Kids and Families (HBKF/nursing and family support services,) Children's Upstream Services (CUPS/children's mental health,) and Family, Infant, Toddler (Part C/early intervention). Several other services have been added to this menu of CIS, including specialized child care services and the Nurse Family Partnership program. Major partners in current planning for integrated services are VDH, DCF, and Department of Education. CIS regional planning teams, consisting of staff from the six services, have been created and district-specific plans for service integration are being implemented via a multi year planning

process: CIS website @ <http://dcf.vermont.gov/cdd/cis>. CIS work plans for each region will be connected with concurrent ECCS/Building Bright Futures planning and priority setting around early childhood indicators/outcomes. Leadership in this planning involves VDH MCH Division, Child Development Division of DCF, Dept of Aging and Independent Living (DAIL,) Dept of Mental Health, and Dept of Vermont Health Access (DVHA, Medicaid, VT's public insurances.) Each region has a CIS coordinator, a CIS multidisciplinary intake team to reviews/triages referrals, and common CIS paperwork, including a CIS referral and intake forms and an AHS authorization form used for consent to share individual information. The CIS model, as intended, includes adapting a bundled services financing structure; functioning of various teams; outreach, referral and intake processes; standards for use of screening, assessment & evaluation tools; development of one individualized plan for each individual client; service delivery; transition planning; data collection and reporting processes. /2012/ Three regions are pilots for implementation of a fully integrated bundled services pilot, which requires a single fiscal agent for all CIS services. A CIS fully integrated pilot initiative includes: creating administrative efficiencies by bundling Medicaid funding into one contract between the state and the region; using a case rate model instead of fee for service; and setting a capped annual allocation of funds for each region as well as a minimum monthly caseload. The ACA Maternal Infant Early Child Home Visiting program, Nurse Family Partnership model, will be implemented by close integration with the CIS referral systems. Further planning and development of Integrated Family Services (IFS) will result in an integration of AHS human services to create a continuum of services for families from pregnancy and birth to 22 years of age (as extending the goals/intent of CIS) //2012//**2013/ IFS (of which MCH is a member) adopted the Strengthening Families framework with additions from Bright Futures to establish a common language among state entities who care for children and families. Total of nine regions functioning as bundled services areas. VFACTS is a comprehensive data system under development that is a single system of single client records and data management: single shared record that supports a team approach in working with families; used for outcomes and data reporting at the regional, state, and federal levels; assist with regional and state teams to monitor CIS performance measures and clinical case management; create reports, letters, transfer client records between regions; reduce redundancy in information and record-keeping; generate claims to Medicaid and private payors. Regional CIS steering committees implement CIS policies and provide ongoing structure for CIS operations. MIECHV Nurse Family Partnership is integrated with CIS referral and other processes. Statewide best practices conference held for CIS Partners and staff May, 2012. //2013//**

CIS and CSHN: CIS and the CSHN collaboration includes the use of Medical Social Workers as an IFSP team member and the use of CSHN staff as advisors. The Part C program was transferred to DCF/CIS and CSHN medical social workers remain members of each core team. The CSHN Child Development Clinic is a major referral to--and referral from--Part C, serving as the medical developmental diagnostic/evaluation resource for the state. Approximately 40% of children enrolled in Part C also receive services from one or more CSHN programs..

/2012/ Building Bright Futures: See also IIIA. May, 2011, the legislature established Building Bright Futures in state statute via Act 104. Mission: ensure a unified system of quality supports for young children and their families with a mandate to advise the Governor/Legislature on how best to achieve this and track results. BBF is a public/private partnership whose leadership, via the State and Regional Councils, crosses and links departments and communities. Three strategic priorities in 2011 are to: 1) Increase and improve access to quality of early care and education programs, 2) Reduce child abuse and neglect among children under age six, 3) Increase number of children receiving screenings to determine developmental delays and promote early interventions//2012//**2013/ LAUNCH application submitted July 2012 requesting funding to support programming related to these goals for Chittenden County. //2013//**

Historically, "Healthy Child Care Vermont" (HCCVT) began via a CISS grant with the intent to build state and local capacity to provide expert public health nursing consultation and training to child care providers. In 2003, the HCCVT initiative began a transition to a new HRSA/CISS grant for infrastructure development of Early Childhood Comprehensive Systems (ECCS), which

includes early care, health and education focused integration. The ECCS grant is funded by the MCHB through Title V, to support the public health presence and leadership. In 2004 this system began to become unified under a 'new' name - Building Bright Futures: Vermont's Alliance for Children. HCCVT continues to partner with Child Care Licensing, Community Resources and Referral agencies, Northern Lights Career Development Center, AAP-Vt, VDH, and ECCS Coordinator. BBF regional councils are focusing on quality child care and consultation services. Lack of capacity in staffing capacity hinders ability to do annual on-site visits of child cares (SPM #2.) Other strategies such as phone consultations and regional inservices are used for TA and education of providers. In 2009, funding cuts and staff reductions have hindered DCF/OLH ability to fully continue with the activities of Child Care Health Consultants - planning as to prioritizing program objectives and possible methods of continuing via other VDH venues.

AHS Secretary has charged the MCH director and the special assistant to the AHS secretary to co-lead the redesign of the state system of care for children with disabilities. This is a very timely goal, with the new CSHN State Implementation grant, the maturing of the CIS implementation, and several other related efforts: Act 264 (the expansion of a regional case problem-solving method for children with severe emotional disturbance and special education needs, to include potentially all children who receive special education and services from an AHS program--this is a hierarchical, regional-to-centralized stepwise process to develop comprehensive care plans and assign fiscal responsibility for their implementation); Children's Medicaid Hi-tech program redesign; unified services plans (using Medicaid home and community-based services waivers to bring all fee for service and waiver services for a child into one plan under one budget); completion of a state plan for services for individuals with autism spectrum disorders; Building Bright Futures planning (regional planning for early childhood services, especially early care, health and education via EECS funds); Blueprint for Health (incorporating Medical Homes); case management initiatives within Medicaid; and others. In 2010, CIS Intake coordinators have begun to be hired by provider agencies to oversee intake/coordinator responsibilities for Regional CIS Teams. VDH MCH Coordinators in each region will be members of the CIS Intake Teams, as will mental health and early intervention (Part C) providers. Connections to CSHN will be made through early intervention and VDH MCH Coordinators. CSHN and CDC services are linked to the CIS teams in a consultative capacity and continue to provide direct services to children and families. A common referral, intake and authorization form will be used by the region teams. CSHN, in collaboration with DAIL, has applied for MCHB SIG for children and youth with ASD and other developmental disabilities. CSHN specialty clinics are making progress in "graduating" young adults to adult specialty care providers, also a necessary part of the system. The Vt Blueprint for health, enhancing medical homes for adults, currently targets particular chronic conditions, but intends to expand to the pediatric population. /2012/ CSHN has been awarded an MCHB SIG grant for children with autism and related developmental disabilities. Goals and activities include: (1) Partnerships between professionals and families of children and youth with ASD/DD, in the project and in all aspects of the system of care, with at least 50% parent/individual members on the Advisory Council, and support of parent participation with incentives for time and travel. (2) Children and youth with ASD/DD have access to high quality medical homes which use an algorithm from positive screen, to diagnosis, to early intervention, use health care management checklists for ASD and other DD, and collaborate with community-based teams for children with ASD/DD. (3) children and youth with ASD/DD have access to adequate health insurance and financing of services needed. The VT legislature recently passed an insurance funding initiative for ASD. (4) Early and continuous screening for ASD/DD by Medical Homes expands, leading to timely evaluation, diagnosis and appropriate treatment, through reaching all medical homes with a Developmental screening practice improvement project; adaptation of screening tools for children who are English Language Learners; training and mentoring staff and parents are mentored in evidence-based interventions for children < 6. (5) Community-based services are organized for easy use by families, by supporting Autism awareness activities statewide, creation of ASD resource website and phone support based at Vermont Family Network. (6) Transition to adult health care, work, by improving medical homes' capacity to provide care for young adults, and by creating and disseminating Best practice

guidelines for transition are developed by and for youth and providers. //2012//**2013/ Please see IIB, CSHN Infrastructure, which describes coordination with Dept of Aging and Independent Living (DAIL) and Department for Children and Families/early intervention. //2013//**

/2012/ In January 2010, VCHIP, DVHA, Maine Public Health applied and received CHIPRA (Children's Health Insurance Program Reauthorization Act) Quality Demonstration Grant Program funding. Project is called "Improved Health Outcomes for Children" 4 main components: 1) Evidence based child health performance measures, 2) expanding health information technology to improve the use of child health data, 3) enhancing payment reform and expanding patient-centered medical home assessments to pediatrics (link to Blueprint) and 4) promoting collaborative learning environments that can serve as a national model//2012//**2013/CHIPRA enabled capacity to create common pediatric measurement outcomes for primary care for asthma, ADHD, preventive services, obesity//2013//**

To address quality improvement for children using Medicaid, VDH has contracted with the University of Vermont College of Medicine's Vermont Child Health Improvement Program (VCHIP) to plan and implement numerous quality improvement projects with a wide range of providers and institutions. Projects ranging from improvement of OB care in birth hospitals to improvement in adolescent health supervision and involve state agencies, providers of pediatric care, private health insurers, and consumers and has resulted in national recognition. For example, a VCHIP program involving collaboration with VDH is Improving Prenatal Care in Vermont (IPCV) Sets of materials and tools are designed and tested in the IPCV Learning Collaborative. The state-wide initiative was designed to help improve pregnancy outcomes of low weight and preterm birthrates by implementing updated, evidence-based prenatal care, and developing improved office systems. VCHIP's ADHD initiative (with VDH and Dept of Education) is a multidisciplinary approach to coordinate assessment and treatment of school-aged children with this disorder. VCHIP has added a children's chronic disease focus, providing consultation to FAHC clinical programs for children with endocrine disorders, renal disorders, and cystic fibrosis. VCHIP is a partner in the intended SIG process, for review, redesign, and evaluation for CSHN programs within the larger system of services. In addition, VCHIP continues to partner with CSHN related to SIG and with CSHN Child Development Clinic to implement a practice improvement project. Primary aims of this effort are to provide efficient scheduling and responsive appointments for children and families and reports subsequent to clinic visits. /2012/ The turnaround of CDC reports following the diagnostic evaluation has been cut in half as a result of this effort. Additional measures to improve appointment scheduling and enhance communications between CSHN and primary care and key referral sources are in-process. As measured by positive feedback, these efforts are being well received. Although VCHIP's role on this project has ended, work has been incorporated into the CSHN State Implementation Grant and is ongoing quality assurance has been institutionalized into ongoing CDC practice.

//2012//**2013/ For 2009-2011, The Improving Developmental and Autism Screening in Primary Care project was implemented to promote guideline-based developmental care in the medical home by providing routine surveillance, recommended developmental and autism screening, and connections to evaluation and intervention services for children with a concern or with a developmental delay. Using a rapid-cycle change framework, VCHIP established six goals to guide practice-based activities during the quality improvement intervention: 1. 95% of children less than 3 years of age have developmental surveillance at all well child visits, 2. 95% of children have a documented developmental screening using a validated tool at the 9, 18, and 24 (or 30) month well child visits, 3. 95% of children have a documented autism screening at the 18 and 24 month visits, 4. 90% of children identified with a concern or developmental delay have a documented follow-up plan (observation, recheck in office, or referral) 5. 90% of families indicate their concerns about learning, development and behavior were addressed. //2013//**

The Vermont Department of Health works closely with the tertiary care facilities that provide services to Vermonters (Fletcher Allen Health Care in VT, Dartmouth Hitchcock Medical Center in

NH, and the Albany Medical Center in NY). Services are provided through the Newborn Intensive Care Units (NICU), the maternity service departments, health service providers through the Healthy Babies system of care and the CSHN programs. In addition, the Regional Perinatal Program (partially funded by Title V) provides training and data analysis to participating birth hospitals in Vermont and New York State. /2009/CSHN is awaiting final approval of a significant new contractual arrangement with Dartmouth to add a developmental pediatrician and a pediatric psychologist to serve VT children both at Dartmouth and in southern and western Vermont. In 2010, CSHN began to subsidize a board certified developmental pediatrician and a psychologist at Dartmouth to serve Vermont CDC children on the eastern side of the state. /2011/As of July 2011, CSHN has ended this contract with Dartmouth. Unfortunately, this was not a successful partnership, despite significant effort to make it such. Having identified the positive elements of the Dartmouth agreement, CSHN will focus on those aspects through separate agreements to ensure that children and families do not lose out on them. There will be no reduction in access to developmental diagnostic services, because the developmental pediatrician will continue as an independent contractor to the VT program, serving children in the eastern part of VT. //2012//

CSHN continues to provide partnership support to the UVM LEND-ILEHP program, to support training of in-practice professionals in neurodevelopmental disabilities. The CSHN medical director participates in the lecture series. CSHN contracts with ILEHP to provide "Community Clinic" assessments for children with especially complex, community-systems-involved, developmental concerns. ILEHP also hosts an annual week-long conference on the care of children with autism. In 2010, VT ILEHP received LEND expansion grant through which training in the ADOS/ADI-R was provided to all CDC developmental pediatricians, nurse practitioners and neuropsychologist, as well as to several community providers, including a pediatrician and 2 psychologists. The LEND autism training grant provided another round of training to VT clinicians in the administration of the ADOS and the ADI-R. /2012/ CSHN, through the HRSA VT SIG for Autism, will be supporting the ILEHP program to develop web-based information and self-administered training modules for medical homes, parents, and providers, on the following topics related to children with autism and other neurodevelopmental disabilities: comprehensive healthcare checklist for anticipatory guidance and chronic care management of primary health care and common health complications; toilet training and continence issues; and evaluation and management of sleep disturbances and of nutritional and feeding concerns. CSHN, through the special relationship which Title V programs have with Title XIX, will also be supporting ILEHP's work in case management with 40 Medicaid-eligible children who will be receiving diagnostic services through the UVM Center for Children, Youth, and Families pilot autism center. //2012//**//2013/ CSHN continues to collaborate extensively with LEND-ILEHP in the objectives of the ASIG and in the purchase of developmental pediatrician services for CDC. //2013//**

In 2009, Child Development Clinic began to offer experiences for UVM Child Psychiatry fellows. UVM has been approved to offer fellowships beginning 7/09 to expand the capacity of child psychiatry services in Vermont as well as to increase the expertise in caring for children who also have developmental disabilities. /2012/CSHN is partnering with UVM to pilot a university-based Autism Center in the Department of Psychiatry, VT Center for Children Youth and families. The Center will see 40 Medicaid patients in the first year and 60 in the second year; CSHN social workers will be providing wraparound services and care coordination to these patients and their families, in addition to the services of a developmental pediatrician through ILEHP (see paragraph above).//2012//**//2013/ In the pilot year, a developmental pediatrician (ILEHP-LEND) and a medical social worker (CDC) were funded to provide care coordination. Our experience this year helped determine that this coordination is better addressed in an integrated fashion rather than creating a separate but compete silo. In 2012, these children will receive the same model of care coordination as children who are seen within CDC clinics and also as the children who are seen in the NICU follow up clinics //2013//**

/2012/ The VT Family Based Approach (VFBA) is a paradigm for promoting mental health and

wellness and preventing and treating psychopathology that applies to evidenced based strategies from the family perspective (Hudziak, 2008) The goal of VFBA is to use evidenced based prevention and intervention strategies to keep the well well, protect those at risk from developing psychopathology, and effectively treat those who are suffering from mental disease. This approach will be piloted in 2011-2012 by the EEE program of the Addison Central Supervisory Union (Middlebury) school district by 1) training family wellness coaches who will mentor families in the areas of physical, social and emotional wellness (40 four year olds in the first year) and 2) mentoring program will pair high school students with elementary students in areas related to music, sports, reading, etc. //2012//**2013/ Vermont Center for Children, Youth and Families (VCCYF) in connection with MCH piloted the Family Based Approach in one VT county, enrolling 40 preschool age children and their families //2013//**

The VDH is represented on the state advisory team on welfare reform and continues to work with the Office of Vermont Health Access and the Department of Children and Families in a variety of initiatives to coordinate programs and activities. Improvements continue to be made to the WIC/Medicaid combined application and eligibility determination process, for example, and VDH and the Department for Children and Families collaborate to improve services and outcomes for parenting teens and their children.

Another important collaborative relationship exists through the EPSDT School Access program. Each VDH regional office has a public health nurse/school liaison assigned to the task of improving access to health care for school aged children and strengthening the connection between VDH and the schools within their health district.

VDH/MCH is a member of multiple interagency taskforces focused on domestic and sexual violence. VDH leads up an internal Domestic Violence Advisory Group and sits on the Agency of Human Services DV Steering Committee. Both groups are focused on addressing the prevention of and response to DV within these organization and among constituent populations. MCH is also a member of the domestic violence fatality review commission, which reviews all annual DV-related homicides to identify systems or policy-related issues to prevent future incidents. Finally, MCH is a member of the legislatively-mandated Sexual Violence Prevention Task Force. As such, VDH contributes to the ongoing discussion and developments of programming and initiatives related to the prevention and response to childhood sexual violence.

The VDH works closely with the Vermont Area Health Education Center (AHEC) via contractual and collaborative activities in a variety of statewide and community based projects. The Office of Tobacco Control coordinates with AHEC on provider training re: brief intervention for smoking cessation and collaboration on health care professional workforce issues. AHEC is working on an assessment and intervention tool for providers to use in counseling patients who are obese or overweight. AHEC coordinates the longstanding series of community nursing Grand Rounds -- education sessions are offered 4-6 times yearly via interactive TV for nurses statewide who work in the community (home health, school settings, public health, etc.)

Child Fatality Review Team: VDH MCH and Injury programs participate in this multidisciplinary team that reviews the deaths of all resident children, ages 0-18, with particular attention to child protection/neglect issues and systems issues that may need to be addressed in order to prevent child and adolescent fatalities. In recent years, the Committee has focused on child deaths from all unnatural causes, not just abuse and homicide, such as motor vehicle crashes, suicide, gun related causes, and unsafe sleep environment for infants. The team participates in the annual New England wide meeting of CDR teams.

State Agency Coordination for CSHN: CSHN participates in a variety of interdepartmental planning and policy-making settings. CSHN has a particularly close relationship with Medicaid, promoting and assisting eligibility for children, collaboration in the area of prior-authorizations, and reimbursement of CSHN program activities for Medicaid children, through fee-for-service and

Medicaid Medical Case. CSHN continues to provide the regional social work staff for the Part C early intervention system (Family, Infant and Toddler Program, FITP) within the Department for Children and Families, and has a seat on the ICC. CSHN is participating in several other AHS-Department of Education initiatives, Act 264 planning; Regional Autism Centers. Individual-child and system-level coordination and planning continue with the Department of Disabilities, Aging and Independent Living (including Medicaid hi-tech program; Personal Care Services; Traumatic Brain Injury project; Developmental Disabilities Services; Vocational Rehabilitation). CSHN MSW's continue to provide consultative support to regional Part C teams and limited targeted direct services. Processing of "payer of last resort" payments for Part C and CSHN is planned for automation for 2010. CSHN continues to work with DCF and OVHA (Medicaid) to facilitate transitioning to automated payment methods for Part C and CSHN will continue to be seamless for dually-enrolled children. See IIC for discussion of VFN.

Centralized planning at the AHS has increased in momentum as a result of the passage of Challenges for Change. The planning entered a more concrete phase, with discussion of a common intake, a single electronic record, and a first round of piloting an RFP process for a single budget for 0-6 year olds at the regional level. Subcommittees are being created to address specific integration fronts. One focus is the integration of CSHN with programs are part of the Department of Disabilities, Aging and Independent Living (DAIL), Division of Developmental Services--including the Children's Personal Care Services program, the Bridge Program (regional DS case management, through community-based non-profits), and the Children's Hi-Tech program (in-home nursing for children assisted by technology). Another focus is at-risk children in at-risk environments. Arising separately, but in critical need of connection with CIS/IFS, is the Autism State Plan and a new legislative mandate to assure that the services needed by individuals with autism are covered by health insurance. As described above, the MCH Director and the CSHN/MCH operations director are key members of the CIS/IFS planning. /2012/ The Child Development Clinic/CSHN medical director, is involved in the autism-specific planning, now moving with greater momentum because of the award of the HRSA VT SIG autism grant in September, 2010. VCHIP and CSHN continue to partner in practice improvement activities in specialty clinics (cystic fibrosis, nephrology, endocrinology), in Child Development Clinic, and in PCP practices. VCHIP's role in the CDC practice improvements ended in May, 2011, but the work continues through ongoing programming and quality assurance at CSHN//2012//**2013/ CSHN continues to collaborate extensively with VCHIP in the implementation of the ASIG, both in individual objectives and activities and in the overall evaluation of the project //2013//**

F. Health Systems Capacity Indicators

Section III F Health Systems Capacity Indicators July 2012

Health Systems Capacity Indicator 01: The rate of children hospitalized for asthma per 10,000 children less than five years of age.

Overall, though variable due to small numbers, the rate of hospitalization of Vermont children less than 5 years old with asthma has shown a decrease over the past 17 years, from a high of 27.2 per 10,000 Vermont residents in 1993 to a rate of 19.1 per 10,000 Vermont residents in 2008. Asthma is a useful indicator of the effectiveness of preventative disease management in both children and adults. Proper access to medical care, quality clinical management, and appropriate patient education of asthma within a patient-centered medical home (PCMH) can reduce or prevent acute care utilization, hospitalizations and markedly improve the quality of life for children and adults with asthma. The Asthma Program, begun in 2000 (via CDC planning grant), has achieved its initial goals of developing an asthma surveillance system and creating a state asthma plan. The current program is designed to emphasize patient self-management,

comprehensive community engagement (including environmental improvement), clinical excellence, through the use of NAEPP guidelines by practitioners, and integration into the Vermont healthcare system as a whole. Pending availability of funds, other activities such as education and support of childcare providers and school nurses will be implemented. As a partner with the Blueprint for Health the VDH Asthma Program is actively involved in workflow and quality improvement for practices currently participating. One example is the AiRR program where education and home assessment for asthma trigger reduction has been implemented on a pilot basis in the Rutland region.

Increased surveillance capacity has enabled better data to be obtained from hospital discharge data and emergency department data. Behavioral Risk Factor Surveillance Survey (BRFSS) continues to be a valuable tool for measuring asthma prevalence as well as measures of morbidity and treatment-seeking behavior in adults.

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

Narrative:

There has been a general increase in the percent of VT Medicaid enrollees aged less than 1 year who received at least one initial periodic screen, increasing from 81% in 2002 to 89% in 2011. Included in Title V measures are those concerning children who received a Medicaid-funded service, infants who received preventative visits, and children (aged 6-9) who received a dental service. VDH continues updating of the Provider's Toolkit for the dissemination of best-practice guidelines and screening tools to providers of pediatric care -- this toolkit is now "live" on the VDH website. VDH staff work with AAP and AAFP monthly to identify system, policy, clinical or reimbursement issues that might pose a barrier to Medicaid-eligible children receiving routine, high-quality preventive care. Continuing development of provider guidelines that clarify CPT coding procedures for providers to bill for the provision of routine EPSDT screenings. Continued outreach to enroll children will occur as Vermont implements its state system for universals health care.

The Child Health Insurance Program (Title XXI): Children who have another form of insurance are not eligible for CHIP, but continue to be eligible for the expanded Medicaid/Dr. Dynasaur program described above. These under-insured children are enrolled with Medicaid as a secondary payer of last resort, after insurance (or commercial HMO), on a fee-for-service basis. Vermont's comprehensive health care programs for children can offer nearly universal coverage for families. In the state legislative session of 2005, more efforts were made to expand coverage to a universal, state funded system of health care. The proposed legislation did not pass, but a legislative committee was created to examine possible solution for Vermont in the financing of universal coverage for its citizens. In May, 2006, the legislature and the governor agreed on a compromise bill to establish increased health care coverage by establishing premium assistance to low income Vermonters that will allow them to purchase the newly created Catamount Health or an employer sponsored health insurance. By October 1, 2007, the Catamount Health Plan was be available to Vermonters who are not currently eligible for the state's other funded programs. Catamount will offer Vermonters the choice of private health plans, which offer basic and uniform benefit packages. In certain circumstances, some Vermonters may be eligible for premium assistance. In addition, Vermont is proceeding with a plan to require those adults on state insurance programs who currently are offered health insurance but do not take it to take their employers option. The state will make a benefit analysis to determine if it is more cost effective to assist the individual with premium assistance and move them off state rolls or to keep them on the state insurance.

VDH continues to coordinate efforts with the Department for Children and Families in the Fostering Healthy Families initiative, a program that addresses the health needs of children in

state custody who are automatically eligible for Medicaid. The program utilizes the Health Intake Questionnaire (HIQ) for children in custody that are referred to the regional CIS Intake Team; serving as liaison between Family Services and the medical home to interpret needs or facilitate the implementation of a health plan; serving as consultant to DCF around health issues by maintaining or strengthening systems that support foster families.

Health Systems Capacity Indicator 04: The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

The percent of VT women receiving adequate or intensive prenatal care, based on the older definition of month prenatal care began, increased from approximately 69% in 1999 to 88% in 2011. This trend in the Kotelchuck index was also seen in data based on the new NCHS method for calculating month prenatal care began. VDH will continue to monitor these trends, and PRAMS data is being analyzed to identify any new or increased barriers women report to accessing prenatal care. VDH efforts to increase access to medical care for pregnant women, such as prenatal outreach via CIS and WIC and EPSDT, are geared towards continually improving this percentage. Efforts are ongoing to work with birth hospitals to improve accuracy in the count of prenatal visits in the last trimester. Additional work is being completed on the use of provider generated delivery data (OBNET) which will reflect more accurate count of prenatal visitation. PRAMS topic-specific data briefs have been used for Title V Strengths and Needs Assessment and the family planning needs assessment. Other analyses involve SSDI analysis of Medicaid data base and hospital data bases for maternal drug use and infants diagnosed with neonatal opiate withdrawal syndrome used for program planning by VDH and Dept of Mental Health and VCHIP. Programs providing treatment to pregnant women using illegal drugs have seen a sharp increase in their caseloads; however the programs involved are only seeing women seeking treatment. Vermont has examined the Medicaid database and the hospital databases for drug use and infants diagnosed with drug withdrawal. Although these numbers will not include infants where the symptoms of drug withdrawal are not recognized, and women who are not diagnosed, these numbers did provide an estimate of the broader problem than that seen by the programs' caseloads 2011 Legislative Session requiring report for January 2012 from VDH and DVHA (Medicaid) on existing programs and scope of services including case management available to pregnant women identified as high risk. Also, the Maternal Infant Early Childhood ACA funded home visiting program is the Nurse Family Partnership. Both these efforts will have a direct and indirect effect on supporting women to receive the recommended amount of prenatal visits as quantified by the Kotelchuck Index.

Health Systems Capacity Indicator 07A: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

After a decline in the percent of Medicaid-eligible VT children 0-21 years old who received services from 81.2% in 2002 to 77.5% in 2005, the rate showed an increase again from 2006 though 2009 when it reached 81.8%. This trend will be closely monitored. Vermont works aggressively to enroll eligible children into Medicaid programs in order to increase the percentage of children who have access to health insurance. Extensive outreach and public information campaigns have been a focus of Vermont's EPSDT program. Outreach for Medicaid enrollment occurs via the VDH district offices, the programs of the Department for Children and Families, and via schools and community organizations that serve families with young children. Age-appropriate information letters are sent regularly to families. Other Medicaid outreach and access activities occur via a statewide central information and enrollment line, website, or via the 211 statewide information line. For a discussion of Medicaid and SCHIP, and the 2011 Legislative actions on establishing universal health care for Vermonters, see Section IIIA and HSCI#2. Data for tracking this measure are available via Medicaid and the EDS system. The Medicaid data,

unlike many other data sources for Title V related analysis, does not reside in the Health Department. A special software license is required to access the data and a required training needs to be completed before access is granted. Up to 10 VDH staff have 'real-time' access to the Medicaid data base.

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

The CMS-416 data showed a steady increase in the percent of EPSDT-eligible children aged 6-9 years who received dental services, from 59.6% in 1999 to 70.1% in 2010.

The Office of Oral Health continues to promote outreach and the development of a dental home. For activities, see discussion under NPM#9 and SPM #5. In 2009, SSDI analysis of the Medicaid data for the EPSDT/Oral Health program - began as an evaluation of a pilot project at a large pediatric practice targeted to children 3 and under. A dental hygienist was placed in the practice and trained providers to use an oral health risk assessment, and then followed up with families of children determined to be at risk (90% of the children screened) to help them find a dentist who would accept Medicaid if the child did not already have a dentist. The objective of the study was to determine if there was a decrease the number of children with tooth extractions in the pilot project compared to the rest of the state. While no significant differences were found, multiple problems with the evaluation were identified including small numbers, a short follow-up period, an inability to identify the children screened, and it was found that many of the 1-3 year old children already had dental problems at the time of the screening. A broader descriptive analysis of the dental health claims of a cohort of children born in 2001 who were enrolled in Medicaid for at least 95% of the time was performed which included the distribution of age at first visit, and the costs for both preventive and restorative dental care in general and by age at first visit. Findings included that almost two-thirds of the costs were for restorative care. The results of the oral health study were presented to the Pediatric Council, a committee with representatives from the VT chapter of the American Academy of Pediatrics and the major insurance companies. The finding that two-thirds of the dental costs for young children in Medicaid are for restorative care has lead to interest in providing reimbursement to physicians for providing fluoride varnish.

Early childhood caries prevention efforts among family practitioners, pediatricians, primary care providers, dentists, dental hygienists, and VDH. The School-based Fluoride Mouthrinse Program has been in existence for over 30 years, providing free weekly fluoride mouth rinse to children in schools that do not have community water fluoridation. Over 90% of eligible Vermont schools participate. Tooth Tutor Dental Access Program, which began in 1999, reaches out to Medicaid eligible children via Early Head Start, Head Start and elementary/middle schools to facilitate enrollment in a dental home. Several middle schools and high schools are now participating. The 2005 Oral Health Plan resulted in a legislatively approved program called the "Dental Dozen" -- 12 targeted initiatives to improve access, quality of oral health services, assure adequate dental workforce for Vermont's future and increase Medicaid fees for dentists participation in the Medicaid program. In 2009, a Dental Hygienist was placed in large pediatric practice to train providers in oral health risk assessment and also to assist as needed families to find a dental home. A Dental Director was hired in August, 2009. Six dental access grants were awarded to assist practices to increase the numbers of patients with Medicaid in their practice. A dental access grant awarded to the Vermont State Dental Society has resulted in placements of new dentists in the state who see patients with Medicaid in both FQHC and private practices. In 2010, a school based oral health survey of 1st, 2nd, and 3rd graders was conducted to gather up-to-date information regarding the oral health status of Vermont's children. Support has been given to independent efforts to improve children's access to dental care, including a mobile dental van, hygienist practices in school based settings, and a collaboration between pediatric dentists, physicians, and Head Start programs. In 2010, the Office of Vermont Health Access approved payment for the application of fluoride varnish by medical professionals. In 2011, efforts focused upon building coalition support to continue to increase access, promote efficiency within existing programs, and increase promotion of recent initiatives. /2012/ statewide Oral Health Coalition has been updating the 2005 State Oral Health Plan. To create an oral health evaluation and

surveillance plan along with burden document. Create action steps to focus on low income children and pregnant women//2012//**2013/Oral Health planning continues with participation by MCH. Statewide dental sealant plan with strategies to increase access to sealant for children by such strategies as reaching out to all providers such as family practice, OB/GYN, pediatricians. Expand use of dental hygienists, in public schools via Tooth Tutor and TT 2.0, and school based dental clinics. Projects funded via EPSDT. Vt received CDC cooperative funding to support oral health programming. Data indicating that children ages 6-14 have best record of getting into dental care, more emphasis needs to be for children ages less than 2 years old and in late teens and young adults. Legislation passed to provide Medicaid dental coverage for pregnant women and up to 60 days postpartum //2013//**

Health Systems Capacity Indicator 08: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

Narrative:

CSHN has made process improvements to capture the information about SSI status of children enrolled in CSHN programs. In addition, we receive information from SSA about children who have successfully applied and received SSI. Their information is reviewed to see if they are participants in a CSHN program, and the information about their new SSI status is available to their CSHN team. The children who are not "in" CSHN but who have received SSI tend to have conditions affecting mental health and behavior. Their information indicates whether they are already participants in VT's children's mental health division program. As CSHN, with the support of our NFI grant, and, indeed, as the entire Agency of Human Services, encompassing (among others) children's mental health and children's developmental services programs, works feverishly to implement the Children's Integrated Services system within the Integrated Family Services system, a common element is assuring that families have access to care coordination supports. "Case management" has been identified by the state as one area of service which is not thoroughly implemented, even while most other aspects of EPSDT are. The state has funded (in 2009) a new Bridges case management service statewide to help bridge this identified gap. Care coordination for the pediatric population with the most intense health and developmental needs is being consolidated in a interdepartmental "umbrella" program, CHASS, for children with hi-tech needs, children who are eligible for Medicaid personal care services, children needing palliative care, and CSHN.

In gathering the data for this measure, Vermont is resubmitting the data findings from one year ago. Our analysis of current-year data has led to the conclusion that the query of the CSHN Client Database is not valid. The statewide Children's SSI enrollment is up slightly in FFY 2011 over FFY 2010 (1827 versus 1757.) The percentage of children with SSI in FFY 2010 is consistent with the percentage with SSI in FFY 2011 (84% of children were eligible in both years.) The CSHN enrollment remains constant as compared to a year ago (4778 in FFY 2010 and 4753 in FFY 2011.) VDH has seen no drop in the number or percentage of CSHN children who have Medicaid coverage, which might serve as a marker for CSHN children with SSI. These consistencies notwithstanding, the repeated queries to identify Vermont children under the age of 16 who are eligible for SSI benefits and who received a CSHN service, show a reduction in the area of 50%: Number of children with SSI and CSHN: 739 in FFY 2012; 371 in FFY 2011; Percent of children with SSI and CSHN: 42.1% in FFY 2010; 20.3% in FFY 2011. CSHN concludes that in the process of restructuring the CSHN database to distinguish those children who are registered with the program from those who are enrolled in a CSHN-affiliated clinical service, a data link was broken. The result being that a significant portion of CSHN children, when queried, do not show up as having SSI and having been served by CSHN. CSHN data and tracking staff will continue to research this inconsistency.

Health Systems Capacity Indicator 05A: Percent of low birth weight (< 2,500 grams)

Health Systems Capacity Indicator 05B: Infant deaths per 1,000 live births
Health Systems Capacity Indicator 05C: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester
Health Systems Capacity Indicator 05D: Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])

The comparison of these indicators for HSCI #5 (using principle payer field from birth certificate) showed a highly significant difference ($p < 0.001$.) The difference in outcomes between births paid by Medicaid to non-Medicaid births is believed to be associated, in large measure, with socioeconomic disparities between the two groups. Health disparities amongst Vermont residents were analyzed in considerable depth in a 73-page report published by VDH in June 2010. The report included a set of 26 recommendations that provide priorities for future public health planning and programs.

IN addition, the 2011 Legislative Session required reporting for January 2012 from VDH and DVHA (Medicaid) on existing programs and scope of services including case management available to pregnant women identified as high risk. Also, the Maternal Infant Early Childhood ACA funded home visiting program is the Nurse Family Partnership. Both these efforts will have a direct and indirect effect on supporting women to receive the recommended amount of prenatal visits as quantified by the Kotelchuck Index.

Health Systems Capacity Indicator 06A: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)

Health Systems Capacity Indicator 06B: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children

Health Systems Capacity Indicator 06C: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women

Vermont's eligibility for Medicaid and SCHIP are the same at 300% FPL for infants and children up to age 18 years. Pregnant women under 200% FPL are also eligible. For a discussion of Medicaid, SCHIP, and Vermont's Global Commitment and the 2011 Vermont legislative actions on universal health care, see Section IIIA. See also Section IVE Health Status Indicators.

Health Systems Capacity Indicator 09A: The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.

Narrative:

The Title V program, both nationally and in Vermont, has been moving to become a more data-driven system. As the data requirements of this program have increased, the need for data support has also increased. THE SSDI funded support from VDH Health Surveillance has been invaluable for effective planning and programming for the Division of MCH. The MCH Division Director and MCH leadership staff meet regularly with MCH Surveillance staff for briefings on trend analyses from general surveillance, trends, and specific requests for data.

The Title V Needs Assessment is formally updated every five years. However analyses and reports are needed continuously during the five years to identify changing needs and priorities. The SSDI Coordinator has participated with the MCH Leadership Team in their Strategic Planning Process. This process has sought to identify maternal and child priorities and align the MCH Strategic Plan with the broader Vermont Department of Health (VDH) and the Agency of Human Services (AHS) Strategic Plans, the Title V benchmarks (National Performance Measures, Health Outcomes, Health Status Indicators), the Title V State Performance Measures, MIECHV/Home Visitation Benchmarks, and Health Vermonters 2020 objectives. The SSDI has provided data support for this process, and as this process has evolved the priorities for data analyses have also evolved and changed. In addition, a series of data briefs were prepared on hospital utilization patterns by Vermont children aged 0-19 years using trends over time and principal reason for admission.

As part of the strategic planning process, Kindergarten readiness was identified as a key indicator to evaluate early childhood and school age MCH program planning and effectiveness. A goal was established to collaborate with Early Childhood community partners and the Department of Education to strengthen and standardize data collection and reporting systems. Since 2000, the Vermont Department of Education has gathered data on school readiness for children entering kindergarten. Elementary school teachers are surveyed six to ten weeks after the start of the Fall term and asked to assess the school readiness of each kindergarten child in their care, based on five domains of "Social and Emotional Development," "Approaches to Learning," "Communication," "Cognitive Development and General Knowledge," and "Physical Health and Development." These items are aligned with the Vermont Early Learning Standards. Factors that impact a child's ability to learn, such as chronic illness, fatigue and hunger are also assessed. Teachers are asked to report whether the child is receiving special services, such as special education or English as a second language, and whether the child had attended any type of early childhood program prior to entering kindergarten. In October-November 2011, surveys were completed for 4,550 out of 6,042 Vermont children enrolled in kindergarten, across 201 elementary schools, representing a response rate of 75.3%. Each completed survey comprised 141 variables. Although the Department of Education has a system in place to collect this information, they did not have the resources to analyze the data. As part of this collaboration the SSDI Coordinator analyzed the survey data and prepared a statewide report, plus School District/Supervisory Union level reports. The Department of Education has distributed these reports to partners and the supervisory unions.

In 2011, the VDH was awarded grants from HRSA/MIECHV to develop and implement a pilot program of nurse home visits to low-income first-time mothers and their children. The goal of the program is to improve maternal and child health; to reduce childhood injuries and abuse and neglect; to improve school readiness and achievement; to reduce domestic violence; to improve family economic self-sufficiency; and to improve coordination of referrals and the use of community resources and supports. The Nurse Family Partnership (NFP) evidence-based model was selected as the basis for the home visiting program in Vermont. The SSDI Coordinator has been involved in this program from the beginning. Along with a second Public Health Analyst he identified three Vermont communities as having the highest needs based on an assessment of 28 social, economic and health risk factors and outcomes. The SSDI Coordinator was responsible for developing the assessment plan comprising 35 measures in 6 benchmark areas that was reviewed and approved by HRSA. The SSDI Coordinator has worked closely with the Home Visiting Coordinator and NFP staff on adapting the data collection forms originally developed by NFP to meet the additional requirements of the HRSA 'benchmark plan.' These data will be supplemented from administrative data sources such as Vital Records and the Department of Children and Family's database of children with substantiated reports of abuse and neglect. Over the past three months he has developed a data management system in MS Access to accommodate over 200 data elements per client family (mother and child) required to produce benchmark reports.

Recruitment of clients in the two highest priority geographic areas will begin in June, 2012, while recruitment in a third pilot area will commence in the Fall of 2012. The SSDI Coordinator has met with staff at the first two sites to review the data collection forms and requirements.

In addition, SSDI support to MCH programs included : A review of the Title V state performance measures which resulted in dropping one existing measure and the addition of a new measure; selection and development of MCH-related Healthy Vermonters 2020 measures; development of the MCH Strategic Plan and performance measures, data support for the Strong Start grant, analysis of moderately preterm rates by geographic regions for the Vermont Child Health Improvement Project (VCHIP) collaboration with the Title V program, analysis of Medicaid data for the Family Planning Assessment, ad hoc requests from the MCH Director.

Ongoing MCH SSDI related data activities include the WIC/Medicaid data are matched to Vt resident births. Birth records are matched to metabolic screening and WIC records. Beginning in

2010, both blood spot screening records and newborn hearing screening records were incorporated directly into VDH Client Management Information System and automatically linked to birth record. A report based on the WIC/Birth record match presented to MCH Leadership Team. MCH surveillance reports are produced quarterly. Report on Vt data from 2007 National Survey Children's Health. VT Preconception Health Report produced using national standards for determining indicators. Use of PRAMS survey to evaluate Medicaid match -- PRAMS sample drawn from birth certificate with information on mother's use of Medicaid. Improvements to MCH data reporting for use by MCH staff in the field, such as reporting on smoking prenatal smoking, adequacy of prenatal care, preterm births, etc. Continue with regular PRAMS Data Briefs and MCH Quarterly Reports. Assessment maternal deaths shows slight increase due to change in ICD 10 cause of death code. To assist Maternal Mortality Review Panel created by 2011 VT legislation. Use of Life Course theoretical approach in developing analyses of PRAMS, National Survey, ACE, BRFSS data.

Health Systems Capacity Indicator 09B: The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.

The Youth Risk Behavior Survey has been conducted in grades 8 -- 12 every two years. Because of the strong interest in the data available from this survey from both educational and health professionals, approximately 94% of all eligible schools participate. Before 2011, students in grades eight through twelve took the Vermont Youth Risk Behavior Survey. In 2011, VDH conducted two surveys: a high school survey of students in grades nine through twelve, and a middle school survey of students in grades six through eight. All results in the 2011 high school survey report are for grades nine through twelve only. For discussion of tobacco program activities, see Section IIIA and NPM #5.

IV. Priorities, Performance and Program Activities

A. Background and Overview

Section IV A Background and Overview Vermont Title V July 2011

Vermont continues to work toward goals of promoting a comprehensive system of care for its MCH population which includes access to care for both clinical health care and population based services. Along with this goal comes the responsibility to build a comprehensive system of care that is of a high quality and responsive to the needs of the population. VDH has promoted the medical home concept for both medical and dental health care needs. To this end, VDH has worked to establish strong relationships with a myriad of organizations, such as professional groups, hospitals, community-based organizations, home health agencies, schools, and so forth. The VDH's Blueprint for Health (Chronic Care Model) is a specific action plan for these long-standing goals by enhancing the quality of health care and promoting client self-management. In the 2011 Legislative Session, a comprehensive health care reform legislation was passed, creating Green Mountain Care, a publicly financed health care program designed to contain costs and provide comprehensive, affordable, high quality health care coverage for all Vermonters (See section III A for full description.)

Evidence of success has been revealed though many of the Title V measures and similar data. VDH continues to work at providing support and prevention services to all teens and support services to pregnant and parenting teens. Groups such as the Coordinated School Health Committee and the Fit and Healthy Advisory Committee, are enabling an enhanced collaboration between prevention programs. These programs cover a variety of prevention activities, such as physical fitness, good nutrition, tobacco, drug and alcohol use, mental health and sexual activity, and are broadly aimed at supporting assets in teens and promoting healthy development. VDH planning and assessment is also focused on economic disparities, such as those revealed through the data found in HSCI #5, showing a more negative rates for the measures of low birth weight and rates of prenatal care utilization for women using Medicaid insurance. The 2010 Disparities report also deals with economic, social, racial and educational influence on health status.

Vermont was ranked the second healthiest state in the nation according to the United Health Foundation, together with the American Public Health Foundation and Partnership for Prevention, America's Health Rankings: A Call to Action for People and Their Communities. Of all states, Vermont has the lowest percentage of children living in poverty and was also highly ranked for ready access to prenatal care (second best in the nation.) Vermont ranked as the best in the nation for breastfeeding rates after 12 months (39.7%) and was also among the top seven states for the rate of infants ever breastfed (86.2%) according to CDC 2010 Breastfeeding Report Card. The 2009 Publication of The Health Status of Vermonters compiled by VDH shows that in HP2010 measures, Vermont is doing measurably better than the rest of the nation in 19 areas but still has work to do in the areas of binge drinking and obesity. The 2011 report, "F as in Fat," by the Trust for America's Health, showed that in the past 20 years, the number of obese Vermonters increased from 10.7% of the population to 23.5% in 2010. Binge drinking rates among adults are 17% (compared to 15% nationally.) While the rate of youth alcohol use has declined, 39% of Vermont students in grades 9-12 report they drank alcohol at least once in the last 30 days and 23% reported binge drinking.

Vermont's prevalence of overweight and obese children is unacceptably high and beginning efforts are being put into place to reduce this condition. Programs via WIC (Fit WIC) and school health are directed at parent education and referral for children. Data is also describing the issue of women of childbearing age who are overweight or obese -- strategies to reach this population are in the planning phases. In examining breastfeeding, a related important health measure, NPM #7 indicates that the percent of mothers who are breastfeeding at 6 months is increasing -- the WIC program is implementing a major breastfeeding support program for its mothers.

Vermont's YRBS indicates a significant drop in the percent of students who reported smoking at least once in 30 days, and also alcohol use is declining. Programs in schools, the national QUIT line, and pilot intervention models for physicians' offices are strategies to reduce smoking rates. Also, drug and alcohol use in pregnancy is a renewed priority for Vermont. The state is gradually implementing and expanding its offerings of methadone clinic services. Other efforts include the expansion of the Rocking Horse program is a community based educational support group for low income pregnant/parenting mothers. A 2009 Rocking Horse evaluation indicates significant shift in participants' perception of handling stress more effectively, greater awareness of risk from drinking during pregnancy, improved parenting, and increase in self esteem.

The Office of Rural Health, with the Vt New Hampshire Bi States Primary Care Assn and UVM College of Medicine, is working with the Farm Health Task Force, a statewide task to examine the needs and possible actions to address the issue of farm workers safety. Goals are to gather Vermont-specific data to better describe the issue of farm health/safety, to improve access to health care services/medial insurance for farmers and families, support increased farm safety programs, and increase education and outreach for those involved in farm-related occupations. In fall, 2011, faculty from the University of Iowa will present a 5 day symposium for health care practitioners about the health issues specific to farm workers (arthritis, exposure to toxins, injuries, respiratory problems, etc.) A particular focus on health risks for children was part of the curriculum. Another contributor was the New York Center for Agricultural Medicine and Health. This will be the third such educational session held in Vermont by UI faculty.

In 2009, Act 1 passed by Legislature 1/09 in response to a case of a teen girl who was raped/ murdered by a family member June 2008. Much publicity and calls for new laws resulted from this death. Act 1 creates systems changes that strengthen sex offender investigation/prosecution laws. Also requires deliverables such as a tool kit of evidenced based curricula on sexual abuse education required for use in school health education courses, community education/outreach on keeping children safe, education for school and child care staff, and strengthening regulations re: mandated reporters.

B. State Priorities

Vermont's MCH planners and program administrators continue to work and collaborate on state priorities. The MCH Division Director holds regular meeting with the MCH Leadership Team and also MCH/SSDI surveillance staff to continually update staff on MCH trends and other analyses. A full discussion of the latest thinking on the state performance measures is in Section IIC with related discussions in Sections IVC and IVD. The themes of assets and promoting resiliency are also evidenced in planning activities in other state agencies, such as via the ECCS planning, state mental health and alcohol offices, and in the AHS state planning document Vermont Well Being.

The Region 1 Title V leaders continue to be invested in MCH population planning using an assets and resiliency framework. There have been multiple meetings in Boston and conference calls about how to incorporate Lifecourse and social determinants into MCH planning at the state and local level. A Fall 2010 session was held in Vermont with faculty from BUSPH. The 2010 Vermont Health Disparities Report examines health disparities using framework of educational status, SES, racial/ethnic, etc. A March 2011 LCHD session of Public Health Grand Rounds was held for VDH staff by the MCH Planner with assistance from the MCH Director.

A discussion of the 10 Priority Goals and State Performance Measure follows (See IIIA, IIIB, IIID, and IVD) See 2010 Strengths and Needs Assessment for discussion of the 2010 Priorities.

1. Pregnant women and young children thrive. SPM: % women reporting their pregnancies are intended. According to data from the National Survey of Family Growth (NSFG), in the United States, approximately half of all pregnancies across the age spectrum are "unintended" and may be associated with social, economic, and medical costs. In general, women who lack preparedness for pregnancy are less likely to receive timely prenatal care, and their infants are more likely to lack sufficient resources for healthy development. Vermont's rate has remained essentially unchanged (between approximately 60% -66%) New efforts to address this measure may be found in the upcoming 2012 Family Planning Needs Assessment. Also planned is a program providing guidance and a screening question for providers to ask women patients about their pregnancy intentions (modeled after Oregon's One Key Question program.) See NPM 8, SPM 10.

2. Youth choose healthy behaviors and will thrive. SPM: % youth who did not binge drink on alcohol in the last 30 days. The perceived acceptance of drug-using behavior among family, peers, and society influences an adolescent's decision to use or avoid alcohol, tobacco, and drugs. The perception that alcohol use is socially acceptable correlates with the fact that more than 80% of youth nationally consume alcohol before their 21st birthday, whereas the lack of social acceptance of other drugs correlates with comparatively lower rates of use. For this measure, Vermont is testing the approach of using assets-based wording to measure the absence of binge drinking in youth, so as to emphasize the social and cultural changes that must take place for youth to understand that binge drinking can become the antithesis to the social norm. This measure has remained basically unchanged, ranging between 77% and 79%.

3 and New SPM 10. Women lead healthy and productive lives. SPM: % women ages 18-44 who report eating at least five or more servings of fruit and vegetables per day. The importance of improving preconception health in women of childbearing age has become a priority for health and public health professionals in their efforts to improve birth outcomes. Women need to be supported in certain actions, such as in eating a healthy diet, maintaining a proper weight, getting adequate exercise, avoiding smoking and substance abuse, and obtaining regular health care. One measure of these healthy habits is consumption of adequate amounts of fruits and vegetables. In 2011, VDH is updating the Obesity Prevention Plan with further strategies on educating women of child bearing age about healthy eating. VDH MCH has changed to the method of measuring this goal by adding the measure of the % women giving birth to a live infant who has a preconception BMI between 18.5 -- 24.9. Current indicator for this SPM is 49.9%. This change will address women who are over or under weight preconception. New plans for addressing this new SPM will be developed via the preconception work (SPM #1) and the Obesity STAT (July 2012.)

4. Youth successfully transition to adulthood. SPM: % youth who feel like they matter to people (YRBS.) Assets research for youth shows an association between healthy youth behaviors and certain defined assets. VT added 5 asset questions to the 2001 YRBS to gather information on youth assets in relation to youth risk taking behavior. Maine also uses: "Do you feel that in your community, you feel like you matter to people." Region 1 used this approach of assessing population assets in addition to a population needs in the 2005 Title V MCH Needs Assessment. Choosing a youth asset indicator for Priority Goal #5 is viewed as a strategy to operationalize the assessment of youth assets in addition to analyzing youth risk-taking behavior. This measure has remained at approximately 33-35 % and in 2011 it was 28.3%. Work with ADAP, schools, Youth Suicide Prevention Coalition, and some aspects of the Community Transformation Grants addresses this SPM.

5. All children receive continuous and comprehensive oral health care within dental home. SPM: % children using Medicaid who use dental services in one year time period. The VDH Office of Oral Health works in concert with dental providers to achieve a system which encourages quality dental care as provided in a dental office where comprehensive continuous care can be achieved. Tooth Tutor dental hygienists to provide assessment and referral of students to a local dental home. VDH assists dentists with grants, loan repayments, and

recruitment and retention efforts in order to ensure adequate workforce for a dental home. The measure has remained unchanged at about 50%. See also discussion of HSCI 7B.

6. Children and families live in healthy environments. SPM: % 1 yr olds screened for blood lead levels. Children are most vulnerable to lead poisoning when they are under six years old, and especially at ages one and two when they normally exhibit hand-to-mouth behavior. The CDC recommends children be screened for lead poisoning at ages one and two years. This measure has not increased despite many innovative programs, remaining at 78.6 % for 2011. VT has the second oldest housing stock in the nation - 60% built before 1978 when lead paint was banned. In 2006, the Commissioner of Health and Attorney General established a joint task force to research and evaluate issues surrounding lead poisoning, to develop recommendations for reducing the prevalence of childhood lead poisoning, and to coordinate efforts between VDH and the state and community partners tasked with lead abatement projects. VDH's Childhood Lead Prevention Program (CLPPP) has 3 focus areas: primary prevention, testing and surveillance, case management of lead poisoned children. In 2009, legislation passed: defining Vermont elevated blood lead level as 5µg/dL or greater, sets screening targets for 1 year olds (85% screened) and 2 year olds (75%) that must be met by health care private/public clinical systems by January 2011 otherwise the Commissioner of Health must issue rules to require screening, updates essential maintenance practices, updates requirements for real estate transactions, prohibits unsafe work practices, expands requirements for child care centers in building built pre-1978. VDH is providing training to primary care practices in lead screening so as to meet new statewide screening targets and collaborating with Medicaid about possibility of practitioner reimbursement. Also, VDH is developing system to allow rental landlords and facilities managers, etc to file compliance statements electronically. Implementing education programs on essential maintenance practices trainings at construction-related courses in high schools and colleges. GIS tracking of neighborhoods with high lead infested housing to guide notification of risk to families living in high risk areas.

7. Communities provide safety and support for families. Performance Measure: The percent of youth grades 8-12 who report always wearing a bicycle helmet when riding a bicycle. Helmet use when riding a bicycle can substantially prevent injury or death if the rider is involved in a crash. In Vermont's 2009 YRBS, ¾ of students in grades 8-12 rode bicycles in the past 12 months. However, 63% - over 17,000 students -- reported rarely or never wearing helmets. In fact, riders were most likely to report never wearing helmets: 48% never, 15% rarely, 11% sometimes, 13% almost always, and 13% always. Males, older students, and students from racial or ethnic minority groups were more likely to report rarely or never wearing helmets. The percent of bicycle riders reporting that they rarely or never wore helmets decreased for several surveys, but has since increased. In 1993, 82% of riders reported rarely or never wearing helmets, compared to 50% in 2001 and 55% in 2007. In 2009, there was a sharp increase in the percent of riders, particularly females, who reported rarely or never wearing helmets. In 2009, students who rarely or never wore helmets were more likely to report other risky behaviors, such as not wearing a seatbelt, fighting, driving a car under the influence, and alcohol, cigarette, and marijuana use, even after controlling for demographic differences. However, students who rarely or never wore a helmet were not significantly more likely to have exercised every day in the last week than those who always or almost always wear helmets (26% v. 24%.)

8. All children, including CSHN, receive continuous and comprehensive health care within a medical home. SPM: The length of time between referral from pediatric primary care provider to the first Child Development Clinic kept appointment for children identified as having a potential developmental delay or ASD. The length of time required from the date that a child (ages B-8) is identified in the medical home as having a potential developmental delay or autism spectrum disorder to the date that the child and family attends an appointment at the VDH Child Development Clinic. The length of time is calculated by monitoring the average number of days elapsed between referral of the child by the medical home to the first kept appointment date at the Child Development Clinic. A 10% reduction in this amount of time is the desired goal. Baseline will begin using data from CY 2011 via the VCHIP SIG project. Annual reporting data

accessed from CostShare data. It is calculated that the time from referral to appointment in 2009 was 177.7 days and that has decreased to 140.9 days in 2011.

9. Children live in stable, supported families. Performance Measure: The rate per 1,000 of substantiated cases of child abuse and neglect for the population of children ages 0-17 years. This measure is calculated at 4.8 %. It is well recognized that child abuse has severe negative effects on the child and optimal family functioning. Child abuse severely affects the child's ability to function in school and socially and, due the research on Adverse Childhood Experiences, more is becoming known about the effects on adult mental and physical health. Vermont began using the ACE core questions in the VT BRFS in 2010 and will have data for use in planning in the fall of 2011. In addition, the Healthy People 2020 measure of IVP 38 is being used in the Vermont 2020 planning process. Vermont's MIECHV program (use of the Nurse Family Partnership) is also using this measure for the Benchmark: Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits, Construct: Reported Substantiated maltreatment for children in program.

10. Children and Families are emotionally healthy. A new performance measure is being considered for this Goal to replace the 2005 measure. Related activities are described as follows. A multidisciplinary workgroup that included pediatricians, family physicians, psychiatrists, psychologists, and representatives from public and private mental health agencies working to develop a vision and framework for addressing gaps in the delivery of mental health services for Vermont's children and families. Specific projects include: Vermont's ADHD (Attention Deficit Hyperactivity Disorder) Initiative, through which primary care providers (PCP's) are supported in delivering high quality diagnostic and treatment services to school-age children with ADHD. Treatment plans are developed to target a child's individual strengths and weaknesses, bring together educational and medical interventions, and help eliminate gaps in the child's services or medical care. Plans for pilot projects to place mental health professionals in pediatric offices. This collaborative model links the community mental health agency with physician practices and uses a team approach to assist primary care providers integrate new processes for mental health services into their practices; gives them the tools needed for screening, diagnosis, treatment and on-going management; and provides psychiatric consultation services to the physician. Medicaid reimbursement for services covers the costs of these interventions. This initiative has increased the number of children receiving services overall and reduced the waiting time for child psychiatry services by several months. In response to the needs of individuals with autism spectrum disorders (ASD) - Act 35: 2007 legislation requires the creation of an interagency proposal for a coordinated, life-long system of care designed to address the needs of individuals with ASD and their families. 2010 Legislation expanding insurance coverage for children with ASD. CSHN is focusing on the redesign of its Child Development Clinic component, with new support from the MCHB CSHN SI grant. Children with an autism spectrum disorder comprise the largest portion of all children receiving diagnostic services at CDC, a striking increase from one and two decades ago. CDC contracts with a child psychiatrist with special expertise in the care of the children with developmental disabilities, to provide consultation and team-based direct service for children in CSHN as needed. In addition, CDC will begin providing training opportunities for UVM child psychiatry fellows beginning in July, 2009. In 2011, Vt CSHN received MCHB 3 year systems improvement grant for children with autism and related developmental disabilities.

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	100.0
Numerator	4	10	23	10	10
Denominator	4	10	23	10	10
Data Source		VT Newborn Screening 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	100	100	100	100	100

Notes - 2011

Data for 2011 are unavailable at the time of submission. They should be available in September 2012. 2011 data are an estimate based on 2010.

a. Last Year's Accomplishments

Vermont continues to achieve 100% screening information on all known Vermont births, including home births. Our experience with the expanded newborn screening panel, including CF, continues to go smoothly. We continue direct case management of each baby with a concern on his/her screen to assure that repeats, urgent care, and initiation of treatment occur in optimum time frames. The CSHN pediatric nurse continues to provide clinical backup to the Newborn Screening Chief (also a nurse) in her absence as well as daily participation in case management and tracking activities. Case management across state borders (NH, MA, NY) continues smoothly. We continue the seamless transition from positive screen and diagnosis, to clinical follow up, through CF clinic, Metabolic clinic, and through transfer to similar clinics in neighboring states as needed. The NBS Chief continues to be in the leadership of NERGG. We continue to utilize our state database which includes metabolic and hearing screening and is accessible to Medical Homes to view results. The state policy for retention of bloodspots has been reviewed and implemented.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to implement the expanded newborn screening panel			X	X
2. Continue outreach so no baby is lost to follow up	X	X	X	X
3. Continue seamless transition to clinical care for diagnosed babies	X		X	X
4. Continue cross border NBS and EHDI efforts		X	X	X
5. Continue active participation and leadership in NERGG			X	X
6. Assess program costs as expanded implementation stabilizes compared with fee based resources and adjust accordingly			X	X
7. Continue access and utilization of web-based NBS database.			X	X
8. Implement policy about retention of bloodspots			X	X
9.				
10.				

b. Current Activities

As above. The CSHN nutritionist is now co-located with the UVM/FAHC pediatric geneticist and genetics counselors, and the location of the clinic is now at FAHC. Travel clinics will continue to be provided closer to families. The nutritionist is the clinic coordinator, while the current nurse coordinator continues in her role as backup to the NBS Chief in all activities.

c. Plan for the Coming Year

Continue implementation of the NBS panel. Continue outreach so no baby is lost to follow up. Continue seamless transition to clinical care.

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:	5775					
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)	5742	99.4	8	0	0	
Congenital Hypothyroidism (Classical)	5742	99.4	62	6	6	100.0
Galactosemia (Classical)	5742	99.4	0	0	0	
Sickle Cell	5742	99.4	0	0	0	

Disease						
Biotinidase Deficiency	5742	99.4	1	0	0	
Cystic Fibrosis	5742	99.4	29	4	4	100.0
Methylmalonic acidemia (Cbl A,B)	5742	99.4	1	0	0	
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	5742	99.4	28	0	0	
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	5742	99.4	2	0	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	65	65
Annual Indicator	59.8	59.8	59.8	59.8	75.4
Numerator					
Denominator					
Data Source		National Survey CSHCN Chartbook 2005-2006	National Survey CSHCN Chartbook 2005-2006	National Survey CSHCN Chartbook 2005-2006	National Survey CSHCN Chartbook 2009-2010
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	80	80	80	85	85

Notes - 2011

For 2011-2014, 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. The 2009 estimate is based on the 2005-2006 survey data, which is the most recent survey available.

a. Last Year's Accomplishments

1. CSHN continues significant infrastructure support for Vermont Family Network; we have continued regular meetings with the VFN leadership and engaged VFN feedback on CSHN activities and material.
2. The Hearing advisory council continues to be very active. New parent membership has been recruited successfully.
3. CSHN continues to fund Vermont Family Network to monitor the statewide system of care CYSHCN

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue written expectations of family centered care in (direct services) grants and contracts	X	X		X
2. Continue regular meetings with Vermont Family Network (VFN) about children/family needs and all Title V and CSHN issues and policies				X
3. Continue regular meeting with Children's Hearing Health Advisory Council whose leadership and membership includes significant parent representation				X
4. Continue significant infrastructure support to VFN		X	X	X
5. Support of financial technical assistance consultant through VFN grant.		X		
6. Continue to fund VFN to monitor the statewide system of care CYSHCN				X
7.				
8.				
9.				
10.				

b. Current Activities

As described above

1. All FY12 grants and contracts included patient-centered performance management goals and repercussions.
2. CSHN piloted the co-location of a CSHN social worker/care coordinator in a primary care practice.
3. More than 50% of the membership of the steering committee for the ASIG is comprised of parents and consumers.

c. Plan for the Coming Year

As described above

1. Continue contractor and grantee expectations for family-centered care.
2. Continue regular meetings with VFN leadership about all CSHN and Title V issues.
3. Continue regular meetings with Hearing advisory council.
4. Continue significant infrastructure support to VFN, including a funding mandate to monitor the statewide system of care for children and youth with special health care needs.
5. Continue systems-level changes implemented at Child Development Clinic, to increase the number of patients and reduce waiting times between referral, appointment and diagnostic report. Regular QA monitoring will continue.
6. CSHN is considering implementing patient satisfaction surveys.
7. All FY13 grants and contracts include patient-centered performance management goals and repercussions.
8. A CSHN-funded, VFN employee will sit at CSHN at least one day per week to provide families with financial technical assistance.
9. CSHN plans to increase partnerships at the local level with the office of local health, children's integrated services, and the blueprint for health medical home initiative.
10. Continue and potentially increase the colocation of a CSHN social worker/care coordinator in a primary care practice.

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	62	62	62
Annual Indicator	51.6	51.6	51.6	51.6	44.3
Numerator					
Denominator					
Data Source		National Survey CSHCN Chartbook 2005-2006	National Survey CSHCN Chartbook 2005-2006	National Survey CSHCN Chartbook 2005-2006	National Survey CSHCN Chartbook 2009-2010
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	50	50	55	55	65

Notes - 2011

For 2011-2014, 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. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

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.

NOTE: Due to relatively small numbers, the apparent decline between 2005-06 and 2009-10 in percentage of children receiving care in a medical home was not statistically significant at the $p < 0.05$ level ($z = 1.8$).

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. The 2009 estimate is based on the 2005-2006 survey, which is the most recent available.

a. Last Year's Accomplishments

The Medical home goals all continue to be relevant. The Medical home and the promotion of its connection with the larger network of health supports for families of CSHCN is a core aim of the SIG grant. In support of the Medical Home and its care for children with developmental concerns we are strengthening the capacity of Child Developmental Clinic statewide and its affiliation with child psychiatry. Our participation in the AHS CIS/IFS process allows us to advocate strongly for the medical home to be included as central players in each child's care. VDH and VCHIP partnered on a project to train and support medical homes in conducting developmental screening and referring to children's integrated services/early intervention and to child development clinic.

The SIG grant is spearheaded a major reassessment of the most effective affiliations of CSHN effort. As specialty care providers more often assemble their own teams and are less reliant on public health for their clinical function, public health is able to direct more support to coordination

of care with family and medical home.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expand capacity of Child Development Clinic (CDC) to take new referrals from Medical Homes	X	X		X
2. Continue regional collaboration between CDC and PCP's	X	X		X
3. Continue to advocate for Medical Homes centrally to Children's Integrated Services (CIS) planning and implementation process		X		X
4. Continue VDH CDC based child psychiatry consultation model for children with developmental disability enrolled in CSHN; provide consultation to medical homes when there is a developmental and psychiatric co-occurring diagnosis	X	X		X
5. Track the percentage of CSHN enrolled children with an identified PCP		X		X
6. Continue co-location of CSHN care coordination staff in pilot medical homes		X		X
7. Implement Medical Home components of HRSA Autism SIG project		X		X
8.				
9.				
10.				

b. Current Activities

Currently, the Blueprint for Health, a model for care of individuals who have chronic conditions, is expanding to the VT pediatric population. Three practices have already signed on. CSHN is a key player in providing care coordination and linkages to specialty care. CSHN care coordination re working with regional care community health teams to ensure access to and quality care for children and youth with special health care needs. The MCH director and VDH commissioner are directly participating. Expanded the capacity of CDC to take new referrals from Medical Homes HRSA/MCHB awarded (beginning 09/2010) VT CSHN a 3-year state improvement grant for children with autism and related developmental disabilities. Goals and activities include practice supports in developmental screening, diagnosis, and ongoing primary care for children with ASD.

c. Plan for the Coming Year

1. Explore shift from specialty-centric to Medical Home-centric supports originating in CSHN, and best fit with Blueprint planning.
2. Continue regional collaboration between CDC and PCP.
3. Expand partnerships between administrative staff and CSHN care coordinators with blueprint regional health care teams and provide outreach on CSHN and other MCH services.
4. Continue pilot project to colocate CSHN social worker/care coordinator in primary care pediatric practice to support families of CYSCHN and build practice capacity in the future.
5. Continue to advocate for Medical Home centrality to Children's Integrated Services in AHS planning process.
6. Funding through Autism SIG grant for ILEHP program to develop training for medical homes on the following topics related to children with autism and other neurodevelopmental disabilities: comprehensive healthcare checklist for anticipatory guidance and chronic care management of primary health care and common health complications; toilet training and continence issues; and evaluation and management of sleep disturbances and of nutritional and feeding concerns.
7. Continue work on the MCHB State Implementation grant for children and youth with autism

spectrum disorders.

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	72	72	75	75	75
Annual Indicator	69.4	69.4	69.4	69.4	68.9
Numerator					
Denominator					
Data Source		National Survey CSHCN Chartbook 2005-2006	National Survey CSHCN Chartbook 2005-2006	National Survey CSHCN Chartbook 2005-2006	National Survey CSHCN Chartbook 2009-2010
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	75	75	75	75	75

Notes - 2011

For 2011-2014, 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 the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

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. The estimate for 2009 is based on 2005-2006 survey data, which are the most recent available.

a. Last Year's Accomplishments

Continue the streamlining of CSHN accounts payable (for health care) with that of Medicaid. CSHN and Medicaid now both utilize a single processing agent, and collaboratively implement prior authorization and medical necessity reviews for shared children. For families, maintaining Medicaid coverage is as difficult as ever, with failure to pay a monthly prospective premium resulting in loss of coverage for an entire month. Another fragile node in the system is graduation from the 0-18 Dr. Dynasaur program into the less comprehensive state plan and other options for low income young adults. Much of CSHN staff time is spent on patching together coverage for children in the various gaps, while assisting families in understanding the benefits and requirements of the insurances they do have. We continue to purchase insurance for a small number of patients.

As part of the final year of the CSHN SIG, CSHN contracted with a financial technical consultant to support CSHN families in navigating the complexity of the health insurance/payor system. As such, CSHN has successfully transitioned a number of patients with private health insurance to public health insurance: Vermont's Catamount Health, Working People with Disabilities, and VHAP programs, as well as enrolled a few patients with high prescription costs to pharmacy assistance programs.

With support of the ASIG, work continues in operationalizing the legislatively mandated coverage of services for children with ASD.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue, with NFI support, internal (to CSHN practice) and external (interagency and public/private) financial redesign to improve financial access to health care		X		X
2. Continue to support families in accessing, understanding, and maintaining health care coverage		X		X
3. Continue to provide infrastructure support to VFN to provide information and guidance to families about health care funding		X		X
4. Continue to review, revise, and implement changes in CSHN role as payer of last resort, while maintaining role in assuring access		X		X
5. Continue to advocate with Medicaid as need arises for policy clarification or adjustment		X		X
6. With the expansion of CSHN coverage for hearing aids (up to age 21,) continue to require families (who appear to meet Medicaid income criteria) to apply for Medicaid when applying for CSHN services		X		X
7. Through HRSA autism SIG, collaborate on the implementation of new law requiring insurance coverage of ASD treatment for young children		X		X
8.				
9.				
10.				

b. Current Activities

As above. At the AHS level, the CIS/IFS planning effort also includes revision of some financial arrangements. VT still has a Medicaid waiver, Global Commitment, which allows some flexibility and creativity in funding packages. The CSHN/MCH operations director is actively involved in these discussion. The CSHN medical director is a participant in a legislative study committee to examine the impact of requiring insurances to cover services for individuals with autism spectrum disorder.

c. Plan for the Coming Year

1. Continue to provide infrastructure support to VFN to provide information and guidance to families about health care funding. In the coming year, CSHN will enhance its provision of financial technical assistance to CSHN families through a grant to the Vermont Family Network. This Family Support Consultant will work with families to review individual insurance policies, complete applications for Medicaid, Katie Beckett, Working People with Disabilities (18+ population), navigate public and private payor systems, and provide training, advocacy, and support.
2. Continue to support families in accessing, understanding, and maintaining health care coverage.
3. Continue to review, revise and implement changes in CSHN role as a payer of last resort, while maintaining role in assuring access; CSHN continues to plan for an amendment to the Administrative Rule that governs its financial assistance program. As of January 1, 2013 CSHN will no longer provide financial assistance to families, but will transition to a system of technical assistance to support families in navigating the health insurance/payor system (currently covered families will have a 1 year grace period of coverage). These funds will be reinvested into care coordination, financial technical assistance, increased respite allocations, and additional supports for the CSHN expanded population.
4. CSHN will strengthen partnership with Department of VT Health Access to ensure appropriate and adequate insurance covered for CYSHCN, particularly in the area of pharmaceutical coverage.
5. CSHN and VDH will closely monitor and partner around developments as VT works towards implementation of a single-payor health insurance program.
6. Through the autism SIG grant, collaborate on the implementation of the new health insurance requirement for autism treatment services for young children.

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	75	92	92	95	95
Annual Indicator	89.3	89.3	89.3	89.3	70.3
Numerator					
Denominator					
Data Source		National Survey CSHCN Chartbook 2005-2006	National Survey CSHCN Chartbook 2005-2006	National Survey CSHCN Chartbook 2005-2006	National Survey CSHCN Chartbook 2009-2010
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	75	75	80	80	85

Notes - 2011

For 2011-2014, 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. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

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. The 2009 estimate is based on 2005-2006 survey data, which is the most recent available.

a. Last Year's Accomplishments

Traditional Title V strategies have been ways to reduce the distance between families and specialized services, by holding itinerant clinics in multiple locations and by home visiting. More recent strategies have aimed at connecting services, no matter where they are, affording a degree of individualization and family-centeredness that are not possible in a more sole-source provider model. CSHN is now moving away from direct clinical services and in the direction of supporting families in navigating community-based services through regional care coordinators, and bridging between primary and specialty care and community-based services. At the same time, Child Development Clinic has incorporated in its teams some more local staff, so that when CDC "comes to town"--and leaves--there is still a local team member to follow through. Elsewhere in this report, much mention is made of the AHS Integrated Family Services and Children's Health and Support Services (CHASS) planning effort whose goals are also to make services easier for families to access, so there is synergy in mission. Work on the content

continues. In the past year, several programs serving overlapping populations have been merged, including CSHN (Hi-tech, Bridge Care Coordination, and Children's Personal Care Services). In addition, autism has become focal point for system design, through a MCHB-funded systems improvement grant.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to maintain statewide distribution of CDC clinics and increase capacity	X	X		X
2. Continue to realign clinic staff to provide direct support to families in their regions and clinics and make the "system" usable and accessible for families, and towards connections with medical homes		X		X
3. Intensify participation in AHS interagency planning for groups, especially around ASD; integrate with overlapping programs		X		X
4. Continue infrastructure support of regular meetings with VFN to address issues identified through contact with their clients/families			X	X
5. Continue to collaborate with multiple state agencies, particularly around case management programs and developmental services affecting CYSHCN. Provide leadership of systems design		X		X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The pediatric expansion of the Blueprint model has been described elsewhere, but is a model incorporating primary care and connections between internal (in the PCP office) and external (in the community) care coordinators. Currently, blueprint is expanding to pediatric population with 3 pilot practices participating. CSHN care coordinators will formulate and maintain ongoing relationships with Blueprint community health teams. The CIS model has penetrated the entire state of VT; currently 3 teams have been a consolidated system approach to early intervention, children's mental health, and nursing and family support, rather than a loose network of linked fee-for-service providers and a host agency. Other programs are coming on board currently. CSHN social work/care coordinator job descriptions have been rewritten to emphasize and strengthen community-based knowledge and relationships. The ultimate goal is to staff every district health office with a medical social worker/care coordinator to provide direct service and capacity building service to the region re CYSHCN. CDC regional model is being realized. CSHN social workers are being integrated into every CDC visit in order to provide continuous care coordination following the evaluation, diagnosis, and ongoing treatment.

c. Plan for the Coming Year

1. Continue to realign some CSHN staff away from specialty clinics towards community-based connections with medical homes.
2. Intensify participation in interagency planning at AHS, including integration with several overlapping programs, as part of Integrated Family Services/Children's Health and Support Services (CHASS) efforts.

3. Continue to increase capacity and accessibility of CDC.
4. Improve coordination efforts between medical home, Child Development Clinic, care coordination, and children's integrated services/early intervention care team.

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	7.5	55	55	58	60
Annual Indicator	52	52	52	52	51.8
Numerator					
Denominator					
Data Source		National Survey CSHCN CAHMI website 2005-2006	National Survey CSHCN CAHMI website 2005-2006	National Survey CSHCN CAHMI website 2005-2006	National Survey CSHCN Chartbook 2009-2010
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	55	55	60	60	65

Notes - 2011

For 2011-2014, 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. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

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. The 2009 estimate is based on the 2005-2006 survey, which is the most recent available.

a. Last Year's Accomplishments

1. Received a MCHB State Implementation grant for children and youth with autism spectrum disorders, with a goal of increasing the capacity of primary care providers serving adults to welcome adults with ASD or other developmental disabilities into their practices.
2. Clinical services to children with cystic fibrosis as the transition to adults, through a Department of Medicine pulmonary clinic, including financial assistance with health care costs, and medical social work.
3. CSHN has successfully transitioned a number of adult patients with private health insurance to public health insurance: Vermont's Catamount Health, Working People with Disabilities, and VHAP programs, as well as enrolled a few patients with high prescription costs to pharmacy assistance programs.
4. CSHN medical director continues on the Developmental Disabilities Council.
5. VFN's CSHN liaison conducted survey and outreach to CSHN families of patients that were 17 years of age, to assess transition needs and provide information and support, topics included: adult health system primary providers and specialists, employment and SSI benefits, post-secondary education and life-long learning, housing and community/social inclusion, health insurance, guardianship and independent living supports, emergency planning, and financial planning and special needs trust.
6. VFN's CSHN liaison, represents VFN and families on the Youth in Transition State Leadership Team.
7. The Autism state plan addresses services across the lifespan. The ASIG Goal 6 addresses transition to adult services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The CSHN Medical Director will continue to participate in the Vermont Developmental Disabilities Council with a focus on the transition subcommittee and transition projects				X
2. Develop/distribute letter to CSHN families as they transition out of CSHN, connect families to VFN for support and services		X		
3. Support VFN in supporting families around transition issues		X		X
4. Completed HRSA Autism transition guidance materials				X
5. Develop strategies to support Medical Homes in care for young adults with ASD and DD, through HRSA A-SIG				X

6. Provide financial technical assistance to families/patients as they transition into adulthood and are no longer covered by child-health insurance programs.		X		
7.				
8.				
9.				
10.				

b. Current Activities

1. It is a difficult transition from health insurance available to children and health insurance for young adults with chronic illness. Continuity of coverage and maintenance of eligibility are challenging to young adults who are newly on their own in every aspect of daily life, and yet the absence of coverage causes disruptions in care and health status. CSHN's role as a filler of gaps helps to restore continuity once the gap is discovered --but prevention is the better course. We are hopeful that solving the transition gaps will be part of state health reform efforts. Provide care coordination to families about medical and educational care through transition.
2. CSHN has received HRSA ASIG funds, including transition goals for transition in PCP care, and transition guidance.

c. Plan for the Coming Year

1. Continue to provide grant support to VFN for their assistance to families and individuals with transition needs.
2. Implement a transition plan for families ending their time at CSHN, connecting them to VFN and other services.
3. Work directly with families currently being served by CSHN that are age 21+ to find alternative sources of financing for health insurance premiums, medical services and products, and family supports, including respite, such as transitioning to VT's Catamount Plan without a 12-month uninsured gap, or application to the State's Working People With Disabilities program, another entry point into Medicaid.
4. Work in partnership with the Blueprint for Health Medical Home Initiative and health insurance reform as VT moves to a single-payor health plan.
5. HRSA Autism SIG work includes transition guidance materials and strategies to support Medical Homes for adults with ASD and DD.

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	90	90	80	80	85
Annual Indicator	79.8	74.4	65.1	71	71
Numerator					
Denominator					
Data Source		National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization 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	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	75	75	80	80	85

Notes - 2011

Data for 2011 is an estimate based on the National Immunization Survey and reflects the 4:3:1:3:3:1 schedule for children 19-35 months in 2010. Data prior to 2009 was reported for the 4:3:1:3:3 and 4:3:1:3 schedules, and rates are not comparable. Data for 2011 had not been published by CDC at the time of submission.

Notes - 2010

Data from National Immunization Survey reflects the 4:3:1:3:3:1 schedule for children 19-35 months in 2010. This reflects a change in national standards with the addition of Varicella vaccine. In 2009 and 2010 the 4:3:1:3:3:1 schedule was reported; in 2008 the 4:3:1:3:3 schedule was reported; and prior to 2008 4:3:1:3 was reported. These rates are not comparable. The comparable 4:3:1:3:3 schedule in 2010 was 77.7%.

Notes - 2009

Data from National Immunization Survey reflects the 4:3:1:3:3 :1 schedule for children 19-35 months in 2009. This reflects a change in national standards with the addition of Varicella vaccine. Data in 2008 was reported for the 4:3:1:3:3 schedule, and prior to 2008 as 4:3:1:3 and the rates are not comparable.

a. Last Year's Accomplishments

1. District Offices hold monthly iz clinics based on demand and staffing capacity. Intervention primarily needed when there are barriers to accessing the medical home, such as not having medical insurance. Families contacted by phone/letter when due for next Iz.
2. Iz screening and follow up is conducted routinely for all children seen in WIC clinics. Follow up services include assistance in locating a regular health care provider, obtaining the child's most current immunization record from their primary care provider, in understanding Medicaid benefits related to immunization, and transportation assistance. When needed, vaccines are administered through the VDH District Office and the information is shared with the Primary Care Provider.
3. Ongoing distribution of a one page "Have Your Tots Had all their Shots" flyer, features a simplified immunization schedule and a toll free phone number to reach VDH Iz Program for more information.
4. Ongoing - via EPSDT - Post cards with the most recent immunization schedule mailed to Medicaid parents at 3 months, 8 months, and 20 months reminding them their child was due for immunizations.
5. VDH works with Refugee Resettlement to facilitate Iz and informed consent for refugees.
6. Coordinate with Child Care programs to notify parents when their child is due for Iz. Overall data gathering to assess levels of Iz for children enrolled in day care.
6. Using CASA software, assess 2 year olds in VDH programs - identify and inform parents if their

child needs Iz.

7. VDH staff stay informed on Iz topics via a variety of methods, including distance learning (CDC and California DL Health Network)
8. District Offices have been connected to the Iz registry. Many offices have been able to populate the registry with a large percent of their children who are enrolled in WIC.
9. Regular AFIX reporting from provider sites.
10. Continuing incremental increase in the number of children enrolled and practices participating in the Immunization registry.
11. Begin to set process for receipt and distribution of new vaccines, such as Rotovirus.
12. Provider manual created and distributed containing up to date clinical information regarding vaccine administration.
13. Maintenance of immunization section on VDH website and updating with crucial new information.
14. Programming to address legislative rules change increasing number of vaccines required for school entry effective as of August 2008.
15. Completed changes in Vaccine distribution system - VDH Central Immunization Office takes orders directly from providers and arranges for shipments. Combined state and federal funds pay for vaccine - system is seamless to front line provider.
16. Funding assistance to providers to upgrade their refrigeration capacity.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Ongoing immunization clinics held by VDH district offices	X			
2. Vaccines for Children (VFC) program ensures universal access to immunizations for Vt children	X		X	
3. Continue expansion of Vt immunization registry				X
4. EPSDT/CIS programs for outreach to families provides support for accessing immunization services	X	X		
5. AFIX program to support clinical practices in increasing rates of fully immunized clients		X		
6. Coordinate with child care programs and schools to support families to fully immunize their children	X	X		
7. Implement new legislatively updated list of vaccines required for school entry			X	
8. New statewide ordering and distribution system incorporating new federal and state financing sources			X	X
9. Enhanced outreach to physicians to improve rates of fully immunized children			X	
10.				

b. Current Activities

As above and also the following:

1. Offset the recent reduction in Iz rates continues to be a priority for Commissioner and VDH.
2. Analysis of Iz rates to determine specific areas of concern, such as lower rates in specific geographic areas or lower rates of certain vaccines.
3. Enhanced outreach to providers in collaborative effort to increase vaccination rates for 4:3:1:3:3:1 schedule (including varicella)
4. Planning for media campaign to parents about importance of immunizations.
5. Planning of outreach to practitioners about how to encourage families to accept vaccination
6. Continue to increase immunizations recorded and providers participating in statewide Iz registry. VDH is now importing data from Fletcher Allen Medical Center as well as from all four major insurers in VT.

c. Plan for the Coming Year

As listed above and including the following:

1. Continued planning for universal access to vaccines for all Vermonters as legislated by Catamount statute - will benefit adults and children of all ages.
2. Continue to implement new childhood vaccine schedule and outreach to providers in collaborative effort to increase vaccination rates for 4:3:1:3:3:1 schedule (including varicella)
3. Planning for large scale social marketing campaign for providers and parents to increase awareness and acceptance of Iz.
4. Coordination with insurers to expand immunization payment systems.
5. Planning and implementing large scale vaccination systems for ongoing response to annual flu season.
6. Planning and response to requirements as set forth in Act 157 regarding immunization reporting, exemption forms revision, immunocompromised children in schools, etc.

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	6	6	7	7	6
Annual Indicator	8.7	7.4	6.7	7.5	7.5
Numerator	113	93	81	91	91
Denominator	12971	12536	12078	12186	12186
Data Source		VT Vital Records and VT population estimates	VT Vital Records and VT population estimates	VT Vital Records and VT population estimates	VT Vital Records
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?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	7	7	6.5	6.5	6.5

Notes - 2011

Reliable data for 2011 are not available at the time of submission. The 2011 estimate is based on 2010 data (which is still preliminary). Population estimates for 2011 will be available in November 2011.

Notes - 2010

2010 birth data for Vermont was still preliminary at the time of submission.

Notes - 2009

2009 birth data for Vermont was still preliminary at the time of submission.

a. Last Year's Accomplishments

1. Priority is given to outreach to pregnant teens and their families including: home visits, classes and support groups, transportation to medical appointments, labor support as needed, support with educational needs.
2. Parent Child Centers focus on education and support around risky behaviors and pregnancy prevention, in particular targeting high risk teens (both male and female). This is done within the public school environment as well as with teens who utilize PCC services.
3. Teens enrolled in CIS are strongly encouraged to finish high school or their G.E.D. and given support for prevention of second pregnancy.
4. Coordination with organizations such as Parent Child Centers, Department of Education, and Planned Parenthood to support general prevention programs and also education efforts directed at teens considered "at-risk"
5. Coordination with VCHIP, AAP, AHS, and Department of Education on broad prevention efforts using Assets-based approach to working with teens and their families.
6. Support for community and state wide activities to postpone subsequent pregnancies due to higher infant morbidity and mortality rates when pregnancies occur in younger women (15-18) and are spaced less than two years apart.
7. Continue to work with schools and the communities to provide esteem building and future directed programs for teenage girls.
8. Support physical activity initiatives such as Run Girls Run and Fit and Healthy Kids to build esteem and educate importance of personal health.
9. Coordinate with Department of Children and Families to promote pregnancy prevention theme in planning prevention programs for children and adolescents.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Services give priority to teens who are parenting and are at risk for subsequent pregnancies	X	X		
2. Pregnancy prevention programs for at risk teens via Parent Child Centers, schools and other community organizations	X	X		
3. Collaborate with VCHIP, AAP, Department of Education on broad based prevention programs for all teens, using asset based approaches		X	X	
4. Continue with self esteem and physical activity programs such as Run Girls Run and Fit and Healthy	X	X		
5. Maintenance of system to insure availability of emergency contraception to teens girls	X			X
6. Collaboration with Planned Parenthood of Northern New England on referrals, funding and services for teen clients	X	X		
7. ACA grant-funded programs such as PREP, Learning Together, and home visitation support teens to avoid first pregnancy or subsequent pregnancies	X	X	X	X
8. Conduct family planning needs assessment and apply findings to statewide planning and programming to reduce teen pregnancy	X	X	X	X
9.				
10.				

b. Current Activities

Programs as listed above and also the following:

1. Continue with collaboration with Planned Parenthood of Northern New England to increase referrals between client populations.
2. Collaborate with PPNNE and other providers of reproductive health services on conducting the Family Planning Needs Assessment and followup from the Title V Strengths and Needs Assessment.
3. Submission of ACA grants to access federal funds for pregnancy prevention, teen support programs re: risk taking behavior, and establishing evidenced based home visiting programs and strengthening existing home/community programs fr pregnant and parenting teens.
4. ACA enabled expanded reimbursement for family planning clinical services via Medicaid and implemeted via PPNNE.

c. Plan for the Coming Year

Activities as listed above and also the following:

1. Continue with collaboration with Planned Parenthood of Northern New England to increase referrals between client populations.
2. Collaborate with PPNNE and other providers of reprodictive health services on follow up from Family Planning Needs Assessment and Title V Strengths and Needs Assessment.
3. Planning and implementing programs as funded by ACA grants for teens at-risk and pregnant and parenting teens such as PREP and MIECHV.

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	71	72	72	72	65
Annual Indicator	66.3	66.3	66.3	61.9	61.9
Numerator	271	271	271	167	167
Denominator	409	409	409	270	270
Data Source		2003 Screening	2003 Screening	2010 Screening	2010 Screening
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	65	65	70	70	70

Notes - 2011

Data for 2011 was not available and an estimate based on 2010 survey is provided. Data from a 2010 VT survey was based on a survey tool developed by the Association of State and Territorial Dental Directors and CDC.

Notes - 2010

Data from a 2010 VT survey, based on a survey tool developed by the Association of State and Territorial Dental Directors and CDC.

Notes - 2009

Data is from a one-time non invasive screening of 1,238 children in grades 1-3 in the year 2002-2003. There has not been another screening conducted since that time. Medicaid data indicates there were 2,546 children ages 6-9 years receiving sealants during FFY09. The Medicaid data is not reported as a percentage here due to inability to determine a denominator of Medicaid children of that age group who need sealants.

A new, comparable VT survey was underway at the time of submission, based on a survey tool developed by the Association of State and Territorial Dental Directors and CDC. Results should be available in the Fall of 2010.

a. Last Year's Accomplishments

1. Ongoing collaboration with EPSDT for dental outreach and access to care activities.
2. Ongoing collaboration with Tooth Tutor and fluoride programs (school-based and community water systems). Expansion of these programs as capacity and funding allows.
3. Planning for implementation of the 12 strategies from the Oral Health Plan. Legislation authorized the "Dental Dozen" initiative and associated state funding. VDH partnered with Office of VT Health Access and Dept of Education to provide a "backpack" message to parents encouraging a dental visit as part of routine health care.
4. WIC screening of children and referral to dental services.
5. Collaboration with child care providers to supply education about oral health to their families.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC screening and referral of families for oral health services.	X			
2. 2. EPSDT outreach and informing letters and focus on education about benefits of sealants.	X	X		
3. District level planning for followup to Oral Health plan and enhanced access.			X	X
4. Placement of a dental hygienist in a large pediatric office	X		X	X
5. Collaboration with PCP's to perform oral health assessments and varnish applications.	X		X	X
6. Medical reimbursement for oral health assessments and varnish applications.			X	X
7.				
8.				
9.				
10.				

b. Current Activities

Activities as listed above and also the following:

1. Focus on expanding the dental hygienists presence in VDH district office.s
2. Collaboration with VDH and AAP to train pediatricians to perform oral health screening of children ages 0-3 years and perform varnish applications.
3. Additional opportunities for training of dental professionals are happening through collaborations with Head Start.
4. Work with Dept of Education, local schools, Medicaid, to inform children and families about the benefits of obtaining age-appropriate sealants for children.
5. Focus on expanding Tooth Tutor 2.0.

c. Plan for the Coming Year

Activities as listed above and also the following:

1. Placement of a dental hygienist in a pediatric clinical practice.
2. Continue collaboration with VDH and AAP to train pediatricians to perform an oral health evaluation for children under three and counseling with the primary caregiver. Promote the fact that Medicaid reimbursement for varnish applications for children up to age 5 is now authorized.

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	2	2	2	2	2
Annual Indicator					
Numerator					
Denominator	104674	103210	101601	104243	104243
Data Source		Death certificates; VT 2007 population estimates	Death certificates; VT 2009 population estimates	Death certificates; VT 2010 Census data	Death certificates; VT 2010 Census 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.			Yes	Yes	Yes
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	2	2	2	2	2

Notes - 2011

Vital statistics data for VT 2011 deaths - especially deaths occurring out-of-state - and 2011 population estimates were not available at the time of submission. Preliminary data should be available by the end of 2012. The 2011 population estimate is based on 2010 Census data.

Notes - 2010

In 2010, 4 children aged 14 or younger died due to traffic motor vehicle accidents in Vermont, a number below the threshold for which rates are to be calculated. The 3-year average (2008-10)

is also less than 5. Vital statistics data for VT 2010 deaths - especially deaths occurring out-of-state - are preliminary.

In addition to the 4 MVTA deaths, one child under 14 died in 2010 in an off-road accident involving an ATV.

Notes - 2009

In 2009, 1 child aged 14 or younger died due to traffic motor vehicle accidents in Vermont, a number below the threshold for which rates are to be calculated. The 3-year average (2007-09) is also less than 5. Vital statistics data for VT 2009 deaths - especially deaths occurring out-of-state - are preliminary.

The total of deaths for 2009 was updated to 2 (in 2012) but this is still below the reporting threshold for small numbers.

a. Last Year's Accomplishments

1. Coordination within VDH and state government and community organizations on car safety issues, such as between VDH, Governor's Highway Safety Council, Child Fatality Review Committee, Safe Kids Vermont, VCHIP, Local Motion, etc.
2. Continued development of the Vermont Injury Prevention Plan (in draft stage) with action steps on MVA.
3. Reexamine other opportunities for collaboration with the Governor's Highway Safety Program, such as with car crash prevention and, specifically, in education of parents as they instruct their teen children on driving techniques.
4. Information about car seat safety and referral programs to car seat distribution programs via VDH programs such as WIC.
5. Support of bike safety fairs and bike helmet distribution systems via Safe Kids.
6. Begin process of VDH STAT for injury, examining VDH capacity to address public health issue of injury, one priority being prevention of morbidity and mortality from motor vehicle crashes.
7. Continued analysis of data describing motor vehicle crashes and resulting morbidity and mortality - use of data in VDH strategic planning and in planning with partners such as the Child Fatality Review Committee, the VDH Injury Prevention Program and SafeKids Vermont.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinate with VDH/state government and community organizations on traffic safety issues	X	X	X	X
2. MCH and EMSC and Safe Kids Vt collaborate on projects designed to improve safe driving habits of Vermonters, especially teens.	X	X	X	X
3. Incorporate Safe States STAT recommendations into planning and programming for traffic safety issues.				X
4. VDH participation in the Child Fatality Review Team: review of child deaths due to MVC and recommendations for prevention				X
5. Local grants to community for Safe Routes to Schools projects	X	X		
6. Referral and outreach of families to community car safety seat programs	X			
7. VDH participation in Safe Kids Coalition and Governing Board			X	X
8.				
9.				
10.				

b. Current Activities

Activities as listed above and also the following:

1. Application to Safe States and acceptance for VDH to receive a STAT visit in August, 2012 (STAT: State Technical Assistance Team) for analysis of VDH Injury programming infrastructure and capacity and recommendations for improvement.
2. VDH conducts VDH specific STAT analysis of Injury capacity. Prioritize public health issues of suicide (adult and youth), motor vehicle crashes, and elderly falls. Plans being developed as to how to develop capacity (staffing and funding) to create a FTE injury position within VDH.
3. Grant to Local Motion (Vermont based bike and pedestrian safety group) for planning a social media campaign promoting use of bike helmets for all ages.
4. Grant to research organization to conduct focus groups with adult ATV users on safe use of ATV's for adults and children.
5. Increase use of EMSC "SIREN" data systems of pre-hospital transports.
6. Increased collaboration with VDH EMSC on injury prevention efforts, especially those for reducing MVC.

c. Plan for the Coming Year

Activities as listed above and also the following:

1. Collaborate with partners to pass appropriate Vermont safety legislation, such as further restrictions on texting/cellphone use, primary seat belt law.
2. Review and create action plan as follow up to Safe States report from August 2012.
4. Continue efforts to develop staffing and funding support for injury prevention at VDH.
5. Continue collaboration with VDH EMSC on injury prevention projects such as increasing availability of driving simulators in Vermont drivers' education programs.

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	60	60	60	60	60
Annual Indicator	53.8	58.2	58.4	58.4	58.4
Numerator					
Denominator					
Data Source		National Immunization Survey - 2006	National Immunization Survey - 2007	National Immunization Survey - 2007	National Immunization Survey - 2007
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?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	60	65	65	65	65

Notes - 2011

The 2011 rate is an estimate based on the provisional 2007 rate from the National Immunization Survey. The numerator and denominator were not reported. In July 2007, CDC revised the way that breastfeeding rates were calculated, which are now based on year of child's birth. The 2010, 2009, 2008, 2007 and 2006 rates are therefore not comparable with 2005.

Notes - 2010

The 2010 rate is an estimate based on the provisional 2007 rate from the National Immunization Survey. The numerator and denominator were not reported. In July 2007, CDC revised the way that breastfeeding rates were calculated, which are now based on year of child's birth. The 2010, 2009, 2008, 2007 and 2006 rates are therefore not comparable with 2005.

Notes - 2009

The 2009 rate is an estimate based on the provisional 2006 rate from the National Immunization Survey. The numerator and denominator were not reported. In July 2007, CDC revised the way that breastfeeding rates were calculated, which are now based on year of child's birth. The 2009, 2008, 2007 and 2006 rates are therefore not comparable with 2005.

a. Last Year's Accomplishments

1. Continue with Breastfeeding Friendly Employer project
2. Continue with electric and manual breast pump distribution to eligible WIC mothers
3. Ongoing community based activities of local breastfeeding coalitions, such as "Baby Showers," educational activities, infant comfort stations at public events, posters, etc.
4. Annual activities for World Breastfeeding Week, including proclamation from Governor.
5. Continue providing prenatal and postpartum support through peer counseling in 4 established districts - Bennington, Middlebury, Rutland, St Albans
6. Updated the breastfeeding section of the VDH WIC manual
7. Annual breastfeeding symposium co-sponsored with the Vermont Lactation Consultant Association

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. VDH and partners support of Breastfeeding Friendly Employer programs and provide TA related to new breastfeeding mothers in the the workplace legislation.	X	X	X	
2. 2. Breastfeeding support programs via WIC such as education, pump distribution, peer counseling, and individual support.		X	X	
3. 3. VDH support of local breastfeeding coalitions.		X	X	
4. VDH/DCF support of child care services that serve infants and toddlers who are breastfed.	X	X		
5. Grow and Glow in WIC training for WIC staff on breastfeeding support for WIC clients.	X	X		
6. Collaboration within VDH and with partners to update and plan action steps for breastfeeding goals of Obesity Prevention Plan.				X

7. VDH support of annual Lactation Consultant Association conference and other state/local conferences.		X	X	
8. Breastfeeding training for physicians and, nurses to complement peer counseling community programs			X	X
9. VCHIP QI project for breastfeeding support services in hospitals			X	X
10. Support breastfeeding component of MIECHV nurse home visitation program			X	X

b. Current Activities

Activities as above and also the following:

1. Grow and Glow in WIC - training staff in breastfeeding support skills presented presented in Burlington as a refresher for current WIC staff and required for new staff. Approximatley 50% of participants in the February 2012 training were community partners from hospitals and local agencies
2. Annual breasfeeding symposium with community partners and hospital and private practice lactation consultants
3. We continue to add new employers as "Breastfeeding Friendly Employers"
4. Mother-Baby Breastfeeding Study offered breastfeeding trainings for physicians, advance practice nurses, and RNs in 3 districts with peer counselors: Middlebury, Rutland, and St Albans. CEU's offered for 1-hour breastfeeding training modules on a variety of breastfeeding topics, such as latch and insufficient weight gain
5. Vermont WIC partnered with VCHIP to bring a maternity care QI project to Vermont hospitals. Breastfeeding Performance Bonus funds received from FNS were used to revise the 2-day "Birth and Beyond California" presentation which will be presented to Vermont hospitals in September 2012
6. Breastfeeding Performance Bonus funds were also used to develop an iPhone app for WIC Breastfeeding Peer Counselors, based on the Peer Counselor Handbook from the FNS 2010 Peer Counseling Training

c. Plan for the Coming Year

1. Continue with activities as listed above wiht Breastfeeding Friendly Employer designations, WIC staff competency trainings, conferences, breastfeeding outreach
2. Insure breastfeeding education and support is contained in the new home visiting programs as funded by MIECHV/ACA grants. Incorporate breastfeeding education more fully into existing statewide home visiting services.
3. Revise Breastfeeding section of state Obesity Prevention Plan to renew focus on activities that will advance policy and evidenced based practices to support longer duration and increase in exclusive breastfeeding.
4. USDA will release the new "Business Case for Breastfeeding" training platform in fall, 2012. Vermont training will occur in first quarter 2013 in central Vermont region
5. Expand peer counseling program as funds allow

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	98	98	98	98	98
Annual Indicator	96.3	95.5	97.8	97.6	98.2

Numerator	5861	5572	5529	5510	5473
Denominator	6088	5832	5655	5645	5574
Data Source		VT Universal Newborn Hearing Screening 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	99	99	99	99	99

Notes - 2011

5,473 out of 5,574 infants* (98.2%) born in Vermont hospitals received hearing screens before discharge. [*Included in this total were 7 infants born enroute to hospital and 3 unplanned home births that were transferred to hospital.] An additional 32 out of the 5,574 infants received hearing screening outside a hospital setting - making a total of 5,505 infants screened, or 98.8% of hospital births.

Birth certificate data for 2011 remain preliminary.

Notes - 2009

Hearing screening data for 2009 was revised in 2011 based on final data.

a. Last Year's Accomplishments

1. We have continued to follow up on a daily basis with hospitals about missed or referred babies. This is a very hand-on process which builds collaborative relationships with the 12 birth hospitals, each of which has somewhat different practices and environments. Our administrative support person has demonstrated remarkable talent in database work as well as skills in phone outreach with families and providers. She has also taken on the responsibility for the "helpdesk" as our web-based information has become available on line to PCPs.
2. The Advisory Council, continues to be the longest-running, consistently productive VDH/MCH/CSHN advisory group. In September of 2011 we received our permanent chapter status with Hands & Voices through the national organization. Hands & Voices provides support to families of children who are deaf and hard of hearing and offers organized activities for children and families.
3. All 12 community hospitals in Vermont are offering outpatient hearing screening and rescreening. Community-based audiologists assist to rescreen babies. FAHC is now offering sleep deprived diagnostic auditory brainstem testing. The funds for the equipment provided by VTEHDI. As a result of sleep deprived testing and the VTEHDI staff care management of infants who refer on universal newborn hearing screening we are improving the percentage of infants identified with permanent hearing loss by 3 months of age.
4. 6 medical homes accepted training, education, mentoring and hearing screening equipment

from the VTEHDI program around office-based screening; plans to expand in the coming year.

5. 16 homebirth midwives received training, education, mentoring, and hearing screening equipment from VTEHDI. 9 hearing screening units were placed regionally across the state for midwives to share. Midwives are now screening infants in their practices and the data is being shared with VTEHDI. In 2011 60% of infants born at home received a hearing screening representing a statistically significant increase from prior years where less than 10% of the population received a hearing screening.

6. Two of the four Early Head Start Programs received hearing screening equipment through the EHDI National program known as NCHAM. VTEHDI supports the efforts of the Head Start Programs and offers mentoring, training and education. One child in the category lost to follow up was identified through the efforts of Early Head Start initiatives.

7. The EHDI program is perhaps our best example of "moving down the pyramid" of functions, the incremental shifting of direct service to the community, while focusing on assurance, monitoring, and care management.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue hands-on, daily interaction with screening hospitals around follow up of babies, to assure that none are lost to follow up.		X	X	X
2. Continue individual and group TA to screening hospitals on practices and policies			X	X
3. Continue to assist the audiology practice community in continuing education opportunities			X	X
4. Continue to support the key guidance and leadership of the advisory council			X	X
5. Continue to implement the objectives of the HRSA and CDC EHDI grants in their third year	X	X	X	X
6. Expand support for medical home office-based screening	X	X	X	X
7. Continue transition from primary provision of gap-filling services, to system integrity monitoring, TA, and case management for missed/referred babies			X	X
8. System of training and support for home birth practitioners.	X	X		
9. Support for screening via Head Start.	X	X		
10.				

b. Current Activities

As above.

1. 9 medical homes across the state are involved with VTEHDI primary care pilot project and are providing hearing screening/rescreening to infants and children in their practices. The pilot project has expanded to include monitoring of children born with high risk factors for developing hearing loss in childhood. Quarterly reports are sent to the medical homes alerting them to the children in their practice who fall into the high-risk category and are in need of rescreening.
2. 3 Naturopaths and 3 home birth midwives have received training, education, mentoring and hearing screening equipment for testing infants born at home.
3. The final two Early Head Start Programs in Vermont are in the process of receiving training, education, and mentoring from VTEHDI in order to provide hearing screening services to their population of children. VTEHDI is providing equipment through HRSA funding.
4. During this year VTEHDI was able to provide equipment to several of the birth hospitals and private audiology practices to increase community capacity of screening and diagnostics of infants and young children. Funding came from a combination of our HRSA grant and income from the Hearing Out Reach program.

5. VTEHDI continues to provide financial support through our HRSA grant for the Vermont Parent Infant Program. A little over a year ago this program received dramatic cuts and VTEHDI services are working to fill the gaps.

c. Plan for the Coming Year

As above and the following:

1. Continue hands-on, daily interaction with screening hospitals around follow-up of babies.
2. Continue individual and group TA to screening hospitals.
3. Continue to assist the audiology practice community in continuing education opportunities
4. Continue to support the key guidance and leadership of the advisory council.
5. Continue to implement the objectives of the HRSA and CDC EHDI grants in their second years.
6. Continue care management for missed/refer and transferred babies.
7. Expand hearing screening pilot projects with primary care physician offices, homebirth midwives and Early Head Start programs. The goal of these projects is to reduce loss to follow up and to monitor children with high risk factors for developing hearing loss in early childhood
9. Expand hospitals reporting to VTEHDI electronically.
10. Expand capabilities of the Childhood Hearing Health System database at the Vermont Department of Health.
11. Continue financial support to the Vermont Parent Infant Program.

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	2	2	6	6	4.5
Annual Indicator	8.5	6.7	4.9	4.4	4.4
Numerator	11700	9100	6600	5700	5700
Denominator	137750	135800	134700	129100	129100
Data Source		Kaiser Foundation, State Health Facts			
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	4	4	3.5	3.5	3

Notes - 2011

Insurance data are unavailable for 2011. They are expected to be published by Kaiser Foundation in March, 2013. The 2011 estimate is based on 2010 data.

Notes - 2009

In 2005, 2008 and 2009, the Vermont Banking, Insurance, Securities and Health Care Administration (BISHCA) carried out a Vermont Household Health Insurance Survey of children 0-17 years old. In 2005, the survey found that 4.9% of VT children (0-17) were uninsured; in 2008 2.9%; and in 2009 2.8% were uninsured. While the age groups used for the two data sources are slightly different, the BISHCA findings appear to be at variance with the Kaiser reports for 2005 and 2008.

a. Last Year's Accomplishments

a. Last Year's Accomplishments

1. Distribute Green Mountain Care "Do You Have Health Insurance" posters to schools via VDH OLH School liaisons. School nurses distribute Medicaid information via mailings to parents. Schools kept up to date with Medicaid eligibility information from VDH EPSDT program.
2. Continued efforts in working with schools to make health insurance status a component of the school emergency card, thus data can be submitted once per year to the VT Department of Education. This information is then reported on the VT School Nurse Report.
3. Screen all WIC applicants for health insurance status, provide information on application process as needed. All pregnant women, infants and children who meet WIC income guidelines are income eligible for Medicaid.
4. Continue statewide mechanism to follow up with families who were sent a Medicaid application, but who did not apply. The follow up will attempt to both identify possible barriers to applying and assist families in actually applying. Review lessons learned from prior year activities and identify new strategies.
5. Coordinate with state and local agencies to inform eligible clients about rules for new state health insurance programs and new federal requirements for Medicaid.
6. Examine impact of new Medicaid funding system on financing for services to MCH population.
7. Work with DCF to support child care providers to inform their families about potential eligibility for Medicaid insurance.
8. See also NPM #4 for CSHCN

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Outreach to potentially eligible children and families via school nurses.		X		
2. Screening and referral to Medicaid services via WIC clinics and programs.	X	X		
3. Coordinate with DCF to support child care providers to refer eligible families to Medicaid.		X		
4. Coordinate with state and local organizations to inform families about the new state and federal regulations on state insurance programs, Medicaid, Catamount/Green Mountain Care, and ACA related benefits	X	X		
5. Continue regular mailings of ESPDT informing letter for families	X	X		
6. Use of data from School Nurse Health Insurance Survey to	X	X		

assist families with access to medical/dental home.				
7. See also NPM #4 for CSHCN.	X	X	X	X
8. Collaborate with Medicaid programs to implement new health insurance regulations/programs as authorized by the federal ACA legislation.	X	X	X	X
9. Outreach to providers on new Medicaid and private insurance offerings for children and families as authorized by ACA federal legislation.		X	X	X
10.				

b. Current Activities

Activities as listed above and also the following:

1. Tracking of data from school nurses on numbers/percent of students who have health insurance and who have been to their medical/dental homes within the past year.
2. VDH informing families about new Green Mountain Catamount Health Care insurance programs and options.
3. See also NPM #4 for CSHCN
4. VDH planning and coordination with schools and communities to disseminate and act on newly available information about children's access to medical/dental homes. For example, use data to identify children without medical/dental home and work with those families to access care.
5. VDH continues active role in assessing impact of new health care legislation and other changes in health insurances (such as Green Mountain Care) and works via its programs and coalitions to assist families with access to health care services.

c. Plan for the Coming Year

Activities as listed above and also the following:

1. Collaborate with Medicaid programs to implement new health insurance regulations/programs as authorized by the federal ACA legislation.
2. Outreach to providers on new Medicaid and private insurance offerings for children and families as authorized by ACA federal legislation and Vermont sigle payor as passed 2011.
3. See also NPM #4 for CSHCN

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	25	25	25	25
Annual Indicator	29.6	29.6	29.3	27.8	28.8
Numerator					
Denominator					
Data Source		CDC Pediatric Nutrition Surveillance Report - 2008	CDC Pediatric Nutrition Surveillance Report - 2009	CDC Pediatric Nutrition Surveillance Report - 2010	CDC Pediatric Nutrition Surveillance Report - 2011
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	25	22	22	22	22

Notes - 2011

The Pediatric Nutrition Surveillance summary published by CDC does not include information on numerator and denominator.

Notes - 2010

The Pediatric Nutrition Surveillance summary published by CDC does not include information on numerator and denominator.

Notes - 2009

Provisional data for 2009 was updated in 2011.

a. Last Year's Accomplishments

1. Ongoing: Screening of every child at routine WIC visits - offering of specialized follow up for those with BMI at or above the 85%
2. Collaboration with family's PCP for children who are overweight or obese.
3. Nutrition and activity programs such as Fit WIC
4. Myriad of breastfeeding support programs via WIC and community groups - to prevent obesity in early childhood (see NPM #11)
5. Collaborate with DCF on programs supporting good nutrition and physical activity in child care centers
6. Completed certifier training modules to standardize training for CPA's
7. Community physical activity programs as supported via Blueprint and Obesity Prevention Plan (See SPM #6)
8. Development of Eat for Health nutrition information information on VDH website
9. General nutrition education for families including special events such as nutrition-themed playgroups
10. WIC staff bi-monthly Nutritional conference calls highlight successful nutrition and physical activity events. Well attended free events include fun and games at fitness club, ice skating and sledding at a local park and cooking demonstrations with local farmers at Farmers' Market.
11. VDH staff placed at providers offices in certain regions to provide WIC enrollments and nutrition education services.
12. Reviewed and completed all pages of the Vt WIC website including sections on breastfeeding, infant feeding, and childhood nutrition
13. Develop display boards/videos for VDH district offices with nutrition messages.
14. Ongoing program to to place Masters of Science dieticians in District Offices and WIC clinics to learn about community based public health programs.
15. Provide WIC staff with Motivational Interviewing training with a focus on childhood obesity prevention to enable staff to counsel WIC families to change nutrition and physical activity behaviors.

16. Strategies to market Text for Baby statewide.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Screening of every child at WIC visits and offering of specialized follow up for those who are overweight or obese.	X			
2. Collaboration with PCP for those children who are overweight or obese.	X			
3. 3. Nutrition and physical activity programs such as Fit WIC.	X			
4. Breastfeeding education and support programs.	X	X	X	
5. Collaborate with DCF in programs supporting good nutrition and physical activity in child care settings.	X	X		
6. Community physical activity programs as supported by the Blueprint and Obesity Prevention Plan.	X	X	X	
7. Nutrition displays at WIC clinics via display boards and videos.	X			
8. Pediatric provider toolkit "Promoting Healthier Weight in Pediatrics."		X	X	
9. 9. Community grants for nutrition and physical activity initiatives.		X	X	
10. 10. Training in pediatric overweight/obese issues for WIC staff and VDH chronic disease designees.		X	X	

b. Current Activities

Those activities as listed above and the following:

1. Provide WIC staff with new nutrition education materials developed by National WIC Association to increase parents' confidence in providing healthy foods.
2. Continue to train Health Outreach Specialist staff to perform WIC certifications
3. Refreshed look of the WIC's quarterly newsletter which is mailed to every WIC household and added Dr. Lewis First, Chief of Pediatrics at Vt Childrens Hospital, as a contributing author on topics including childhood overweight/obesity
4. State level staff will provide increased TA and oversight of the follow up activities on all high risk participants, including overweight children.
5. WIC/VDH/VCHIP coordination on development and testing of pediatric provider toolkit "Promoting Healthier Weight in Pediatrics" which is on VDH website.
6. Community CHAMPPS grants to develop nutrition and physical activity initiatives for children and families.
7. VT WIC in third year of USDA Special Projects Grant entitled "Support Long-term Breastfeeding with the New WIC food packages" to increase supports for women planning to breastfeed their infants.

c. Plan for the Coming Year

Those activities as listed above and including the following:

1. Hold a one-day training for all WIC staff on physical activity and childhood nutrition
2. Continued expansion of community physical activity programs as supported via Blueprint and Obesity Prevention Plan. Use of physical activity sessions in WIC second nutrition contact.
3. Provide training and TA to VDH chronic disease designees for assessment and planning for nutrition and physical activity programs directed towards families and children at the community level. Project must emphasize policy and environmental changes.
4. Continue coordinate with Atty General's efforts to establish new statewide regulations/recommendations geared for obesity prevention per legislative mandate.

5. Revise Breastfeeding section of the state Obesity Prevention Plan to renew focus on activities that will advance policy and evidenced based practices to support longer duration and increases in exclusive breastfeeding.
6. See also discussion NPM #11, SPM #3, SPM #10.
7. VDH working with DCF and child care providers to create guidelines and to increase serving of nutritious meals and snacks.

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	14	14	14	12	14
Annual Indicator	15.8	17.0	16.0	14.9	14.9
Numerator	996	1050	956	906	906
Denominator	6316	6161	5977	6070	6070
Data Source		VT Vital Records birth certificate data	VT Vital Records	VT Vital Records	VT Vital Records
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?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	13	12	12	10	10

Notes - 2011

Vital statistics data for 2011 VT births were unavailable at the time of submission. Preliminary 2011 data should be available in January 2013. The 2011 estimate is based on 2010 data.

Notes - 2010

Vital statistics data for 2010 VT births were still preliminary at the time of submission.

a. Last Year's Accomplishments

1. Pregnant women continue to receive screening and referral to Vermont Quit line by private providers and "safety net" providers such as community health clinics and family planning clinics.
2. Vermont Quit Network offers cessation protocol designed especially for pregnant women through the Quit Line (Quit by Phone) service. This protocol offers extensive counseling for women. Pregnant women can also use the other services of the network for free support and counseling. During FY 11, 80 women who were planning to become pregnant, were pregnant, or were currently breast feeding accessed the network. With approximately 1,100 pregnant smokers annually, these 80 women using the Quit Line represent 7% of the demographic
3. Screening and referral for pregnant women (and for all women) in WIC clinics and via home visiting services.
4. Referral to the Vermont Quit Network through the VDH Ladies First program.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Smoking cessation services specific to pregnant women via the Vt QUIT Line and telephone counseling service.	X	X		
2. Pregnant women receive screening and referral to Vt QUIT line by health care providers, community health clinics, and family planning clinics.	X	X		
3. Educational materials for women who smoke are distributed by community providers.	X	X		
4. Community coalitions participate in smoking cessation campaigns.	X	X		
5. Addressing pregnant smokers via holistic approach to cessation, new materials and partners in chronic disease.	X	X		
6. Updated print materials for women distributed to community organizations and providers	X	X		
7. Healthy Retailers program to reduce tobacco advertising	X	X		
8. Community coalitions and smoke free zones	X	X		
9.				
10.				

b. Current Activities

As listed above and including the following:

1. Through the Public Health Stat process, ongoing education for VDH district office staff for increased referral to the Vermont Quit Network
2. Community coalitions participate in annual adult cessation common theme campaigns. Hospital partners distribute health education materials directed to women who smoke and hold quit in person classes
3. Community coalitions promote smoke free zone activities to help educate community leaders concerning the dangers of second hand smoke exposure. New materials developed and are being distributed to coalitions for use July, 2012
4. Brochure developed to speak to the health impacts of tobacco smoke exposure to both women and their fetus/children during the spectrum of childbearing age. Distribution plan that includes engaging the nursing and medical community
5. Overall activities to reduce second hand smoke exposure and smoking for all ages to change social norms and tobacco use through media, cessation programming, community coalition outreach, and youth prevention programming. Examples of social norm changes include environmental mechanism to reduce second hand smoke exposure in public places (such as outdoor parks, homes, cars) Healty Retailers Toolkit to reduce impact of tobacco advertising at retail outlets
6. Applied FDA grant for programming to address parents who smoke and pregnant smokers.
7. FY12: 60 women who were pregnant, breastfeeding, or considering pregnancy accessed Vt QUIT line.

c. Plan for the Coming Year

As listed above and including the following:

1. Addressing pregnant smokers holistically through Women's Health/Women of Child Bearing Age -- from preconception to parenthood. Distribution and partnership with agencies that are touchpoints for this population. Updating all materials currently in use by WIC offices.
2. Collaboration with VDH Chronic Disease Specialists at district offices, and creating/linking with online resources.
3. Staff were recently trained with Legacy's brief maternal cessation intervention. We will assess

opportunities for bringing this resource for training in WIC and other medical sectors.

4. Set aside media dollars for promotion of Medicaid cessation benefit for pregnant women, and promotion of the cessation benefit for Medicaid beneficiaries as a whole (capturing more broadly women of childbearing age).

5. National Jewish Health is the state's new Quit by Phone vendor and offers a pregnancy protocol. This protocol's data (soon to be published) is showing increased quit rates among pregnant smokers.

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	4	4	3	3	3
Annual Indicator					
Numerator					
Denominator	45733	45231	45995	46012	46012
Data Source			VT Vital Statistics and US Census population estim	VT Vital Statistics and US Census population estim	VT Vital Statistics and US Census population estim
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.			Yes	Yes	Yes
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	2	2	2	2	2

Notes - 2011

Vital statistics data for 2011 VT deaths -- especially out-of-state deaths -- are currently incomplete. Preliminary data will be available in January 2013. Population estimates for 2011 will be available in December 2012.

The 2011 estimate is based on 2010 data.

Notes - 2010

Five suicide deaths were reported in 2010, which is below the minimum numerator size for reporting. The 3-year average (2008-2010) was also less than 5 (3.7). Vital Statistics death reports for 2010 were still preliminary at the time of submission.

Notes - 2009

Two suicide deaths were reported in 2009, which is below the minimum numerator size for reporting. The 3-year average (2007-2009) was also less than 5. Vital Statistics death reports for 2009 were still preliminary at the time of submission.

a. Last Year's Accomplishments

a. Last Year's Accomplishments

1. DMH and VDH work with VCHIP Adolescent Health Initiative. A major goal is to assure that adolescents are screened for risk and protective factors during preventive health visits.
2. Youth Suicide Prevention Coalition providing statewide training for schools and community based professionals on suicide prevention, identification of at-risk teens, and referral to services.
3. VT Injury Prevention Plan includes action steps for suicide prevention in youth.
4. EPSDT staff and VCHIP (via grant from VDH to VCHIP) planning for the VCHIP Adolescent Health Initiative which is designed to improve the quality of preventive health services to adolescents.
5. Suicide deaths are routinely monitored by Child Fatality Review Team.
6. VDH collect and monitor data on suicide attempts and completions.
- 4.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. EPSDT/VCHIP collaboration on Adolescent Health Initiative adolescents are screened for risk and protective factors at preventative health clinic visits.	X	X		
2. Child Fatality Review Team reviews all child/adolescent suicide deaths.				X
3. VDH collects and monitors data of suicide attempts and completions for MCH and Injury Prevention Programs.				X
4. Collaborate with statewide Youth Suicide Prevention Coalition.			X	X
5. Finalize and pursue actions steps related to youth suicide prevention as included in the state Injury Prevention Plan			X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activities as listed above and the following:

- 1) Dept Mental Health with Center for Health and Learning applied for SAMHSA suicide prevention grant but wasn't funded. Goals 1) build infrastructure with Vt Youth Suicide Prevention Coalition 2) collaboration with United Way on statewide media campaign to de-stigmatize mental health issues and normalize help seeking behavior 3) develop statewide school and community Gatekeeper training 4) work with VCHIP to implement targeted interventions for college-age students. Reassess capacity and move forward on projects as able with partners.
2. Youth Suicide Prevention Coalition continues. VDH is active partner in the grant's planning activities.
3. Dept Mental Health convenes workgroup to assess issues of adult suicide. Planning for this group is to follow the model used by Center for Health and Learning and Youth Suicide Prevention Coalition.

c. Plan for the Coming Year

Activities as listed above and the following:

1. Enhance system for VDH collection and monitoring of data on suicide attempts and completions.
2. Youth Suicide Prevention action steps in Vermont Injury State Plan - strategies to be coordinated with Youth Suicide Prevention Coalition - assess VDH/MCH capacity for follow up.

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	95	95	95	95	90
Annual Indicator	92.3	91.0	86.8	84.8	84.8
Numerator	60	61	59	56	56
Denominator	65	67	68	66	66
Data Source		VT Vital Records birth certificate data	VT Vital Records birth certificate data	VT Vital Records	VT Vital Records
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?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	90	90	95	95	95

Notes - 2011

Vital statistics data for 2011 VT births were incomplete at the time of submission. Preliminary data will be available in January 2013. The 2011 estimate is based on 2010 data.

Notes - 2010

Level III neonatal facilities where VT resident very low birthweight babies were born in 2010 comprised Fletcher Allen Health Care (VT), Dartmouth Hitchcock Medical Center (NH), Baystate Medical Center (MA), and Albany Medical Center (NY).

Two babies with very low birthweight were born out of hospital (one unplanned home birth and one born en route to hospital) which were included in the denominator.

VT Vital Records for 2010 were still preliminary at the time of submission.

Notes - 2009

Level III neonatal facilities where VT resident very low birthweight babies were born in 2009 comprised Fletcher Allen Health Care (VT) , Dartmouth Hitchcock Medical Center (NH), and Albany Medical Center (NY).

One baby with very low birthweight was born out of hospital (one unplanned home birth) which was included in the denominator.

a. Last Year's Accomplishments

1. Assessment of all pregnant women in WIC and CIS for risk factors of VLBW and offering education and resource referral for prenatal care. Specialized referral for women who may be at high-risk.
2. Collaboration with the Vermont Regional Perinatal Project and the March of Dimes to facilitate the training for perinatal staff in the latest evidenced-based protocols for transport of women in PTL and the transport of infants born in community birth hospitals to regional medical centers.
3. Vermont Regional Perinatal Health Project, as part of the Vermont Child Health Improvement Program, continues with programs for training and TA to hospital perinatal staff.
4. VDH coordination with Vermont Child Health Improvement Program's Improving Care for Opioid Exposed Newborns (ICON) for care and services for opiate exposed mothers and newborns - specific communications with select birth hospitals to improve transfer policies and practices.
5. 2011 Legislative Session requiring report for January 2012 from VDH and DVHA (Medicaid) on existing programs and scope of services including case management available to pregnant women identified as medically high risk.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with Vermont Regional Perinatal Project to implement activities for training and TA to participating birth hospitals	X	X		
2. Assessment of all pregnant women in WIC/CIS at risk for poor pregnancy outcomes and facilitate appropriate referral for high risk prenatal care	X	X		
3. Collaboration with VCHIP/ICON for QI in services, policies, and procedures for transfer of opioid exposed mothers and newborns	X	X		
4. Collaborate with VCHIP/ICON for planning of establishment of regional centers of care for opioid exposed neonates and their mothers	X	X	X	X
5. VCHIP training for hospital/community medical/nursing staff on risks of late preterm births.	X	X		X
6. MIECHV program of Nurse Family Partnership designed to increase early entry into prenatal care and improve birth outcomes.	X	X	X	X
7. Development of NEMSIS data collection system for EMS and analysis of pre-hospital services			X	X
8.				
9.				
10.				

b. Current Activities

As above and the following:

1. VDH coordination with Vermont Child Health Improvement Program's Improving Care for Opioid Exposed Newborns (ICON) for care and services for opiate exposed mothers and

newborns - planning for certain hospitals to become regional providers of care to neonates of opioid-exposed mothers. This will allow concentrated training for hospital staff in the evidenced based clinical protocols for the care of these mothers and newborns.

2. VCHIP training for community and hospital based medical and nursing staff on risks and follow up care for late preterm newborns.

3. Ongoing coordination with Medicaid case management program for pregnant women who are medically at risk.

4. Begin implementation of MIECHV nurse home visitation program that has key components of assuring appropriate prenatal care and assistance with medical follow up if medical risk factors are identified.

c. Plan for the Coming Year

Continue with activities as listed above and the following:

1. Continue with planning activities for the creation of regional centers of care for opioid addicted mothers and also for care of the late preterm newborn.

2. Follow up on Legislative for January 2012 from VDH and DVHA (Medicaid) on existing programs and scope of services including case management available to pregnant women identified as high risk.

3. Continue with regional implementation of MIECHV nurse home visitation.

4. Participate in NEMSIS data dictionary development for EMS services to receive appropriate information on prehospitalization MCH related emergency services.

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	93	94	95	95	90
Annual Indicator	89.5	89.0	83.3	83.0	83.0
Numerator	5352	5094	4984	5076	5076
Denominator	5982	5721	5985	6117	6117
Data Source		VT Vital Records birth certificate 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?				Provisional	Provisional
	2012	2013	2014	2015	2016

Annual Performance Objective	90	90	95	95	95
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Notes - 2011

VT Vital statistics data for 2011 births were unavailable at the time the report was submitted. Preliminary 2011 data should be available in January 2013. The 2011 estimate is based on 2010 data.

Notes - 2010

For the current grant cycle, the 'new' NCHS 2003 definition of month prenatal care began will be used. 2009 and 2010 rates are therefore not comparable with previous years.

VT Vital Statistics data for 2010 were still preliminary at the time of submission.

Notes - 2009

For the current grant cycle, the 'new' NCHS 2003 definition of month prenatal care began will be used. 2009 rates are therefore not comparable with previous years. When calculated using the 'old' definition of month prenatal care began, 88.9% percent of infants were born in 2009 to women receiving prenatal care in the first trimester.

VT Vital Statistics data for 2009 were still preliminary at the time of submission.

a. Last Year's Accomplishments

1. CIS program staff and program administrators at DCF and VDH manage and facilitate a comprehensive referral system, which puts entry into early and adequate prenatal care as a top priority.
2. Follow-up and outreach is done with individuals through Health Department staff (especially WIC staff) and community home visitors to ensure first trimester connection with a prenatal care provider
3. Contact with providers to facilitate referrals into the CIS system of care and other services.
4. Office of Rural and Primary Health Care activities to ensure adequate health care workforce in Vermont so as to facilitate pregnant women receiving early and adequate prenatal care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. State and community programs (WIC/CIS) manage and facilitate a comprehensive system of care - priority being entry into early and adequate prenatal care.	X	X	X	X
2. VDH works with statewide partners (AHEC, UVM, etc.) to assess and take steps to support adequate OB and pediatric health providers for each region of the state.				X
3. Outreach with providers statewide and via DO's to facilitate referrals to the CIS systems of care and other appropriate services.	X	X		
4. Outreach and follow up with pregnant women (via WIC/CIS) to insure first trimester connection with a prenatal care provider.	X	X		
5. Planning for Integrated Services with CIS and other DCF services to promote seamless systems of care for pregnant women and children. New systems of ACA funded evidenced based home visiting to complement these services.	X	X	X	X
6. Annual review of data from Medicaid/PRAMS/OBNet to glean information describing the system of care and access for pregnant women.			X	X

7. Analysis of disparities for perinatal outcomes as indicated by HSCI #5.			X	X
8. MIECHV program of Nurse Family Partnership designed to increase early entry into prenatal care and improve birth outcomes.	X	X	X	X
9.				
10.				

b. Current Activities

Activities as listed above and also the following:

1. Planning for Integrated Services with CIS and other DCF services to enhance coordination and promote a seamless system of care for families with pregnant women and young children.
2. Office of Rural and Primary Health Care activities continue activities such as surveillance and provider recruitment to ensure adequate healthcare workforce in Vermont so as to facilitate pregnant women receiving early and adequate prenatal care.
3. Examination of disparities evidenced in Medicaid/non Medicaid perinatal outcomes detailed on HSCI #5.
4. Use of Nurse Family Partnership as MIECHV home visiting program, nurses work with pregnant women to increase early entry into prenatal care.

c. Plan for the Coming Year

Activities as listed above and also the following:

1. Continued emphasis on complex systems integration and the planning for Integrated Services with CIS and other DCF services to enhance coordination and promote a seamless system of care for families with pregnant women and young children.
2. Annual review of data from Medicaid, VDH (PRAMS, BC, etc.) and OBNet to glean information describing the system of care quality and access for pregnant women.
3. MIECHV model of Nurse Family Partnership increases pregnant women's early entry into prenatal care.

D. State Performance Measures

State Performance Measure 1: *The percent of Vermont women who indicate that their pregnancies are intended.*

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	73	73	73	70
Annual Indicator	66.0	65.5	61.8	64.9	64.9
Numerator	4128	3928	3603	3834	3834
Denominator	6253	6001	5827	5904	5904
Data Source		VT PRAMS Survey - 2008	VT PRAMS Survey - 2009	VT PRAMS Survey - 2010	VT PRAMS Survey - 2010
Is the Data Provisional or Final?				Final	Provisional

	2012	2013	2014	2015	2016
Annual Performance Objective	70	75	75	75	75

Notes - 2011

Estimate is based on data from PRAMS survey of women who have recently given birth to live infants. This estimate does not include pregnancies that end in abortions or fetal deaths. The 2011 estimate is based on 2010 PRAMS survey data. Actual data for 2011 were not available at the time of reporting. They will be available in 2013.

Notes - 2010

Estimate is based on data from PRAMS survey of women who have recently given birth to live infants. This estimate does not include pregnancies that end in abortions or fetal deaths. The 2010 estimate is based on 2009 PRAMS survey data. Actual data for 2010 were not available at the time of reporting. They will be available in 2012.

Notes - 2009

Estimate is based on data from PRAMS survey of women who have recently given birth to live infants. This estimate does not include pregnancies that end in abortions or fetal deaths.

a. Last Year's Accomplishments

1. Assessment of women's reproductive health needs and referral as needed to providers of family planning services. Assessment performed by staff in state service programs, such as WIC, Childrens Integrated Services, and by community organizations such as Parent Child Centers and Home Health Agencies.
2. State program coordination with family planning service providers such as Planned Parenthood of Northern New England, primary care providers, and Community Health Centers.
3. Public education about availability and use of family planning methods via brochures and websites. Information available in a variety of languages.
4. Community based teen pregnancy prevention programs for pregnant and parenting teens and teens at risk of pregnancy and their male partners - via schools and Parent Child Centers.
5. Sexuality education offered in schools to increase student knowledge about reproductive health and methods of birth control.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordination of women's health care referral needs and referral to providers of family planning services from such programs as WIC, CIS, PCC, HHA.	X	X	X	X
2. Statewide coordination between VDH/MCH and family planning service providers such as PPNNE, FQHC, and private providers.		X	X	X
3. Public education about the availability and use of family planning methods via media campaigns, print material, websites, etc.	X	X		
4. Community based teen pregnancy prevention programs for pregnant and parenting teens and teens at risk of becoming pregnant in schools, PCC's etc.	X	X		
5. Family planning contraceptive methods more affordable via 2012 Medicaid state plan and ability to cover low income women via ACA Federal legislation.	X	X	X	X
6. ACA funded programs to assist vulnerable women with planning for pregnancies such as PREP, Learning Together, Home Visiting.	X	X	X	X

7. Ongoing PRAMS analysis of women's health experiences during pregnancy and postpartum informs public health and community response.			X	X
8. Develop program for primary care providers to ask women screening question about their plans to become pregnant.	X	X		
9.				
10.				

b. Current Activities

Activities as listed above and also the following:

1. VDH Division of MCH and Office of Local Health increasing collaboration with Planned Parenthood of Northern New England to enhance referral of mutual clients for reproductive health services.
2. VDH/EPSTD school health partnership supporting use of school wellness exams that encourage practitioners to use AAP Bright Futures guidelines in sexuality teaching for youth and their parents.
3. SSDI support for PRAMS data analysis of health behaviors of women during pregnancy and postpartum - data will be used for planning and to refine programs to better assist pregnant women during their pregnancies and in general for health programs to support women during their childbearing years.
4. Implement Nurse Family Partnership (via MIECHV funds) with benchmark constructs of increasing access to preconception care and increasing inter-birth intervals.
5. Conducting statewide family planning needs assessment.
6. Medicaid State Plan via 2010 ACA legislation allows low income women to access family planning and be eligible for Medicaid reimbursement - implement this program via Planned Parenthood of Northern New England.
7. ACA funds for Teen Pregnancy Prevention to Parent Child Centers for "Learning Together" Program.
8. ACA funds for Personal Responsibility Education Program (PREP) program of sexual education programs for teens.

c. Plan for the Coming Year

As above and the following:

1. Collaboration with PPNNE and other providers of reproductive health care for planning as informed by the Title X program requirement for Family Planning needs assessment and the Title V MCH assessment.
2. Seek funding to support and expand Nurse Family Partnership to all regions of the state.
3. Begin planning for implementation of an intentional screening program for primary care providers so as to enable a preconception health and contraception dialogue between provider and women patients.

State Performance Measure 2: *The percent of youth who do not binge drink on alcoholic beverages.*

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	82	82	85	85	85
Annual Indicator	77.0	77.0	79.7	79.7	79.1
Numerator	29744	29744	29357	29357	22085
Denominator	38641	38641	36839	36839	27937
Data Source		YRBS	YRBS	YRBS	YRBS

		Survey - 2007	Survey - 2009	Survey - 2009	Survey - 2011
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	85	85	85	85	85

Notes - 2011

Weighted data for 2011 are based on a YRBS survey carried out in the same year. In 2011, the former YRBS Survey was split into two separate surveys, one administered to children in grades 6-8 and one administered to children in grades 9-12. The present data for children in grades 9-12 are not directly comparable to earlier years data for children in grades 8-12.

Notes - 2010

The YRBS survey is carried out biennially. The estimate for 2010 is based on a YRBS survey carried out in 2009.

Notes - 2009

Weighted data for 2009 are based on a YRBS survey carried out in the same year.

a. Last Year's Accomplishments

1. VDH Division of Alcohol & Drug Abuse Programs supported 20 Rocking Horse Circle of Support community-based support groups providing education on prenatal alcohol use.
2. Underage drinking initiatives such as Stop Teen Alcohol Risk Teams (START), Alcohol Awareness month and public education about underage drinking
3. Partnered with a community organization to manage the Vt Alcohol & Drug Information Clearing House (VADIC) increasing access to alcohol and other drug resources including brochures, posters, and DVD's.
4. 8 Regional Prevention Consultants offered a variety of services to communities to address alcohol and other drug prevention. Services include program planning, information, training, consultation and community organization.
5. 24 SPF/SIG grantees received funding to continue implementation plans for addressing goals of reducing underage drinking, reducing high risk drinking among persons under age 25 and reducing marijuana use in persons under age 25.
6. Six community coalitions received New Directions grant funds to support the prevention and reduction of underage substance abuse, capacity building and implementation of evidence based practices.
7. Strategic planning on how to connect prevention, intervention and treatment initiatives through the Resiliency Recovery Oriented System of Care (RROSC) process.
8. VDH Division of Alcohol and Drug Abuse Programs provided funding for 88 high schools and middle schools to support Student Assistance Programs (SAP's). SAP's provide prevention education, screening, referrals, training and consultation.
9. Implemented a ParentUP booster campaign targeting parents of both middle and high school students.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support Community Based Prevention grantees on strategies to address youth binge drinking	X	X	X	
2. Development of Resiliency Recovery Oriented System of Care community plans to create system of prevention, intervention,	X	X	X	X

and treatment services.				
3. Parent UP media campaign about underage drinking targeting parents of both middle and high school students.	X	X		
4. Underage drinking initiatives such as Stop Teen Alcohol Risk Teams, and public education campaigns about underage drinking.	X	X		
5. Regional Prevention Consultants offer services to communities on drug and alcohol abuse prevention.	X	X		
6. VDH PH STAT recommendation for decreasing alcohol use during pregnancy	X	X		X
7.				
8.				
9.				
10.				

b. Current Activities

Activities as listed above and also the following:

1. The Division of Alcohol and Drug Abuse Programs will support 16 Community Based Prevention grantees to continue evidence based strategies to address youth binge drinking. (this activity replaces activities #5 & #6 listed above)
2. Support the development of Resiliency Recovery Oriented System of Care (RROSC) community plans to create a community based system of prevention, intervention and treatment services.
3. VDH Division of Alcohol & Drug Abuse Programs provided funding for 85 high schools and middle schools to support Student Assistance Programs (SAP's). SAP's provide prevention education, screening, referrals, training and consultation.
4. VDH Division of Alcohol & Drug Abuse Programs continued to promote the ParentUP campaign targeting parents of both middle school and high school students. Information and materials are available on the VDH/ADAP website, available at the VT Alcohol & Drug Information Clearinghouse and community START grantees.
5. Conducted PH STAT on alcohol use during pregnancy with MCH and ADAP staff.

c. Plan for the Coming Year

As above and the following:

1. VDH Division of Alcohol & Drug Abuse Programs provided School Based Substance Abuse Service grants to 21 Supervisory Unions for the delivery of substance abuse prevention and early intervention services. (this activity replaces activity #3 above)
2. Followup on STAT recommendations, such as messaging to providers on recommendation that no amount of alcohol is considered safe during pregnancy.

State Performance Measure 3: *The percent of women of childbearing age who consume at least two servings of fruit and three servings of vegetables daily.*

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	35	35	38	38	35
Annual Indicator	35.0	35.0	33.1	33.1	28.3
Numerator	38680	38680	34126	34126	29300
Denominator	110600	110600	103223	103223	103600

Data Source		BRFSS Survey - 2007	BRFSS Survey - 2009	BRFSS Survey - 2009	BRFSS Survey - 2011
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	35	38	38	40	40

Notes - 2011

Note that: in 2011 there were significant changes to the fruits and vegetable questions on the BRFSS. The 2011 data are not comparable to previous years.

In earlier years there was no specific time frame placed on the questions which simply asked, "how often do you...". In 2011, respondents were asked about their consumption in the past 30 days. The fruit consumption questions had additional minor changes such as the juice question was changed to specify drinking 100% fruit juices, rather than just juice. Significant changes were made to the vegetable questions. In the past, respondents were asked how often they eat green salad, carrots, potatoes, and other vegetables. Beginning in 2011, the questions were changed to ask about consumption of dark green vegetables, orange vegetables, beans, and other vegetables. The weighting methodology used to produce population estimates was also changed in the 2011 survey.

As a result of all these changes, reported consumption of vegetables decreased from 2009 to 2011. This change does not necessarily reflect a change in underlying eating behaviors.

This measure is in the process of being replaced by another state performance measure.

Notes - 2010

The 2010 estimate is based on 2009 BRFSS survey of VT women 18-44 years. The BRFSS fruit and vegetable survey questions are only asked in Vermont every other year. Weighted data for 2011 will be available in February 2012.

Note that BRFSS question does not differentiate between fruit and vegetable servings. Numerator reported is population estimate for women 18-44 years who reported eating 5 or more servings of fruits and vegetables, combined.

Notes - 2009

Weighted data based on 2009 BRFSS survey of VT women 18-44 years. Note that BRFSS question does not differentiate between fruit and vegetable servings. Numerator reported is population estimate for women 18-44 years who reported eating 5 or more servings of fruits and vegetables, combined.

a. Last Year's Accomplishments

1. State level CHAMMPS grants awarded to communities to focus on policy and environmental change for healthy choices. Activities include increasing access to fresh fruits and vegetables via farm to school programs, working with local food shelf to offer produce from farmers and community gardens, and creating new community gardens in underserved areas.
2. Farm to school grants awarded to schools for planning and implementation of farm to school to integrate the program in community, classroom, and cafeteria increasing children's exposure and acceptance of new fruits and vegetables.
3. Update state nutrition wellness policy guidelines for nutrition standards for food served and sold in schools outside of the school meal program.
4. Healthy retailer program.
5. Pediatric prevention toolkit.
6. Promote access to healthy food and support breastfeeding in workplaces for all employees

through: offering model Healthy Food policies for food served at workplace events, in vending and cafeterias; distributing the Worksite Wellness Resource; hosting an annual Worksite Wellness Conference; giving out annual worksite wellness awards (78 in 2012)

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Women in WIC are offered education about fruits and vegetable consumption and supports such as Farm to Family coupons and EBT WIC cards for purchase of fruits and vegetables.	X	X		
2. School based programs such as health classes, food services, and other courses offer education to children and youth about the importance of fruits and vegetables.	X	X	X	
3. 3. Collaboration with DCF/ECCS to support child care providers to promote fruits and vegetable consumption with the children and mothers who use their services.	X	X		
4. 4. Coalition with advisory committee for VT Obesity Preventin Plan on objectives relating to diet and nutrition.			X	X
5. Folic Acid education about food sources in WIC clinics	X	X		
6. 6. Nutrition training for WIC and community health workers.		X		
7. Collaboration with state agencies on activities around worksites, schools and communities via H.887.	X	X	X	X
8. Maintenance of media campaign for Eat for Health website.	X	X		
9.				
10.				

b. Current Activities

As above and also the following:

1. Ongoing partnership in the statewide Farm to School Network.
2. Governor's Hunger taskforce working toward recommendations to increase access to nutritional foods for all Vermonters.
3. Adding a Farm to Family coupon for produce at farmers markets for women enrolled in the Ladies First cardiovascular disease risk reduction program.

c. Plan for the Coming Year

As above and also:

1. VDH partner with DCF to enhance licensing requirements for early childcare to support healthy eating and physical activity.
2. Develop Healthy Retail store designation for retailers who offer and promote healthy choices including fruits and vegetables and limiting the promotion of tobacco and alcohol.
3. Work with town planners and state officials to enhance the physical environment in ways that support physical activity and healthy eating. (such as via Community Transformation Grants)
4. Identify and work with schools and worksites in rural, low income (highest need) areas of the state.
5. See also NPM #11, NPM # 14, SPM #10.

State Performance Measure 4: *The percent of youth who feel like they matter to people.*

Tracking Performance Measures

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

Annual Objective and	2007	2008	2009	2010	2011
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Performance Data					
Annual Performance Objective	48	48	50	50	50
Annual Indicator	47.4	47.4	46.5	46.5	55.1
Numerator	18192	18192	16262	16262	15051
Denominator	38355	38355	34936	34936	27312
Data Source		YRBS Survey - 2007	YRBS Survey - 2009	YRBS Survey - 2009	YRBS Survey - 2011
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	50	55	55	55	55

Notes - 2011

Weighted population estimate based on YRBS survey carried out in 2011.

Notes - 2010

The YRBS survey is carried out biennially. Data for 2010 is based on the weighted population estimate from the YRBS survey carried out in 2009.

Notes - 2009

Weighted population estimate based on YRBS survey carried out in 2009.

a. Last Year's Accomplishments

1. School Health curricula and programs dealing with development of self esteem and confidence building. Anti-bullying and anti-racism education programs required to be taught in the public schools by state legislation.
2. School and community mentoring programs via schools, Boys and Girls Clubs, Boy/Girl Scouts, 4H, faith based groups, etc.
3. Substance abuse/Drug and Alcohol prevention programs via schools and community based grants - refer to SPM 3.
4. Vermont Child Health Improvement (VCHIP) project development of positive youth development materials for teens and parents of teens - such as adolescent emotional development assessment tool designed to be used by primary care providers in youth "well child" visits.
5. Incorporation of youth suicide prevention action steps in the planned revision of the Vermont State Injury Prevention Plan.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support of school health curricula and programs dealing with development of self esteem, such as anti-bullying and antiracism programs.			X	
2. Support of school and community mentoring programs.			X	
3. VCHIP development and distribution of positive youth development educational tool for providers, youth, and parents.	X	X		
4. Support of substance abuse/drug and alcohol prevention programs.	X	X		
5. VCHIP initiatives to improve screening, referral, and access to services dealing with youth and mental health needs.	X	X	X	
6. EPSDT/School wellness exam requirements use of Bright	X			

Futures and mental health and wellness in anticipatory guidance.				
7. Education in schools about sexual assault and prevention according to regulations in Act 1.	X			
8. Youth Suicide Prevention Coalition statewide education activities in schools and communities.	X	X	X	
9.				
10.				

b. Current Activities

Activities as listed above and also the following:

1. VDH participation in Youth Suicide Prevention Coalition activities resulting from newly obtained SAMHSA grant. Major activities are training of school personnel, students and community members about recognizing the signs of suicide in youth and how to respond.
2. VDH participation in planning and implementation of educational activities related to Vermont Act 1 - designed to educate students and school personnel about sexual assault and violence and its prevention.
3. EPSDT/Schoolhealth collaboration encouraging use of Bright Futures guidelines in wellness exams - guidelines for anticipatory guidance and assessment of child development and mental health.
4. Community Transformation Grants to youth serving organizations for physical activity and nutrition programs.

c. Plan for the Coming Year

Activities as listed above and also the following:

1. Continued work with Vermont Youth Suicide Prevention Coalition.
2. Incorporate "youth matter" concepts into various program such as family planning, school health, risk behavior reduction, injury prevention, etc.

State Performance Measure 5: *The percent of low income children (with Medicaid) who utilize dental services in a year.*

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	54	54	55	55	55
Annual Indicator	52.9	50.0	52.8	54.2	54.0
Numerator	30321	29584	33322	34100	34137
Denominator	57307	59170	63141	62862	63201
Data Source		CMS-416 report	CMS-416 report	CMS-416 report	CMS-416 report
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	60	60	60	60	60

Notes - 2010

Source of data reported in previous years was Office of Vermont Health Access (OVHA). 2007 and 2008 data were revised in 2010 to reflect published CMS-416 reports. Comparable values for: 2002 = 46.2%; 2003 = 46.8%; 2004 = 46.4%; 2005 = 49.2%; and 2006 = 52.3%. Data from 2007 onwards should not be compared directly with previously published values for earlier years.

Notes - 2009

Source of data reported in previous years was Office of Vermont Health Access (OVHA). 2007 and 2008 data were revised in 2010 to reflect published CMS-416 reports. Comparable values for: 2002 = 46.2%; 2003 = 46.8%; 2004 = 46.4%; 2005 = 49.2%; and 2006 = 52.3%. Data from 2007 onwards should not be compared directly with previously published values for earlier years.

a. Last Year's Accomplishments

1. WIC screen and referral for Oral Health Services.
2. Continue to administer and expand Tooth Tutor programs as capacity allows.
3. Continue to monitor, via the school health emergency card, the number of children reporting they do not have a dental home and school nurses assist with finding dental home.
4. Follow up to the statewide Oral Health Plan and Dental Dozen.
5. Loan/scholarships for dental health professionals administered via Office of Rural Health.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinate with Dental community and Medicaid to insure implementation of pediatric periodicity schedule.	X	X	X	X
2. Expand Tooth Tutor as capacity allows		X		
3. Continue VDH district communications statewide to followup on oral health plan.			X	X
4. Create oral health action and surveillance plan				X
5. Pilot to place dental hygienists in large pediatric offices.		X		
6. Train pediatricians and family practice physicians to perform oral health assessments on infants and toddlers.			X	X
7. EPSDT and school nurse monitor/follow up with children who report not having access to dental home.	X	X		
8. FQHC services offering clinical dental services.	X	X		
9. Loans and scholarships for dental health workforce development			X	X
10.				

b. Current Activities

Activities as listed above and also the following:

1. Placement of a dental hygienist in one of the state's largest pediatric practices to evaluate the oral health needs of children, ages 0-3 who use Medicaid insurance - assess and referral to participating area dentists and also to train providers on oral health risk assessment.
2. Development of 12 strategies from the Oral Health Plan and building capacity through staffing and funding.
3. Continue planning for dental hygienists to be placed in four VDH district offices
4. Data on dental home from school health emergency card is able to be organized and retrieved electronically.
5. Vt Dental Periodicity Schedule created in conjunction with recommendations of American Academy of Pediatric Dentistry. Posted on VDH website.
7. Opening of a dental clinic in the Morrisville area FQHC.
8. Presented a Tooth Tutor training and conference in conjunction with Vt Dental Hygienists' Assn Annual Meeting.
9. Provided daylong training in Baby Oral Health Project in collaboration with Vermont' Head Start programs and the AAPD's Dental Home Initiative.

c. Plan for the Coming Year

Activities as listed above and also the following:

1. Continue planning and implementation of Dental Dozen initiative.

2. Work with Medicaid/AAP partners to promote the reimbursement to PCPs to apply varnish for children ages 3-5.
3. Planning continues to expand program to placement of Dental Hygeinist in pediatric practices and in up to 4 VDH district offices.
4. Coordinate with Medicaid and dental providers to implement dental periodicity schedule.
5. Enhance the ability of Tooth Tutor (TT 2.0) to track individuals over time to ensure that the families make and keep appointments at least annually.
6. Head Start Tooth Tutors continue to train dental office staff to see children ages 0-3; at least 10 offices will be targeted.
8. Create oral health action plan and surveillance plan with oral health coalition.

State Performance Measure 6: *The percent of one year old children who are screened for blood lead poisoning.*

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	82	82	83	84	85
Annual Indicator	84.6	82.6	83.8	77.9	78.6
Numerator	5249	5368	5443	5062	4993
Denominator	6203	6495	6495	6502	6349
Data Source		Lead sreening Program	Lead sreening Program	Lead sreening Program	Lead sreening Program
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	85	90	90	90	90

Notes - 2011

In 2011, the Vermont Child Lead Screening program changed the method used to calculate the numerator for this measure. Previous calculations were found to have undercounted the number of children screened. Comparable rate calculations for 2005 through 2007 are 79.9%, 80.1% and 79.2%, respectively. The rates for 2008 onwards should not be compared directly to previously published rates for the earlier years.

Notes - 2010

In 2011, the Vermont Child Lead Screening program changed the method used to calculate the numerator for this measure. Previous calculations were found to have undercounted the number of children screened. Comparable rate calculations for 2005 through 2007 are 79.9%, 80.1% and 79.2%, respectively. The rates for 2008 onwards should not be compared directly to previously published rates for the earlier years.

Notes - 2009

In 2011, the Vermont Child Lead Screening program changed the method used to calculate the numerator for this measure. Previous calculations were found to have undercounted the number of children screened. Comparable rate calculations for 2005 through 2007 are 79.9%, 80.1% and 79.2%, respectively. The rates for 2008 onwards should not be compared directly to previously published rates for the earlier years.

a. Last Year's Accomplishments

1. Conducting a 10-month internal planning process to transition from a Lead Poisoning Prevention Program to a Healthy Homes Lead Poisoning Prevention Program
2. Mailing postcards monthly to parents of 10- and 22-month-old children reminding them of the need for lead screening at their medical home
3. Screening 18- and 24-month-old children at WIC appointments if health care provider has not screened the child at 12- and 24-month well child checks
4. Offering training in performing capillary tests to primary care providers as requested
5. Providing free capillary test supplies to health care providers who request them
6. Mailing educational materials and the offer of a lead dust wipe test kit to parents of children whose blood lead levels are in the range from 5 through 9 micrograms per deciliter
7. Offering dust wipe test kits to pregnant and post-partum women at WIC
8. Working with the Vermont chapter of the American Academy of Pediatrics to distribute Lead Care II machines to help encourage screening
9. Collaborating with the Vermont Housing and Conservation Board and the Burlington Lead Program to reduce lead hazards in homes of lower income families
10. Conducting public education and outreach on the dangers of childhood lead poisoning through a variety of activities such as health fairs, home shows, and displays during National Lead Poisoning Prevention Week
11. Collaborating with Lead Safe Homes in Bellows Falls in the distribution and use of lead dust wipe test kits

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Screening 18- and 24- month old children at WIC appt if health care provider has not screened the child at 12- and 24 - well child checks screening referral services at WIC clinics	X	X		
2. Routine mailing of reminder postcards to parents of 10 and 22 month old children.	X	X		
3. Conducting a 10-month internal planning process to transition from a Lead Poisoning Prevention Program to a Healthy Homes Lead Poisoning Prevention Program			X	X
4. Offering training in performing capillary tests to primary care providers as requested	X	X		
5. Providing free capillary test supplies to health care providers who request them	X	X		
6. Mailing educational materials and the offer of a lead dust wipe test kit to parents of children whose blood lead levels are in the range from 5 through 9 micrograms per deciliter	X	X		
7. Offering dust wipe test kits to pregnant and post-partum women at WIC	X	X		
8. Working with the Vermont chapter of the American Academy of Pediatrics to distribute Lead Care II machines to help encourage screening	X	X		
9. Collaborating with the Vermont Housing and Conservation Board and the Burlington Lead Program to reduce lead hazards in homes of lower income families			X	X
10. Conducting public education and outreach on the dangers of childhood lead poisoning through a variety of activities such as health fairs, home shows, and displays during National Lead Poisoning Prevention Week	X	X		

b. Current Activities

1. Continuing ongoing lead educational and outreach activities from FFY 11
2. Working with CDC to deploy the Healthy Homes Lead Poisoning Surveillance System
3. Conducting an external strategic planning process to create a healthy homes collaboration among more than 30 governmental and non-governmental organizations
4. Pilot testing filter paper as another method of lead screening

c. Plan for the Coming Year

In the coming year, the plan is to begin implementing a statewide Healthy Homes Lead Poisoning Prevention Program (HHLPPP) in collaboration with internal and external partners. HHLPPP will be state funded using Vermont Medicaid Global Commitment dollars insofar as funding will no longer be available for the HHLPPP cooperative agreement with CDC. The HHLPPP staff will be at full capacity in the coming year and will be able to focus on conducting outreach to health care providers about lead screening for their one- and two-year-old patients to increase testing rates and help reach the mandates of Vermont’s Lead Law.

State Performance Measure 7: *The percent of youth grades 8-12 who report always wearing a bicycle helmet when riding a bicycle.*

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			13.4	13.4	18.4
Numerator			3392	3392	3954
Denominator			25240	25240	21451
Data Source			YRBS Survey - 2009	YRBS Survey - 2009	YRBS Survey - 2011
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	15	20	20	20	20

Notes - 2010

The YRBS survey is carried out every two years. There was no survey in 2010. 2010 data is populated using 2009 survey data.

a. Last Year's Accomplishments

1. Creation of Title V measure from YRBS data to initiate formal public health attention to this risk behavior.
2. Collaborate with Local Motion and Vermont Safe Kids to support and expand bike safety programs for youth.
3. Collaborate with PHAT (Protect Your Head At All Times) to expand helmet use safety message from snowboarding programs to bike, skateboard, and ATV use.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service
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	DHC	ES	PBS	IB
1. Monitoring with colleagues of Title V measure from YRBS data to initiate formal public health attention to this risk behavior.				X
2. Collaborate with Local Motion and Vermont Safe Kids to support and expand bike safety programs for youth.	X	X		
3. Collaborate with PHAT (Protect Your Head At All Times) to expand helmet use safety message from snowboarding programs to bike, skateboard, and ATV use.	X	X		
4. Collaboration with school nurses to promote "PHAT" safety message.	X	X		
5. Follow up from Safe States recommendations	X	X	X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

As above and the following:

1. Collaborate with Local Motion and Vermont Safe Kids to support and expand bike safety programs for youth. Funds from Title V used to support planning for media messaging.
3. Collaborate with PHAT (Protect Your Head At All Times) to expand helmet use safety message from snowboarding programs to bike, skateboard, and ATV use. Funds from Title V used to conduct focus groups on perceptions of ATV safety

c. Plan for the Coming Year

As above and the following:

1. Closer collaboration with school nurses to promote "PHAT" safety message.
2. Follow up on Safe States STAT recommendations relating to bike and traffic safety programming

State Performance Measure 8: *The length of time between referral from pediatric primary care provider to the first Child Development Clinic kept appointment for children identified as having a potential developmental delay or ASD*

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					90
Annual Indicator		90.0	177.7	153	140.9
Numerator		90			
Denominator		100			
Data Source		CSHN Data	CSHN Data	CSHN Data	CSHN Data
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	80	70	60	60	60

Notes - 2011

The average number of days from referral to first kept appointment. There was a 7.9% reduction in average waiting time between 2010 and 2011.

Notes - 2010

The average number of days from referral to first kept appointment. There was a 13.9% reduction in average waiting time between 2009 and 2010.

The 2010 rate was revised in 2012 based on a chart review and updating of dataset.

Notes - 2009

The average number of days from referral to first kept appointment. The 2009 rate was revised in 2012 based on a chart review and updating of dataset.

a. Last Year's Accomplishments

CSHN staff began to address this measure as supported by the SIG project to update systems so as to decrease the time from primary care provider referral to family being seen at VDH CSHN CDC clinic. The following activities were undertaken:

1. Increase the clinical staffing capacity with the addition of a more physician time, a 2nd psychologist and additional social work staff in the clinic team.
2. Reduce the paperwork requirements, but streamlining the content and timeline of forms sent to families.
3. Renovation of electronic systems to better track the process for families, need for follow-up and to move records between the central office and satellite clinic teams electronically, rather than through paper.
4. Tracking systems and enforcement of a 14-day diagnostic report turnaround.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Adjust referral system so as to be able to offer appointment for developmental disability assessment within 60 days of primary care referral.	X	X	X	X
2. Monitor ability of system to track referrals and time elapsed within the CSHN data system	X	X		X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSHN staff continue to address this measure as begun under the SIG project to update systems so as to decrease the time from primary care provider referral to family being seen at VDH CSHN CDC clinic. Current activities will focus on a continuation of the action steps as listed above.

c. Plan for the Coming Year

CSHN staff continue to address this measure as begun under the SIG project to update systems so as to decrease the time from primary care provider referral to family being seen at VDH CSHN CDC clinic. Activities for the coming year will focus on a continuation of the action steps as listed above.

State Performance Measure 9: *The rate per 1,000 of substantiated cases of child abuse and neglect for the population of children ages 0-17 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					4.5
Annual Indicator		5.2	5.1	5.6	5.6
Numerator			669	724	724
Denominator			130576	129233	129233
Data Source		VT Department of Children and Families			
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	4.5	4.5	4.5	4.5	4.5

Notes - 2011

Data for 2011 were not available at the time of submission. They should be available in January 2013. The 2011 estimate is a projection based on 2010 preliminary numbers.

Notes - 2010

There were 724 substantiated VT cases of child maltreatment in 2010. The 2010 population estimate* for children 0-17 was 129,233, giving a rate of 5.6 cases per 1,000 children.

The number of substantiated cases in 2010 is preliminary.

* Based on 2010 U.S. Census.

Notes - 2009

Updated in 2012:

There were 669 substantiated VT cases of child maltreatment in 2009. The 2009 population estimate* for children 0-17 was 130,576, giving a rate of 5.1 cases per 1,000 children.

* Adjusted intercensal population estimate based on 2010 U.S. Census.

a. Last Year's Accomplishments

1. Beginning planning with VDH/MCH and DCF on creating this measure, especially with the opportunity from MIECHV funding to create a VDH specific measure to address the issue of child maltreatment.
2. Coordination with DCF on identification of families where there may be potential issues of abuse and neglect and appropriate referral
3. Child abuse and neglect included as injury issue in Vermont State Injury Prevention Plan with action steps
4. VDH participation on Child Fatality Review Committee

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. VDH District Staff are aware of risk of child abuse and neglect and refer families who need education and intervention to DCF	X	X		
2. Child abuse prevention as a topic addressed in Vermont Injury Prevention Plan			X	X
3. Tracking child abuse and neglect reporting as part of data assessments for MIECHV program.				X
4. Intervention with MIECHV program of Nurse Family Partnership	X	X		
5. Follow up on recommendations from Safe States STAT visit August 2012	X	X	X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Measure created for Title V application and also for MIECHV construct of measuring "reported suspected /substantiated maltreatment" and "first time victims of maltreatment" for children participating in MIECHV program of Nurse Family Partnership.
2. Coordination with DCF on efforts to support child abuse prevention via common programing.
3. STAT process from Safe States will address child maltreatment as one of the many child injury prevention issues for Vermont.

c. Plan for the Coming Year

Activites as listed above. Continued follow up via programing and outcome data monitoring of MIECHV and follow up from Safe States STAT.

State Performance Measure 10: *The percent of women giving birth to a live infant who had a preconception body mass index (BMI) between 18.5 and 24.9.*

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					
Annual Indicator			50.2	49.5	49.9
Numerator					
Denominator					
Data Source			Vital Records	Vital Records	Vital Records
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	50	55	55	60	60

Notes - 2011

Vermont Vital Records birth certificate data (items 31 and 32 on the U.S. standard certificate of live birth): (a) Mother's height (inches) and (b) Mother's pre-pregnancy weight (pounds).

Notes - 2010

Vermont Vital Records birth certificate data (items 31 and 32 on the U.S. standard certificate of live birth): (a) Mother’s height (inches) and (b) Mother’s pre-pregnancy weight (pounds).

Notes - 2009

Vermont Vital Records birth certificate data (items 31 and 32 on the U.S. standard certificate of live birth): (a) Mother’s height (inches) and (b) Mother’s pre-pregnancy weight (pounds).

a. Last Year's Accomplishments

1. Planning, communication with VDH colleagues in WIC and family planning, and data analysis in preparation for creating this SPM.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinate with other community based nutrition and healthy weight programs such as those funded by Community Transformation Grant	X	X	X	X
2. Planning for primary care screening for pregnancy intendedness and healthy weight	X	X	X	
3. Coordinate with WIC programs that support WIC women participants and families to achieve a healthy weight	X	X	X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Development of the new state performance measure as related to MCH Priority Goal #3 of Women lead healthy and productive lives. Planning takes place via intentional review of all SPM's in monthly VDH MCH leadership meetings.
2. WIC program components of educating and working with post partum women to regain or achieve a healthy weight.
3. VDH Nutrition program initiatives for the general public in support of achieving a healthy weight, such as nutrition and physical activity programs in communities and worksites, farm to family/school/plate
4. WIC breastfeeding support programs.
5. Planning for a preconception health program to support practitioners to discuss intended pregnancy and preconception health, including healthy weight - See SPM #1. 5. See also NPM #11, NPM #14, and SPM#3.

c. Plan for the Coming Year

As above and the following:

1. Progress on implementation of pregnancy and preconception health screening question for primary care providers.
2. PH STAT analysis process within VDH programs that address healthy weight.

E. Health Status Indicators

SSDI data support and analyses has been a major support for such planning activities as the MCH strategic planning in 2010-2011, Healthy Vermonters 2020, the 2010 MCH Strengths and Needs Assessment, the home visiting needs assessment for the Maternal Infant Early Child Home Visiting Assessment, VDH strategic planning, the Vermont Injury Prevention Plan and the Family Planning Needs Assessment (August, 2012.) SSDI support will also be used in monitoring of the MIECHV home visiting constructs. SSDI support is planned for analysis of the 2010-2012 BRFSS data on adverse childhood events and also on developing a lifecourse Title V state performance measure. The MCH Surveillance Quarterly Report is based on preliminary vital records data from the twelve months previous to the publication date -- includes entry into prenatal care, low birthweight, teen births and pregnancies, and infant mortality -- modified after new birth certificate 7/06 with new data elements such as weight gain and smoking.

As a general overview of national, state, and health status indicators, some important observed trends are as follows. One hundred percent of cases identified by newborn screening in the past decade have received timely follow-up thanks to Vermont's Newborn Screening program's thorough and exacting follow up. The percent of children 19-35 months who are fully vaccinated has declined over the past decade from ~90% to ~70% - as more vaccines have been added to the recommended vaccination schedule. The teen (15-17) birth rate has declined by around 25% over the past decade from ~10 per 1,000 to ~7.5 per 1,000. The percent of women who still breastfeed their babies at 6 months continued to increase (through 2007 - the most recent data available from NIS)

The percent of newborns who were screened for hearing increased from 22% to 98% over the past decade due to the efforts of the Newborn Hearing Screening program to build a solid statewide infrastructure. The percent of WIC children aged 2-5 with BMI at or above the 95th percentile has increased from 8% to 14% since 1993, a concerning trend for which many programs are now being planned or implemented. The percent of pregnant women who smoke in their third trimester has declined slightly from ~17% to ~16% over the past decade. The percent of pregnant women receiving prenatal care in their first trimester has increased from 74% in 1990 to 83% in 2010. The percent of children and youth aged 0-20 with Medicaid who visited the dentist in the previous year has increased from 45% in 2000 to 54% in 2010. The percent of children screened for blood lead levels has increased from 59% to 78% over the past decade. The rate of substantiated child abuse has decreased from 7.5 per 1,000 in 2000 to 5.6 per 1,000 in 2010 (although these data may have been influenced by administrative changes in the way cases are defined and managed at DCF). The percent of infants with Medicaid who received one or more initial or periodic screen increased from 81% in 2002 to 89% in 2011. Of special concern, is that significant disparities exist between Medicaid and non-Medicaid population with respect to low birthweight, early entry into prenatal care, and adequacy of prenatal care (Kotelchuck index). The infant death rate is also consistently higher in the Medicaid population, but probably not statistically significant due to small numbers. Low birthweight rates have been relatively 'flat' for more than a decade. Over the past decade, the rates of Chlamydia appear to have increased both for women aged 15-19 (~9 per 1,000 to ~14 per 1,000) and women aged 20-44 (~2 per 1,000 to ~6 per 1,000) although caution should be used in interpreting these results since mandatory reporting was introduced during this period.

Health Status Indicators 01A: The percent of live births weighing less than 2,500 grams.

Health Status Indicators 01B: The percent of live singleton births weighing less than 2,500 grams.

Health Status Indicators 02A: The percent of live births weighing less than 1,500 grams

Health Status Indicators 02B: The percent of live singleton births weighing less than 1,500 grams.

The low birthweight rate has been increasing in Vermont since the early 1990's, however the increase has been found primarily in the moderately low birthweight category. It is essential that policymakers have a longer-term perspective of changes in key indicators. Thus, in addition to the on-going quarterly reports, VDH is preparing (with SSDI support) an annual report to monitor trends in key MCH indicators. This new report system is envisioned to include various measures,

including Title V national and state performance measures, health outcome measures, health status indicators and health systems capacity indicators. VCHIP project to assist birth hospitals with adoption of evidenced based protocols regarding elective inductions and Caesarean deliveries and VCHIP training on late preterm births for VDH district office staff and birth hospital staff conducted statewide in 2010. 2011 Legislative Session requiring report for January 2012 from VDH and DVHA (Medicaid) on existing programs and scope of services including case management available to pregnant women identified as high risk. Also, the Maternal Infant Early Childhood ACA funded home visiting program is the Nurse Family Partnership. Both these efforts will have a direct and indirect effect on supporting women to receive the recommended amount of prenatal visits as quantified by the Kotelchuck Index and positively influencing birth outcomes.

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

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

An SSDI analysis of hospital data was conducted during 2006. Data was analyzed by 5-year age groups examining changes in utilization rates and reasons for inpatient hospitalizations over 10 yrs. Also, SSDI analysis of the 2003 Emergency Department data, the first complete year of ED data. The 2004-2008 ED data will be available for future analysis to monitor changes over time in the number/rate of visits and reasons for the visits. Many VDH staff and statewide partners are involved in monitoring data and trends for infant and child unintentional deaths. The Child Fatality Review Committee performs a thorough review of all child deaths from unnatural causes, especially those due to child abuse, drug overdose, injuries, motor vehicles, and SUDI. The VDH's Injury Prevention Program's Advisory Committee is also a key partner in monitoring trends and responding to the unique issues that affect Vermont's child death rates. For example, a state wide symposium was held in July, 2006 to assess the issue of death and injury associated with young teen drivers. /2008/ VDH providing data support to the Child Fatality Review Committee for the Committee's preparation of a status report on child deaths for the years 1995-2005.//2008// /2009/Report released Spring 2008.//

The Vermont Injury Prevention Program's infrastructure is based on the State and Territorial Injury Prevention Directors Association's (STIPDA) Safe States five component public health approach to injury prevention. The first component is directed at determining the burden of injury and developing a plan of action -- planning for this component is happening at present. The draft list of categories of injuries that have been identified in the Vermont Injury Surveillance Plan (in congruence with CDC grant requirements) are as follows: suicides, falls, motor vehicle injuries, poisoning, firearm-related injuries, homicides, TBI, drowning, and fire-related injuries. /2010/Work continues on analysis of farm related injuries and fatalities - data will be used by Farm Health Task Force, Title V Strengths and Needs Assessment, Injury Prevention Program. Injury analysis and planning support by Children's Safety Network. In June 2008 the Vt Injury Prevention Burden Document was finalized with data ready to inform the creation of the Vermont State Injury Prevention Plan which is to be completed by December 2009. October 2009 scheduled statewide symposium on Childhood Injury Prevention. //2010//

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

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

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

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

Vermont injury data demonstrate that motor vehicle crashes among teens and young drivers are the number one injury for this age group. An SSDI-supported analysis also reported that between

1994 and 2003, 105 children aged 0-14 were injured in nontraffic motor vehicle accidents in Vermont, averaging almost 47% of those injured in traffic accidents. In 2003, as many children were injured in nontraffic crashes as those injured in traffic crashes. More than half of these injuries occurred to the driver, and almost two thirds involved off-road vehicles. Among youths 15-24, there were 156 nontraffic crash injuries, which averaged almost 12% of the traffic crash injuries. In this ten year period, there were 41 deaths among children from motor vehicle crashes, and 213 deaths among youths 15-24. Few of these deaths occurred in nontraffic crashes, three among children and one among youths driving off road. Traffic crashes killed 38 children and 212 youths in that same time period. In addition, it was found that a total of 16 children were injured in snowmobile crashes between 1994-2003, which represented 6.2% of the total snowmobile accidents. There were crash injuries to 60 youths aged 15-24, which was almost one quarter of all snowmobile crash injuries.

Child Fatality Review Team has conducted specific discussions about the issue of underage drinking and relation to risky teen driving behavior. VDH Alcohol and Drug Abuse programs oversee several initiatives with schools and state police to educate teens and the public about risks of under-age drinking and teen driving. //2008/ Regarding the analyses for HSI 4, the data for all nonfatal injuries for children ages 14 and younger reflect a rate of 176/100,000 as taken from the hospital discharge data from inpatient stays. This data reflects the number of injury events, not the actual number of children injured. However, because this number reflects only inpatient stays, it accounts for less than 2% of all unintentional injuries in this age group of 0-14 years. In 2005, a total of 14,791 injuries to children aged 0-14 years were seen in hospital related clinical systems (emergency rooms, outpatient clinics, and inpatient admission) for treatment of unintentional injuries. Of these injuries, 441 were related to motor vehicle crashes and 244 were due to non-traffic motor vehicle events. Considering inpatient stays for the age group of 15-24 years, the rate is 166/100,000. In 2005, a total of 18,198 youths aged 15-24 were seen in hospital-related clinical systems for treatment of unintentional injuries. Of these injuries, 2,181 were related to motor vehicle crashes and 412 were due to non traffic motor vehicle crashes. Thus, a rate for all unintentional injuries for the 0-14 age group is 13,938/100,000 and for the 15-24 age group is 19,997/100,000. //2008// See also HIS 03A.

The Injury Prevention Program was established in 2000 with the hiring of a coordinator via CDC funding. The initial Injury Prevention Plan was released in 2002 and an updated version is being prepared for 2010. Examples of priority areas include motor vehicle crashes, interpersonal violence and child maltreatment, falls and hip fractures in the elderly, farm related injuries, off-road crashes, infant safe sleep, youth suicide prevention, concussion an sports related injury. The Program coordinates closely with MCH Planning, Office of Local Health, the Child Fatality Review Committee, Women' Health. Governor's Highway Safety Commission, Farm Health Task Force, and Safe Kids Vermont. A parent education pamphlet about infant safe-sleep environment has been created and distributed to medical practices and child care facilities. Close coordination with the Vermont Domestic Violence Fatality Commission and the Vermont Network for Domestic and Sexual Violence Prevention. Annual Injury prevention symposiums are held on issues such as poisoning preventing, childhood injury prevention in rural Vermont, and agricultural safety. The statewide Youth Suicide Prevention Coalition (funding from G. L. Smith grant) is providing statewide interventions such as gatekeeper trainings for school and community personnel and public awareness campaigns for parents and youth. Vermont has begun updating the Vermont State Injury Plan. Injury program exploring new focus on farm related injuries and also those injuries related to living in rural areas. The research and goal setting for these issues is being done in collaboration with Vt Farm Health Task Force, Children's Safety Network, and Vt Office of Primary Care/Rural Health. Also, new collaboration nationally and in New England between Offices of Rural Health, MCH/Title V, Child Death Review, and Injury Programs. Rape Prevention Education grant funded program from CDC is planning to distribute community funding via competitive bid that reflect evidenced informed strategies for rape and sexual violence primary prevention strategies. Act 1 passed by Vt legislature in January 2009 requires sexual violence prevention to be taught in the school comprehensive health education programs - RPE program

and Sexual Violence Prevention Task Force developing suggested curriculum to be used in schools to meet this legislative mandate./2012/ CDC "Core" grant competitive funding was not awarded for the next five year grant cycle. VDH creating action plan to carry forward with key injury prevention programs using existing capacity and Injury Prevention State Plan as a guide. Key projects are working with Farm Health Task Force on agricultural safety, youth suicide prevention and assist with statewide media campaign and trainings for school and community people who work with youth, adult suicide prevention (needs assessment with Dept of Mental Health and possible suicide fatality review committee,) ATV safety campaign with Vermont Kids Safe and UVM Extension, safe sleep education of birth hospitals and infant caregivers ("SUDI prevention,) increasing helmet use in ATV, snowboarders, and bicycle users, prescription drug misuse/abuse prevention, sports-related concussion prevention, and increase safe streets construction. //2012//**2013/ Work continues on key issues as listed above. MCH Injury working with EMSC on related projects such as teen driver training and distracted driving. VDH Public Health "STAT" process carried out for Injury and three issues were prioritized: youth/adult suicide prevention, elderly falls prevention, motor vehicle crashes. Planning continues to establish greater capacity for injury prevention work within VDH infrastructure. Safe States "State Technical Assistance Team" visit to Vermont schedule for August, 2012. //2013//**

Health Status Indicators 05A: The rate per 1,000 women aged 15 through 19 years with a reported case of Chlamydia.

Health Status Indicators 05B: The rate per 1,000 women aged 20 through 44 years with a reported case of Chlamydia.

Data on Chlamydia and other sexually transmitted diseases are collected and analyzed from laboratory reports to the VDH. The Sexually Transmitted Disease Program within the Division of Health Surveillance monitors prevalence of these diseases and collaborates with state and community organizations such as Planned Parenthood, American Red Cross, Department of Education and many local groups to direct efforts at prevention, screening and treatment. Over the past decade, rate of Chlamydia appear to have increased both for women aged 15-19 (9/1,000-14/1,000) and women aged 20-44 (2/1,000-6/1,000) although caution should be used in interpreting these results since mandatory reporting was introduced during this period.

F. Other Program Activities

Section IV F VT Title V July 2012

Refugee Program: VDH assists local medical homes to conduct health evaluations for newly arriving refugees. The Refugee Health Coordinator, the State Coordinator, and the District Office staff work closely with the Vermont Refugee Resettlement Program and other community-based organizations to assure that critical health services are both available and culturally appropriate. Goals of the refugee health program: ensure that all newly arrived refugees undergo a medical examination and have a medical home, health outreach for refugees, technical support for health care providers, surveillance for infectious diseases.

Office of Minority Health (OMH) supports VDH strategies to address disease prevention, health service delivery and applied research for minority and health disparate populations. Past activities: development of the ADAP Rite of Passage Initiative, implementation of a DHHS-OMH grant to address disparities in cancer, diabetes, and heart disease within the Lao and American Indian communities, address tobacco cessation and prevention program activities within the minority and GLBTQ populations. Interpreter Task Force coordinates training opportunities for Vermont non-English language interpreters and translators. In 2007, OMH coordinated with local

health coalitions on health issues affecting the families of migrant Mexican farm workers. Goals of OMH strategic plan 1) Building infrastructure 2) Data quality, collection, reporting 3) Cultural competency training 4) Community development and leadership. 2010 Disparities report completed **/2013/ OMH financial support for trainings on GLBT and racial minorities and increased risk of suicide attempt //2013//**

Sudden Unexplained Infant Death (SUID) Reduce the incidence of unexpected infant death via public education about infant care practices and assure system of care for families that provides compassionate investigation and grief services. Procedures and protocols are in place for VDH public health nurses. Safe sleep environment pamphlet for parents is being distributed to medical practices and child care providers. /2012/Vermont Chief Medical Examiner has held statewide trainings for health care professionals and first responders about sudden infant death events and best practice procedures for death scene investigation, more trainings planned for 2012. Spring, 2011: Div of MCH collaborate with FAHC and DCF on presentation to MCH VDH staff about Vermont prevalence of SUID and strategies for prevention. Planning for future outreach to providers and birth hospitals statewide //2012//**/2013/ New safe sleep handout created for parents and providers. UVM Medical Students creating action plan. Full outreach and education campaign planned for fall, 2012 //2013//**

The Office of Rural and Primary Care, funded by HRSA Bureau of Health Professions and the Office of Rural Health Policy to improve access to health services for underserved populations. This is done through planning, technical assistance, grants, coordination and advocacy. Activities: development and administration of medical and dental loan repayment programs, grants to community organizations for services/infrastructure development, training and technical assistance to community based health care organizations, assessment of the need for health services in communities, workforce coverage analysis and trends, and application for Federal designations of underservice and program grants to the statewide AHEC and Free Clinics. The Steering Committee: Medicaid program, Mental Health Department, Department of Aging, Hospital Association, Medical Society, Primary Care Association, Dental Society and Area Health Education Centers. Ongoing is analysis of criteria to identify Vermont communities at high medical need in order to seek Governor Designations of underservice and expand the opportunities for participation in the Federally Qualified Health Centers programs and reassessment of the State Loan Repayment Program for primary care providers. Loan repayment assistance for nurses and primary care providers. Working with the Medicaid Office, Dept of Mental Health and the Office of Alcohol and Drug Abuse programs to examine policy, programming and funding to support the integration of behavioral health and primary care. Other projects: Nurse faculty and student loan repayment program, FQHC Look Alike development, migrant farm worker health and health access assessment, statewide healthcare workforce development planning. Programs include Rural Hospital Flexibility (Flex) grant and the Small Hospital Improvement Program (SHIP.) Working with the Vermont Program for Quality in Health Care (VPQHC) to support Quality Improvement efforts at small and critical access hospitals in Vermont. Working with VDH Office of Public Health Preparedness to coordinate the Hospital Preparedness Program (HPP) **/2013/ ORH working with MCH and Farm Health Task Force on such farm health safety programs as education for health care providers and safety awareness with farmers. Preparing workforce report for legislature. Working with VSAC on loan repayment systems. Coordination with local VDH district offices on these activities //2013//**

AHS Domestic Violence Initiative and Domestic Violence Advisory Groups (DVAG) includes VDH/MCH, Dept of Corrections, Dept for Children and Families, Department of Disabilities, Aging and Independent Living, Injury Prevention, and Medicaid. 2009: S.112 and S.357 passes, strengthening penalties for domestic violence and assistance for victims. Domestic Violence Fatality Review Commission issues annual reports. /2012/CDC Rape Prevention Education subgrantees roll out of Consent Campaign in response to 2010 Act 1 requiring sexual violence prevention training in public school curriculum//2012//. See also Section IVA.

Comprehensive Obstetrical Services Program: Administered by OB/GYN, Fletcher Allen Health Care, Burlington, provides comprehensive, team based, maternity care to women who are socially/economically at-risk. The care coordination team includes an obstetrician, a social worker, a nurse and a nutritionist. Services include comprehensive prenatal care, lab and genetic testing, birth and postpartum services, enrollment in WIC, breastfeeding support, and contraception counseling. Service coordination also happens with the NICU and the intensive services for women who have chemical addictions.

VDH Office of Local Health works closely with MCH. MCH Division Director close advisor for MCH Coordinators who are stationed in each of the 12 VDH district offices. DO coordination assists in local implementation to state initiatives such as Blueprint, MIECHV home visitation program, CIS coordination, Bright Futures, prenatal smoking cessation, ongoing community needs assessments, The WIC program and clinics are implemented via the VDH DO's statewide. Recently, the planning role of OLH/DO has been enhanced with creation of a common strategic plan and building capacity and programming according to criteria for CDC national voluntary PH accreditation program. With support of VDH Health Surveillance, DO prevention teams regularly review local, state, national data to assess trends of MCH population and share the knowledge with community leaders. Examples of local QI projects: WIC no show rates, percent local child cares using immunization registry, perinatal Hepatitis B, working with OB/GYN on including oral health in prenatal visits.

G. Technical Assistance

Request to TA for incorporating elements of Life Course Health Development into MCH and MIECHV program planning and implementation. Funds will be used to pay for consultant to work with Division of MCH to identify and implement methods of using LCHD and related concepts such as social determinants of health and the effects of Adverse Child Experiences in planning. This work will be related to existing VDH efforts such as the SSDI Grant Goal #4: Development of Lifecourse Performance Metrics. The SSDI goals will be accomplished using the following objectives: Objective 4.1 An analysis of questions on the PRAMS survey concerning recent adverse experiences of Vermont families with infants and a report prepared, Objective 4.2 An analysis of questions on the 2011 National Survey of Children's Health related to life course development will be completed and a report produced, Objective 4.3 An analysis of 2010-2012 BRFSS data on adverse childhood events will be completed and a report produced, Objective 4.4 Data support will be provided to the Title V program to develop a new life course State Performance Measure by July 15, 2015. Other possibilities are to work with the oral health and chronic disease planning within Health Improvement and Disease Prevention. Develop events such as regular meetings of VDH staff around LCHD planning, internal website with latest activities and research, and reaching out to colleagues in Education, Department of Mental Health, and Department for Children and Families.

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>	1694662	1684954	1683958		1676345	
2. Unobligated Balance <i>(Line2, Form 2)</i>	0	0	0		0	
3. State Funds <i>(Line3, Form 2)</i>	2180046	2381623	1894933		2277819	
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>	1066452	898672	1058956		898672	
7. Subtotal	4941160	4965249	4637847		4852836	
8. Other Federal Funds <i>(Line10, Form 2)</i>	17743694	27872364	26190141		26852005	
9. Total <i>(Line11, Form 2)</i>	22684854	32837613	30827988		31704841	

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	7794	28874	9629		4551	
b. Infants < 1 year old	114372	335535	148236		133385	
c. Children 1 to 22 years old	1763389	2613734	2261961		2698128	
d. Children with	1919653	1860004	2059802		1825853	

Special Healthcare Needs						
e. Others	0	0	0		0	
f. Administration	69500	127102	158219		190919	
g. SUBTOTAL	3874708	4965249	4637847		4852836	
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	83554		92513		93813	
c. CISS	0		0		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	130000		127599		91600	
g. WIC	13500000		13478647		13348673	
h. AIDS	1400000		1182323		1295915	
i. CDC	1700000		1791514		2004291	
j. Education	100000		96000		96000	
k. Home Visiting	0		0		742651	
k. Other						
Family Planning	830140		800092		783344	
Medicaid administrat	0		0		8395718	
Medicaid	0		8621453		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	1203442	2022151	2788871		2727693	
II. Enabling Services	1697895	1826196	1075442		1261691	
III. Population-Based Services	240754	448365	489193		505179	
IV. Infrastructure Building Services	732617	668537	284341		358273	
V. Federal-State Title V Block Grant Partnership Total	3874708	4965249	4637847		4852836	

A. Expenditures

Expenditure trends. The following factors have had, or are likely to have, an impact on MCH-related expenditures:

Reductions: There were no mandated budget reductions during FY11 following the staff reductions of FY10 and none are anticipated for FY13. The FY13 State budget assumes that there will be no specific reduction targets related to MCH.

Reorganization: The Vermont Agency of Human Services transferred Vermont's Mental Health programs into the Health Department in 2004. Then, effective July 1, 2007, the Mental Health programs were removed from the Health Department and a new Department of Mental Health

was created.

Expenditure documentation: Vermont began using its current accounting system in FY02. The system is named "VISION," which is an acronym for "Vermont Integrated Solution for Information and Organizational Needs". The accounting package includes the Financial and Distribution modules contained within PeopleSoft's software suite for Education and Government (E&G) version 7.5. It is designed to be an integrated financial and management tool. While most transactions are entered into VISION directly, payroll information is currently run on a separate system and summary payroll data are extracted from the Human Resource Management System (HRMS) and uploaded into VISION. The HRMS software is also a PeopleSoft product and is compatible with VISION. Upgrades to both VISION and HRMS will be implemented in tandem. The VISION system was implemented with as few Vermont-specific characteristics as possible so that future upgrades could be accepted with relatively minimal retrofitting work. VISION contains a number of modules that allow for a variety of functions, such as asset management, as well as expenditure tracking.

The Vermont Health Department can provide assurance that we have established "such fiscal control and fund accounting procedures as may be necessary to assure proper disbursement and accounting" [Sec 502(a)(3)].

Cost Allocation: The Vermont Health Department operates under a Cost Allocation Plan is approved by the DHHS Division of Cost Allocation. This Plan determines how we will collect certain overhead costs into cost pools and how those overhead cost pools will be allocated to the various programs and funding sources, including the Maternal and Child Health Block Grant. Because we have an approved Cost Allocation Plan, Vermont does not have an indirect rate agreement, which would be the alternate method for charging overhead costs to programs. Cost Allocation Plans--instead of indirect rate agreements--are relatively rare among Health Departments. Basically, the approved methods collect general overhead costs on a quarterly basis into cost pools at the division level and also at the Department-wide level. Allowable charges from the Statewide cost pool are also determined. These three overhead cost pools (division, department and statewide) are then allocated to all of the programs in the department (including state funded programs as well as federally funded programs). The allocation process is based on the relative direct salary costs of each program in the quarter.

In addition to the distribution of the three cost pools listed above, for the purposes of reporting our expenditures for the Maternal and Child Health Block Grant, the overhead costs of the Children with Special Health Needs unit are also distributed to the direct programs provided by that division. The distribution of these costs is based on the relative direct salary costs of CSHN staff in each of its programs in the quarter. Although CSHN is not designated as a "division" of the Health Department, it seems to be most equitable to distribute these costs in a manner that mimics the distribution of divisional overhead costs. This results in a fairer picture of the true cost of each of the individual clinics and programs operated by CSHN.

The current Plan was initially approved by DHHS Division of Cost Allocation on February 28, 2006. The Vermont Agency of Human Services continues to work with Public Consulting Group, Inc., of Boston, on revisions to this plan as needed. Revisions to the plan are submitted to DHHS Division of Cost Allocation quarterly, and are approved by DHHS quarterly.

Single State Audit. The State Auditor of Accounts arranges for an annual audit in compliance with the Single Audit Act, as well as in conformity with Section 506(a)(1) of the Maternal and Child Health Block Grant. The audit is performed by KPMG under contract with the Vermont Auditor of Accounts. Although the Maternal and Child Health Block Grant does not qualify as a "major" program for audit purposes, transactions may be tested as part of a general review of management control. There were no findings related to expenditures funded by the Maternal and Child Health Block Grant in FY 2011 or prior years. The audit report can be found on the State

Auditor's website at <http://auditor.vermont.gov>.

B. Budget

Consolidated Budget: In Vermont, the Department's budget includes both State funds and all of the federal funds available to the Department. Because it is a consolidated budget--rather than a budget that appropriates only the General Fund--the budget for maternal and child health services already includes federal funds and state General and Special funds in a complementary package of resources.

Independent Compliance review: The Vermont Health Department tracks expenditures attributable to the Maternal and Child Health Block Grant. Prior to drawing funds or filing financial status reports, however, the data is independently reviewed by the Agency of Human Services (AHS). Cash draws are performed by AHS rather than the Health Department. As part of their review of the financial data, AHS also reviews compliance with certain of the grant financial requirements, specifically including the maintenance of effort requirement and the non-federal match requirement. The quarterly calculations of the allowable claim by AHS, like the calculations of the Health Department, deducts one quarter's share of the maintenance of effort amount from our allowable charges prior to determining the cash draw for the quarter. AHS also determines that the needed non-federal share is available for each quarter. Once each quarter, AHS and the Health Department formally review the allowable federal claim after making adjustment for these factors. In this way, AHS assures that the Health Department has an independent review of our claims for federal funds.

30%-30% Requirement: The Health Department calculates the amount expended on each category. For FFY 2011, 54% of expenditures was made in Component B and 38% was made for Children with Special Health Care Needs.

Administration costs: Administrative costs are defined in the same terms that they were defined in 1989: administrative costs are the extra-departmental costs that are allocated to the Health Department and to the programs within the Health Department. These costs are that component of the allocated costs that are attributable to the support services of payroll, buildings, etc. The definition of "administration" costs does not include costs such as the policy direction activities of the Health Commissioner, etc. The administrative costs of the Maternal and Child Health Block Grant can be readily determined by analysis of the allocated costs, and these costs are tracked on a quarterly basis to ensure that there is no increase in the costs that would exceed the allowable maximum. Administrative costs for FFY2011 were 2.6% of total costs.

Maintenance of effort: [Sec. 505(a)(4)] The maintenance of effort amount for Vermont, based on the amount of unmatched State expenditures reported in 1989, is \$167,093. We deduct one quarter of the maintenance of effort amount from our allowable claims each quarter rather than annually. Quarterly reductions of our allowable costs are more consistent with federal cash management directives than an end-of-year adjustment.

Special projects: [Sec.505(a)(5)(C)(i)] There is continuation funding for the Vermont Regional Perinatal Program, which was a special project that was funded by Title V prior to 1981. The funding for the program is \$52,656.

Consolidated health programs: [Sec. 505(a)(5)(B)] Funds are used to support certain programs that were initiated under the provisions of the consolidated health programs, as defined in Section 501(b)(1). MCH Block Grant funds are used to support the Regional Genetics Program, which was initiated under a section 1101 grant prior to 1981, and is referred to as a consolidated health program in Sec 501(b)(1)(C). The Regional Genetics grant is \$140,056. State General Funds (not Block Grant or other federal funds) are used to support the adolescent pregnancy program at

the Addison County Parent Child Center, which was initiated under a Title VI grant prior to 1981, and is referred to as a consolidated health program in Sec. 501(b)(1)(D). The Addison County Parent Child Center grant is \$32,820.

Other Federal funds: The other Federal funds used to support MCH-related goals are listed in Form 2 and 4. There is no significant change in the type or total amounts of other Federal funds except for the new Home Visiting program.

Source of State matching funds: The State match consists entirely of cash payments of State General funds or State Special funds (e.g., tobacco settlement funds, foundation grants, etc). The State match is exclusively from non-federal funds. These non-federal funds are appropriated as described above and the use of these non-federal funds is monitored by the Agency of Human Services as well as the Health Department, as noted above. The State receives Medicaid reimbursement for clinical services provided directly by the Health Department and this program income is shown as part of the State match on Form 2.

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.