# Maternal and Child Health Services
# Title V Block Grant

# State Narrative for VIRGINIA

## Application for 2007
## Annual Report for 2005

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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.***

## B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

## C. Assurances and Certifications

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

## 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; expires May 31, 2009.

## E. Public Input

In Virginia, opportunity for public input into the MCH planning process is ongoing, utilizing the variety of stakeholders and linkages described elsewhere in the application. Last year Virginia focused specific efforts on obtaining public input for the five-year needs assessment and the 2006 application. These efforts included a PowerPoint presentation describing Title V and the MCH services that Virginia provides was developed and placed on the Office of Family Health Services web page (www.vahealth.org), a web-based surveys that solicited input from both individual citizens and representatives of organizations that serve Virginia's women and children, stakeholder interviews, focus groups and five regional public hearings. Dr. Donna Petersen facilitated a priority- setting meeting that included both the OFHS management team and approximately eighteen external partners. The input obtained from the web surveys, the key stakeholder interviews, the public hearings and the focus groups was reviewed along with quantitative data and incorporated into the priority setting process.

Opportunity for public comment on the 2007 Title V application was publicized on the OFHS website, on the Commonwealth Calendar website, and through direct notification of numerous stakeholders including the 35 district health departments. After transmittal to MCHB, the final application will be available on the OFHS website. The OFHS will continue to seek opportunities during FY 07 to present information on Virginia's Title V funded programs at various meetings with interested parties.

## II. Needs Assessment

In application year 2007, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

# III. State Overview

## A. Overview

The Commonwealth of Virginia, a mid-Atlantic state, encompasses 40,767 square miles. It is bordered by five other states, Maryland, Kentucky, West Virginia, Tennessee, and North Carolina as well as the District of Columbia. The Chesapeake Bay defines the eastern coast. Virginia extends 440 miles from East to West and 200 miles from North to South. Local jurisdictions are comprised of 95 counties and 40 independent cities totaling 135 localities. The VDH has grouped these localities into 35 health districts. Three of the district offices, Arlington, Fairfax, and Richmond are independent with contractual relationships to the state system. (See www.vdh.virginia.gov/LHD/LocalHealthDistricts.asp for a state map showing local health districts.)

***/2007/ Two of the district offices, Arlington and Fairfax are independent with contractual relationships to the state system. Effective July 1, 2006 Richmond Health Department became a part of the state system. //2007//***

Across the state, the terrain varies widely, including mountainous and coastal regions, remote rural areas and large urban centers. Geography impacts services in several areas. One area of Virginia, the Eastern Shore, is actually physically connected to the state via a toll bridge/tunnel making access to the mainland services challenging. Difficult terrain, lack of medical services and transportation issues pose barriers to health care for Virginia's families.

Virginia has a great range between its urban and rural areas. Twenty-five communities have densities of less than 50 persons per square mile. Half of Virginia communities have total populations under 20,000 persons, with 24 of those having less than 10,000 persons. More that three-fourths of the state population lives within metropolitan areas, according to the U.S. Census.

According to the 2003 Census Estimate, Virginia continues to rank as the 12th most populated state with 7,386,330 residents. This is a 4.3 percent increase from 2000. Projections for the years 2000 and 2025 show the population continuing to rise to 8,466,000 persons. A large part of this growth has occurred in Northern Virginia. Virginia has 1,817,037 residents under age 18, the 14th highest child population in the country. This number represents a 21 percent increase from 1990.

The population in Virginia is 49 percent male and 51 percent female. The median age of the population is 35.7 years. Virginia has a greater proportion of younger cohorts than seen nationally. Children and teens under the age of 20 make up approximately 27 percent of the population and women of childbearing age make up approximately 22 percent of the population. In 2003, 6.7 percent of residents of the Commonwealth were under age 5 and 20.5 percent were aged 5-19.

Minority groups in Virginia include African Americans, Asian/Pacific Islanders, Native Americans, and Hispanics. The culturally diverse populations include the following groups: Cambodian, Central American, Chinese, Ethiopian, Filipino, Korean, Loa, Russian/Ukrainian, Somalian, Sierra Leone, South American, Thai and Vietnamese (VDH, Multicultural Health Task Force Report, 1999). The state ranks as 9th largest for immigrant residents and 8th among intended residence for new arrivals. In 2000 Virginia ranked as having the 16th largest Hispanic population and the 9th largest Asian population in the country. There is a continuing trend in racial and ethnic diversity in the state. The Virginia population in 2003 was 5.3 percent Hispanic compared to 2.6 in 1990, 4.5 percent Asian compared to 2.5 in 1990, and 20.4 percent African American compared to 18.8 in 1990. Multicultural population concentrations are greatest in the eastern portions of the state, with Northern Virginia and Tidewater as home to the greatest numbers of minorities. According to the 2000 Census, 10.5 percent of Virginia's children ages 5 -- 17 speak a language other than English at home.

According to the 1990 U.S. Census, three-fourths of state residents had achieved at least a high school diploma or equivalency. The 2003 American Community Summary indicates that the percentage of high school graduates or higher had risen to 84.5 percent. Overall Virginia education data compares favorably to the nation as more adults in the Commonwealth hold bachelor's degrees or have completed higher education than over two-thirds of the country. According to data from the 2003 American Community Summary, approximately 32 percent of Virginia residents hold bachelor's degrees or higher. However, percentages of educational attainment vary greatly by race and location. African Americans and Hispanics fared worse that the total state figure of high school graduates. According to 2000 data published by Annie E. Casey Foundation, 7.7 percent of teens ages 16-19 were high school dropouts down from 10 percent in 1990.

In 1998, the average annual unemployment fell to 2.9 percent. This was at the lowest level since unemployment data was first recorded in the 1970's. Virginia experienced economic fallout from the 2001 recession and the September 11th terrorist attacks with one result being decreased state revenues. Unemployment rose to 3.5 percent in 2001, yet the state average remained below the U.S. figure of 4.8 percent. The Virginia unemployment rate in March 2005 was 3.4 percent, which was below the unemployment rate of 3.9 in March 2004. Virginia's unemployment rate remains significantly lower than the national rate of 5.4 percent in March 2005. However, the unemployment rate differs across the state. The Northern Virginia and Harrisonburg areas had the lowest unemployment rate in March 2005 at 2.9 percent. The Danville area had the highest unemployment rate at 7.4 percent.

The 2002-03 two year average poverty rate in Virginia is below the U.S. figure of 12.3 percent. In 2002-03, 10 percent of Virginia's families were living at or below the Federal Poverty Level (FPL). According to Kids Count, the median income of Virginia families with children in 2001 was $58,700 compared to $51,100 nationally. Based on a 3-year average, 2001-03, Virginia ranks 13th lowest statewide poverty rate. Poverty varies significantly by locality, and by family structure. Four cities, Norfolk, Richmond, Virginia Beach, and Newport News and one county, Fairfax, account for approximately 30 percent of children in poverty.

The increase in the number of children being raised in single parent households impacts the poverty experienced by Virginia children. The 2000 Census shows a continuing increase in the number of female-headed households with children in Virginia. In 2000, female-headed households with children under eighteen years old increased from 6.0 percent of all households in 1990 to 6.9 percent in 2000. According to the Annie E. Casey Foundation, 27 percent of children in Virginia lived in a single parent family and approximately 30 percent of female-headed households with children under 18 years of age were below the poverty level in 1999. According to KIDS COUNT data, in 2001 only 31 percent of the families headed by mothers received child support or alimony. The lack of consistent child support and other support services such as reasonably priced child care remain factors that impact the many single parent families' ability to move beyond the poverty level.

Family poverty and community resources impact the ability to obtain health care. In 2004, the Virginia Health Care Insurance and Access Survey, a telephone interview survey of over 4,000 representative households in the state was completed. The survey showed that much like the U.S. as a whole, the Commonwealth's low-income population has one of the highest rates of uninsurance. The proportion of Virginia families without health insurance living at or below 150 percent of the FPL is close to or exceeds 20 percent. Rates of insurance varied from 6.3 percent for those who were uninsured all year to 11.5 percent for those uninsured at some point during 2004. Over 11 percent of adults aged 19 to 64 lacked health insurance compared to just over 6 percent of all children 18 years and younger. Young adults aged 19 to 24 had the highest rate of uninsurance. Increases in Medicaid and FAMIS (SCHIP) enrollment since 2001 have helped to lower uninsurance rates of children and pregnant women, while higher rates of unemployment and an influx of immigrants have led to an increase in the uninsured adult population. According

to this study, African Americans and Hispanics had significantly higher rates of uninsurance (11.1 percent and 27.4 percent, respectively) compared to whites. Virginians with lower education and those who had never married, were living with a partner, divorced or were separated had higher rates of uninsurance.

Health Status Indicators

Specific health status indicators highlight some of the challenges that Virginia faces. Unintentional injuries took the lives of 2,559 Virginians in 2003, making this the fifth leading cause of death. Motor vehicle crashes accounted for approximately four out of every ten of these fatalities. Although there is a continuing decline in child deaths, the leading cause of death for Virginia children is injury. Violent and abusive behavior has been increasingly recognized as an important public health issue. In 2003, 450 people were homicide victims in Virginia (down from 491 in 2001). Of the 450 homicides, the majority died by firearms and explosives. Approximately 18 percent of all the deaths in 15-19 year-olds were classified as homicides in 2003. Homicide disproportionately affects the young African American male. Forty-six youth ages 10-19 died from self-inflicted injuries in 2003.

***/2007/ In 2004 unintentional injuries remained the fifth leading cause of death (2,458 deaths) and the leading cause of child death. In 2004, 398 people were homicide victims with the majority (72%) resulting from firearms. Approximately 14 percent of all the deaths in 15-19 year-olds were classified as homicides. Forty-one youth ages 10-19 died from self-inflicted injuries in 2004. //2007//***

The racial disparity in a number of health status indicators also presents significant challenges. For example, the infant mortality rate is often used as a state health status indicator. In 2003, the rate was 7.6 per 1,000 live births. However, there continues to be a large disparity between the rates for white and for African American infants. In 2003, the rate for white infants was 6.1/1,000 as compared to 13.9/1,000 for African American infants. The infant mortality rates vary geographically with the highest rates in Chesapeake, Hampton, Portsmouth, Richmond and Roanoke districts and in the Peninsula and Southside health districts.

***/2007/ The 2004 infant mortality rate was 7.4 per 1,000 live births. The white non-Hispanic rate was 5.7: the black non-Hispanic rate was 14.1 and the Hispanic rate was 5.7. //2007//***

Of Virginia women having a live birth in 2003, 84.8 percent received first trimester prenatal care. During the same period, approximately 3.8 percent of women began prenatal care in their 3rd trimester or received no prenatal care throughout their pregnancy. There continues to be differences based on race and ethnicity, with African Americans and Hispanics less likely to have early prenatal care. The gap in early prenatal care between white mothers and African American mothers and other races in Virginia has not significantly changed from 1995 through 2003. Lower utilization by Hispanic women also reflects racial and ethnic disparities that may be magnified for immigrants who may fear contact with the medical system, encounter language barriers, or have a lack of resources and knowledge to obtain care. The Immigration and Naturalization Service estimates that the number of undocumented persons in Virginia in 2000 was 103,000, which is an increase of approximately 87 percent from 1996 to 2000. These individuals do not have access to Medicaid or FAMIS except for emergencies. Prenatal care may not be available to them potentially placing them at greater risk for a poor birth outcome.

***/2007/ In 2004 84.8% of women having a live birth received first trimester prenatal care. Entry into early prenatal care continued to vary by race and ethnicity (white non-Hispanic, 89.8%; black non-Hispanic, 78.9%; and Hispanic 72.7%). //2007//***

Low birth weight is an indicator of limited access to health care and a major predictor of infant mortality. In 2003, 8.2 percent of all live births were low birth-weight infants. Of these, the percentage of low weight births for African Americans was almost double that for whites. There

has been very little change in this statistic.

***/2007/ In 2004, 8.2% of births were low birthweight and 1.5 % were very low birthweight. The percent for black non-Hispanic continued to be much higher than white non-Hispanic (12.6% vs. 7% ). //2007//***

Pregnancy rates for teens decreased over the past five years from 34.1 per 1000 females in 1998 to 27.4 in 2003. However, the black teen pregnancy rate remained more than double that in white teens. Teen pregnancy is a critical public health issue that affects the health, educational, social, and economic future of the family. Some areas of the state had rates more than twice this level.

***/2007/ The teen pregnancy rate continued to decline in 2004 to 26.5 per 1000 females. //2007//***

Access to Health Care

Like many other states, Virginia is experiencing what many people have referred to as a crisis in access to obstetrical care. The effects have been felt most in rural areas, but suburban and urban communities are also experiencing the effects. Several small community hospitals no longer provide obstetrical care and some obstetricians have stopped providing coverage for family practice physicians who have been delivering babies or have stopped providing supervision of certified nurse midwives. Some OB/GYNs have limited their practice to gynecology due to the prohibitive cost of malpractice insurance premiums. This has resulted in women having to travel further to the hospital or delivering in the emergency rooms or perhaps having inadequate prenatal care.

In March 2004, Governor Warner issued Executive Directive 2 establishing a work group to develop recommendations for improving accessibility of obstetrical care in Virginia's rural areas. The General Assembly adopted budget language to direct a similar study by the Secretary of Health and Human Resources to make recommendations for improving access to obstetrical care for the entire state. A workgroup consisting of General Assembly members and individuals and organizations representing rural, suburban and urban communities and interests was established. The work group received feedback from stakeholders and from the public through town hall meetings around the state, a statewide videoconference at 25 locations, and through a public e-mail address. Comments were received from more than a 1,000 Virginians.

Based on the July 1, 2004 Interim report, the Governor provided emergency authority and funding, to increase the Medicaid payment rates for outpatient obstetrical and gynecological services by 34 percent, effective on September 1, 2004. The final report, released in October 2004, includes twenty-seven recommendations in six policy areas including eligibility for services, reimbursement levels, medical malpractice, license/scope of practice, birth injury, and improving access to care. Future reports on the implementation of these recommendations will be made to the Governor and the General Assembly every two years. The full report is available at the following Web site: http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/HD522004/$file/HD52.pdf

The 1998 Session of the Virginia General Assembly included a budget amendment for FY 99-00 that provided for the implementation of a health insurance plan for low-income children. This insurance program was designed to assist working families with uninsured children and addressed the federal legislation establishing the State Child Health Insurance Program (SCHIP) under the new Title XXI of the Social Security Act. Under federal law, each state had the option to expand Medicaid, create their own children's health insurance program targeting low-income children or implement a combination of the two.

The plan that Virginia adopted in 1998 created the Children's Medical Security Insurance Plan (CMSIP). This program was designed for uninsured children who have not had health insurance

for the past 12 months and who are not eligible for Medicaid or the state employee health insurance plan. This was not an expansion of Medicaid under Title XIX of the Social Security Act, but a program that provided Medicaid-equivalent benefit coverage for children in families up to 185 percent of the federal poverty level (FPL). The CMSIP did not require premiums and/or co-payments, but left the addition of premiums and/or co-payments as a future option. The Department of Social Services (DSS) was responsible for determining eligibility, enrolling people, and implementing a statewide outreach program. VDH supported the outreach effort by hosting "local health summits" to bring participants from schools, providers, community service organizations and local governments together. The state WIC program also mailed out over 100,000 packets containing CMSIP information and an application. Local health departments were also involved in CMSIP outreach efforts.

The Virginia Joint Commission on Health Care estimated that 72,000 children were eligible for CMSIP at its inception. However, as of June 19, 2000, only 24,680 children were enrolled and by May 2001 approximately 32,000 were enrolled. Identified barriers to enrollment included the perception that CMSIP is a "welfare" program and a complicated application process. To reduce barriers and increase enrollment, CMSIP was replaced by the Family Access to Medical Insurance Security Plan (FAMIS), as mandated by Senate bill 550 in the 2000 Virginia General Assembly. (For additional information on FAMIS visit www.famis.org). FAMIS was designed to look and act like private health insurance and to be distinct from Medicaid; each utilized different applications with different eligibility requirements and no ability to transfer applications back and forth between the programs. Medicaid applications were processed at local offices of DSS, while all FAMIS applications were processed at a central processing unit. New features of this program included a premium assistance program to enroll eligible employees into their employer's health coverage using subsidies from the state.

Substantial legislative interest was directed at FAMIS during the 2002 Session of the Virginia General Assembly. Seven bills were introduced and subsequently remanded to the Joint Commission on Health Care. The Commission studied these issues in depth. As a result of their study, an omnibus bill and budget amendment were introduced and passed in the 2003 Session of the Virginia General Assembly to incorporate changes in eligibility and benefits that established the following changes:

1) Establish a single umbrella program that incorporates both Medicaid for medically indigent children and FAMIS retaining the program name of FAMIS with the Medicaid portion being known as FAMIS Plus.
2) Require use of a single application to determine eligibility for both Medicaid and FAMIS;
3) Include within FAMIS, coverage for the community-based mental health and mental retardation services provided for children enrolled in Medicaid.
4) Reduce the waiting period from six to four months between the time that a child was covered by private health insurance and when eligibility for FAMIS can be established; and
5) Amend the language that authorizes cost sharing within the FAMIS Plan to require a $25 per year per family enrollment fee and specify that the co-payment amounts shall not be reduced below the co-payment amounts required as of January 1, 2003.

In addition to this change, legislation was also passed that provided for 12 continuous months of coverage under FAMIS and FAMIS Plus if the family income does not exceed 200 percent of the federal poverty level at the time of enrollment. This change will create a more stable covered population of children by removing unnecessary administrative eligibility burdens on the family.

Accordingly, in August 2003, the Medicaid and Medicaid expansion SCHIP programs were re-named FAMIS Plus and the separate SCHIP program continued to be known as FAMIS. These major changes in FAMIS since September 2002 contributed to the continuous upward trend in enrollment. In particular, renaming children's Medicaid FAMIS Plus has made Medicaid and SCHIP relatively indistinguishable. Total enrollment for FAMIS and FAMIS Plus is currently 118,683, which represents 96 percent of the estimated eligibles.

In response to the new product branding, legislation was passed in 2004 that redefined the Outreach Oversight Committee to now become the Children's Health Insurance Advisory Committee. Their mission is to assess the policies, operations, and outreach efforts for FAMIS and FAMIS Plus and to evaluate enrollment, utilization of services and the health outcomes of children eligible for such programs. DMAS has also brought new leadership to its FAMIS program with an increased emphasis on services for pregnant women, mothers and children. Title V staff participate as a members of the Children's Health Insurance Advisory Committee and also work closely with these staff and offer assistance in program design and outreach.

In addition to these program changes, VDH incorporated the FAMIS/FAMIS Plus application into its Web Vision system (computer system for local health district operations). At a minimum, VDH staff are able to assist an eligible recipient with the application. If time permits, VDH can electronically complete the application and then fax it directly to the Central Eligibility Processing Unit for Medicaid eligibility determinations.

***/2007/ Since the FAMIS/FAMIS Plus application was made available on the local health districts' computer system, over 1,000 applications have been submitted to DMAS via VDH. Of those applications, over one-third of the applicant families have been enrolled. In 2006, DMAS was granted an 1115b waiver from CMS to extend coverage to women at time of pregnancy confirmation. This expansion has allowed woman to obtain coverage for prenatal care when it is most beneficial for positive birth outcome. As VDH works actively with this population segment, the volume of applications completed through the WebVision utility continues to rise. //2007//***

Another important legislative initiative involved the expansion of involved state agencies in the sharing of protected health information that was passed by the 2002 Virginia General Assembly as SB 264. This law was designed to clarify the authority of various state agencies to obtain and disclose protected health information in compliance with the rules promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA). The previous law covered the Departments of Health, Medical Assistance Services, Mental Health, Mental Retardation and Substance Abuse Services and Social Services. The newly defined law now includes all the agencies of the Virginia's Secretary of Health and Human Resources. Initial interagency collaboration documented over $1.2 million in cost avoidance through the sharing of health information. The initial data sharing initiative occurred between the Departments of Health and Medical Assistance Services. A recipient match was made to all reported cases of pediatric patients with elevated blood lead levels. This allowed the Department of Medical Assistance Services to notify primary care providers of the results and subsequently follow the patients to ensure that proper monitoring and intervention had taken place. Subsequent collaborative projects involved the sharing of eligibility information and the sharing of foster child enrollment for immediate case assessment and intervention services. As the final HIPAA Security Rule has been promulgated and security audits are being completed, more data sharing projects will be developed. To facilitate this data sharing, a rule was issued by the General Assembly that requires the agencies within the Secretariat of Health and Human Services to develop a data inventory. This effort will allow all agencies to know what information are available and how it is stored. In addition, a secure mechanism for inter-agency data sharing has been established. The final report will be issued in early 2006.

In 1996, mandatory managed care enrollment in a contracted HMO began in selected counties in the Tidewater area of Virginia. To date, Medicaid managed care options are available in most areas of the Commonwealth with the exception of the southwestern counties of the state. All contracted managed care organizations (MCOs) are required to establish a program for high-risk maternity and infant cases, report to DMAS on the program components and outcome measures, and report quarterly on all births. As MCOs have demonstrated outcome improvements through their maternity programs, DMAS is reviewing the VDH BabyCare program. The current BabyCare program components are defined in regulation and have not been amended to reflect current

practice. Therefore, the BabyCare program administered through the local health districts has become fragmented and some health departments have ceased providing services for reasons such as burdensome paperwork, inflexible protocols, lack of adequate mileage and general reimbursement. DMAS recognizes that the central component of BabyCare, intensive nurse case management, is of value to high-risk women. They are working closely with Title V staff to build a program that maintains essential components but is not universally prescriptive to allow for offerings that meet the needs of the marketplace.

***/2007/ In the fall of 2005, a study of how BabyCare is being used in local health departments was commissioned. The report has been discussed with DMAS staff and an interagency workgroup has begun efforts to eliminate barriers. So far several significant changes to the BabyCare program have been implemented by DMAS. These include extending the timeframe requirements for client assessment and enrollment, establishing a reimbursement mechanism for assessment even if the client refuses enrollment, and increasing the mileage reimbursement rates for home visits. These immediate changes were implemented to assist health departments and other types of clinics to maintain their home visitation capacity. Title V staff continue to work with DMAS towards additional substantive changes that will lead to program improvement and increased patient access. //2007//***

The local health districts continue to be essential participants in the MCO delivery system. All provider contracts are negotiated from central office where the OFHS managed care policy analyst plays an essential role in explaining local health district services, services provided by the Children with Special Health Care Needs program, and services provided by the Child Development Clinics. The local health districts, in addition to providing public health services to MCO enrollees, have become key partners for the Care Connection for Children network. They provide case finding services, provide local case assistance and facilitate referrals to local service organizations.

***/2007/ DMAS continues to increase its MCO offerings throughout the state. A second MCO option is available in Northern Virginia and several current MCO vendors have expanded their service delivery network in southwest Virginia. The DMAS goal is to provide two MCO options in all parts of the Commonwealth. //2007//***

State Health Agency Strategic Priorities

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

As a result of this planning and budgeting process, the VDH's overall agency strategic goals include the following:
1. Provide strong leadership and operational support for Virginia's public health system
2. Prevent and control the transmission of communicable diseases.
3. Collaborate with partners in the health care system to assure access to quality health care services.
4. Promote systems, policies, and practices that facilitate improved health for all Virginians.
5. Collect, maintain and disseminate accurate, timely, and understandable public health information.

6. Respond timely to any emergency impacting public health through preparation, collaboration, education and rapid intervention.
7. Maintain an effective and efficient system for the investigation of deaths of unexplained or suspicious deaths of public interest.
8. Assure provision of clean and safe drinking water supplies.
9. Assure provision of safe food at restaurants and other places where food is served to the public.

State MCH Priorities

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

For the FY 2006 needs assessment OFHS initiated special efforts to involve our external partners in setting the MCH priorities. The needs assessment process included the collection of qualitative data through public hearings, focus groups and key stakeholder interviews. In addition, Dr. Donna Petersen, Dean of the South Florida School of Public Health, facilitated a priority setting meeting of OFHS staff and external stakeholders. During the meeting the MCH priorities were developed based on the presentation of needs assessment data and the needs identified by participants.

The Title V needs assessment process served as an essential tool to reflect on system changes and examine the health status of Virginia's families. Although there have been improvements in some areas, there continues to be disparities based on race, income, age, insurance coverage and areas of the state. These variations continue to present challenges. During the next year, the Title V efforts will focus on developing and working closely with our partners to implement strategies to improve access to care, including dental care, prenatal care and breastfeeding support and expand the availability and quality of medical homes for children and women. The Title V program will also develop and promote provider education particularly in the areas of assessing and addressing risks and incorporating mental health into preventive health efforts. Our enhancement of data collection and dissemination efforts to promote evidence-based decision making in planning, policy, evaluation and allocation of resources will continue from previous years. In addition, the Title V program will begin to change our paradigm by focusing on women across the lifespan and not just women during pregnancy. This approach recognizes and promotes the relationship between healthy girls, healthy mothers, healthy babies and healthy older adult women and will focus chronic disease prevention efforts, including healthy weight and physical activity, on women's and children's health across the lifespan.

More detailed MCH-related health status indicators are reported in the FY 2006 Needs Assessment. Virginia's MCH priorities are listed in Section IV of this application. In addition, other emerging health trends, problems, gaps and barriers are also identified in the Needs Assessment Section.

## B. Agency Capacity

The Office of Family Health Services (OFHS) within the Virginia Department of Health has responsibility for the development and implementation of the MCH Block Grant. The mission of Virginia's MCH efforts is to protect, promote and improve the health and well-being of women, children and adolescents, including those with special health care needs. Major goals include improving pregnancy and birth outcomes, improving the health of children and adolescents, including those with special health care needs, assuring access to quality health care services, eliminating barriers and health disparities and strengthening the MCH infrastructure. The Office of Family Health Services is comprised of the divisions of Women's and Infants' Health, Child and Adolescent Health, Dental Health, WIC and Community Nutrition, Chronic Disease Prevention and Control and the Division of Injury and Violence Prevention. The director of the OFHS is Dr. David E. Suttle. He was appointed as director in July 2002.

***/2007/ Alissa Nashwinter is the OFHS Deputy for Administration. She replaces William Bulluck the Business Manager. //2007//***

***/2007/ The Center for Injury and Violence Prevention is now the Division for Injury and Violence Prevention (DIVP). //2007//***

MCH programs and services in Virginia are provided at each of the four levels of the MCH pyramid to protect and promote the health of women and children, including those with special health care needs.

The Division of Women's and Infants' Health assesses and advocates for the health needs of infants and of women, particularly women of childbearing age. One program provides breast and cervical cancer screening, referral and follow-up to low income Virginia women. The division also provides comprehensive family planning services in local health departments (supported in part by Title X grant funds) to assist low-income women to plan and space their pregnancies. A number of local health departments use Title V funds to provide prenatal care. Several programs aim at reducing infant mortality and morbidity through home visiting, regional coalition activities (Regional Perinatal Councils), mentoring pregnant teens (Resource Mothers), nutrition counseling, nurse case management, fetal and infant mortality reviews (FIMR), community-based projects and public and professional education. The Virginia Healthy Start program and the Breast and Cervical Cancer Early Detection Program (BCCEDP) are administered in this division. Another state program coordinates the follow-up of newly diagnosed newborns with sickle cell disease and includes public and family education, testing and counseling regarding the disease. The division recently received a federal grant to develop a web-based curriculum on perinatal depression for health care providers. The division has recently established a position to focus on women's health.

***/2007/ The web-based curriculum on perinatal depression for health care providers is now available at www.perinataldepression.org Almost 400 providers completed the training and received continuing education credit in the first two months that it was available. //2007//***

The goal of the Division of Child and Adolescent Health is to give children, including children with special health care needs, a healthy start in life and help them maintain good health in the future. This is accomplished through the assessing health data, identifying resources, informing the public about child and adolescent health issues, assisting policy makers, supporting private and public health care providers, developing programs and information systems, identifying resources, providing clinical consultation and educational activities, and developing and distributing guidelines and educational materials. Programs administered in the division include the Abstinence Education Initiative, Teen Pregnancy Prevention Initiative, Child Lead Poisoning Prevention, Virginia Newborn Screening Services, Metabolic Treatment Services/PKU

Management, Virginia Congenital Anomalies Reporting and Education System (birth defects registry), School Health, Adolescent Health, Child Development Clinics, Virginia Early Hearing Detection and Intervention Program, Virginia Bleeding Disorders Program, and Care Connection for Children. In addition, division staff participates on the Part C Early Intervention Agencies Committee, the Early Intervention Interagency Management Team, and the Virginia Interagency Coordinating Council.

***/2007/ Anne Rollins was hired to serve as the State Adolescent Health Coordinator. //2007//***

***/2007/ The Childhood Lead Poisoning Prevention program was transferred to the Office of Environmental Health within the Virginia Department of Health. Collaborative efforts relating to lead poisoning prevention will continue between the offices of Environmental Health and Family Health Services. //2007//***

***/2007/ The web-based curriculum on Bright Futures and EPSDT for health care providers and other child-serving professionals is now available at www.vcu-cme.org/bf //2007//***

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

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

The Division of Dental Health's primary goal is to prevent dental disease. Dental services are provided in approximately half of Virginia's localities to pre-school and school age children who meet eligibility requirements through the local health departments. Eligibility for these services may be determined by school lunch status and/or family income. Dental services are available at health department clinics or at dental trailers placed on school property. Adult care is available on a limited basis in certain localities. The Division of Dental Health also supports community fluoridation by monitoring water systems for compliance in conjunction with Virginia Department of Health Office of Drinking Water, reporting water system data to the Center's for Disease Control and Prevention Water Fluoridation Reporting System (WFRS), providing information about the benefits of water fluoridation to citizens and communities, and by providing grant funding for communities to start or upgrade fluoridation equipment.

The Division of Dental Health also supports the School Fluoride Mouthrinse Program through the MCH Block Grant and provides funding for fluoride mouthrinse supplies, training in implementing school mouthrinse programs, brochures and educational information regarding the fluoride mouthrinse program. Most recently, the division implemented the "Bright Smiles for Babies" Program to targeted children from birth to three years old at highest risk for dental decay. This program's goal is to increase early recognition of disease and prevention through training dental and non-dental health professionals on oral health education and anticipatory guidance, screening and risk assessment and fluoride varnish application. The division also administers the Dental Scholarship Program that provides funding for dental students with repayment through service in dental underserved areas or eligible state agencies that provide dental services.

The WIC and Community Nutrition Services Division administers Virginia's Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). The programs goal is to enable women to deliver and nurture healthy children. The program serves approximately 136,000 low- to moderate-income families through local health departments and mobile clinics. The program includes outreach and education components. The division's other programs focus on increasing physical activity, reducing obesity, especially childhood obesity, promoting breastfeeding, preventing osteoporosis and preventing birth defects by promoting awareness of the importance of folic acid.

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

The Division of Injury and Violence Prevention's vision is that Virginia will be a place where people live, learn and play safely. To reduce the impact of injury and violence, the division engages in injury assessment, the development and promotion of prevention programs and policies, and training and community education. The division also promotes and disseminates safety devices, conducts public information campaigns and funds local prevention projects. The division works collaboratively with schools and day care centers, health, social service and mental health providers, law enforcement, fire and EMS providers, and a variety of other community groups across the Commonwealth. The division's unintentional injury programs address home, school and transportation safety including passenger safety, bike safety, playground safety and fire and falls prevention. The division's violence prevention programs address sexual violence prevention, suicide, youth and domestic violence prevention.

The Office of Family Health Services is responsible for addressing several federal (e.g., Title V and Title X) and state mandates for improving the health of women and children. State statues relevant to the Virginia's Title V program authority include the following:

Virginia Congenital Anomalies Reporting and Education System (Code of Virginia Section 32.1-69). Establishes a system to collect data to evaluate the possible causes of birth defects, improve the diagnosis and treatment and establish a mechanism for informing the parents and physicians regarding available resources. This program is administered by the Division of Child and Adolescent Health.

Newborn Screening (Code of Virginia Section 32.1-65). Establishes testing requirements for newborn infants for metabolic disorders. The Division of Child and Adolescent Health administers this program.

***/2007/ Effective March 1, 2006 the newborn screening panel was expanded to be consistent with the American College of Medical Genetics recommended screenings. //2007//***

***/2007/ Effective March 1, 2006 (Code of Virginia Section 32.1-67) was amended to make infants with a condition identified through the newborn screening program eligible for the services of the Children with Special Health Care Needs Program (Care Connection for Children) administered by the Department of Health. //2007//***

Sickle Cell Screening (Code of Virginia Section 32.1-38). Establishes screening and education and post-screening counseling for individuals with sickle cell anemia or the sickle trait. (Sickle cell screening is included in newborn screening program administered by the Division of Child and Adolescent Health. The on-going education and counseling component is administered by the Division of Women's and Infants' Health.)

Newborn Hearing Screening (Code of Virginia Section 32.1-64.1). Establishes the newborn hearing screening program (Virginia Early Hearing Detection and Intervention Program). The Division of Child and Adolescent Health administers this program.

State Plan for MCH and CSHCN (Code of Virginia Section 32.1-77). Authorizes the development and submission of state plans for maternal and child health and children with special health care needs to the federal government and authorizes the state health commissioner to administer and expend federal Title V funds.

Bleeding Disorders Program (Code of Virginia Section 32.1-89). Establishes a program for the care and treatment of persons suffering from hemophilia and other related bleeding diseases who are unable to pay for the cost of services. Also establishes the Hemophilia Advisory Committee with members appointed by the Governor. This program is administered by the Division of Child and Adolescent Health.

Prenatal Testing (Code of Virginia Section 32.1-60). Requires that physicians attending a pregnant woman to examine and test for venereal diseases.

Child Immunizations (Code of Virginia Section 32.1-46). Establishes immunization requirements for children. The Virginia Board of Health in conjunction with the Virginia Department of Education promulgates the rules and regulations regarding this requirement. The Division of Immunizations in the VDH Office of Epidemiology administers the state immunization program.

State Child Fatality Review Team (Code of Virginia Section 32.1-238.1). Establishes the State Child Fatality Review Team to review violent and unnatural child deaths, sudden child deaths occurring within the first 18 months of life and those fatalities where the cause cannot be determined with reasonable medical certainty. The VDH Chief Medical Examiner chairs the team that includes 16 members representing relevant state agencies and organizations.

Preschool Physical Examinations (Code of Virginia Section 22.1-270). Requires that students entering any public kindergarten or elementary school for the first time have a physical examination that becomes a part of the student's school health record. This record is available for review by state and/or local health department staff. Also requires that health departments in all counties and cities conduct the preschool physical examinations for medically indigent children at no cost.

Elevated Blood-lead Testing (Code of Virginia Section 32.1-46.1, 32.1-46.2). Requires that the Board of Health establish a protocol for identification of children with elevated blood-lead levels. The regulations established by the board requires blood-lead level testing at appropriate ages and frequencies, when indicated and provides for the criteria for determining low risk elevated blood-lead levels and when testing is not indicated. This program is administered in the Division of Child and Adolescent Health.

State Health Department Public Health Programs (Code of Virginia Section 32.1-2). Requires that the Board of Health and the Virginia Department of Health administer public health programs including prevention and education activities focused on women's health, including, but not limited to, osteoporosis, breast cancer, and other conditions unique to or more prevalent among women. Also requires the development and implementation of health resource plans, the collection and preservation of vital records and health statistics and the abatement of health hazards.

The Advisory Board on Child Abuse and Neglect (Code of Virginia Section 63.2-1528). Establishes a board to advise the Department of Social Services, the state Social Services Board and the Governor on matters concerning programs for the prevention and treatment of abused and neglected children and their families. The Board consists of Governor appointees as well as relevant state agency heads including the Commissioner of Health. An OFHS staff member represents the Commissioner on this board.

Children's Health Insurance Program Advisory Committee (Code of Virginia Section 32.1-351.2). Establishes a committee to assess the policies, operations, and outreach efforts for the Family Access to Medical Insurance Security (FAMIS). An OFHS staff member serves as the Virginia Department of Health representative on this committee. In addition, the Department of Medical Assistance Services is required to enter into agreements with the Department of Education and the Department of Health to identify children who are eligible for free or reduced school lunches or WIC in order to expedite the eligibility for FAMIS.

Children with health problems or handicapping conditions (Code of Virginia Section 32.1-78). Requires the Commissioner of Health to report to the Superintended of Public Instruction or local superintendent to identify children with health problems or handicapping conditions, which may affect school work and the need for special education.

Child Restraints in Motor Vehicles (Code of Virginia Section 46.2-1097). Requires the Department of Health to operate a program to promote, purchase and distribute child restraint devices to families who are financially unable to purchase the restraint devices. The program is funded through civil penalties. The OFHS Center for Injury and Violence Prevention administers this program.

Asthma Management Plan (Code of Virginia Section 32.1-73.5 and 73.6). Requires the Department of Health to develop, maintain, and revise a written comprehensive state plan and implement programs, using funds appropriate for that purpose, for reducing the rate of asthma hospitalizations. The plan's primary emphasis is, but not limited to, children between the ages of birth and eighteen years. The OFHS Division of Chronic Disease Prevention, in conjunction with the OFHS Division of Child and Adolescent Health, is responsible for this effort.

Youth Suicide Prevention (Code of Virginia Section 32.1-73.7). The Department of Health in consultation with the Department of Education, the Department of Mental Health, Mental Retardation, and Substance Abuse Services, along with the community services boards and the local health departments, have the lead responsibility for the youth suicide prevention program. The OFHS Center for Injury and Violence Prevention is responsible for this effort.

School Health Services (Code of Virginia Section 22.1-274). Specifies that a school board may employ school nurses, physicians, physical therapists, occupational therapists and speech

therapists to provide student support services. Upon approval of the local governing body a local health department may provide personnel for health services for the school district. Staff within the OFHS Division of Child and Adolescent Health Services work closely with the Department of Education's school nursing program.

Domestic Violence Surveillance (Code of Virginia Section 32.1-283.3). The Virginia Department of Health's Chief Medical Examiner shall provide ongoing surveillance of family violence fatalities, prepare an annual report, develop protocols for local family violence fatality review teams and serve as a clearinghouse for information. The OFHS Center for Injury and Violence Prevention works closely with the Medical Examiner's Office on this effort.

Dental Loan Repayment Program (Code of Virginia Section 32.1-122.9:1). The Board of Health is required to establish a dentist loan repayment program for graduates of accredited dental schools who meet the criteria established by the Board. These criteria require that the recipient agree to perform a period of dental service in an underserved area of the Commonwealth. The OFHS's Division of Dental Health administers this program.

Comprehensive Services for At-Risk Youth and their Families (Code of Virginia Section 2.2-2648, 2.2-5001, 2.2-5007, 2.2-5205 -- 06). The State Health Commissioner serves as a member of the Executive Council that is intended to facilitate a collaborative system of services and funding that is child-centered, family focused, and community-based when addressing the strengths and needs of troubled and at-risk youth and their families.
The Comprehensive Services for At-Risk Youth and Families also includes local health department staff on the community policy and management teams, the family assessment and planning teams and a state management team with a representative from the Office of Family Health Services.

Early Intervention Services -- Part C (Code of Virginia Section 2.2-5300 -- 2.2-5308). Establishes an early intervention agencies committee to ensure the implementation of a comprehensive system for early intervention services as required in Part C of the federal Individuals with Disabilities Education Act (IDEA). An OFHS staff member represents the Health Commissioner serves on this committee. Also establishes local interagency councils that include local health department participants.

Culturally Competent Care

The OFHS is committed to providing culturally competent care for the MCH populations. This is being acomplished in a number of ways. First data is collected and analyzed according to different race and ethnic categories and used to inform program development including the targeting of resources. OFHS also collaborates with culturally diverse community groups to ensure their representation in needs assessment, program planning and evaluation. Efforts are made to ensure that brochures and health promotion materials are culturally appropriate and translated into various languages. News releases regarding public health issues are placed in newspapers that are read in different racial and ethnic communities. OFHS staff participate in cultural competency trainings when available. A recent inservice training on racial disparities sponsored by the Office of Health Policy (OHP) was attended by a number of Title V staff. Contracts with the district health departments for maternal and child health services include a requirement that care must be provided in a culturally competent manner.

The Care Connection for Children staff participated in two days of training on cultural competency provided by the Georgetown University Center for Cultural Competency.

The perinatal depression web-based training for providers utilized findings from five minority focus groups to address how to provide culturally competent screening and referral for perinatal depression.

The Virginia Department of Health's Office of Health Policy has recently developed a website that provides resources to assist health care providers to better meet the needs of the Commonwealth's diverse populations. The resources include training materials, research articles, assessment tools and a calendar of events. The website also provides language resources that include a list of commonly used clinical phrases in both English and Spanish. OHFS will work with the OHP to develop additional resources that specifically target the diverse MCH population. The website is available at http://clasactVirginia.vdh.virginia.gov

## C. Organizational Structure

Mark R. Warner was sworn in as Virginia's Governor in January 2002. He became the first Democratic governor in eight years. Jane Woods, a former Virginia legislator who developed expertise in health care while serving as the Vice-Chairman of the Joint Commission on Health Care and Chairman of its Long Term Care subcommittee, was named Secretary of Health and Human Resources. Governor Warner named Robert B. Stroube, M.D., M.P.H. who has served in the past as the State Health Commissioner, and more recently as the Acting State Health Commissioner following the departure of E. Anne Peterson, State Health Commissioner.

Unlike other states, Virginia does not permit the governor to hold consecutive terms and therefore a new governor will take office in January 2006. This will undoubtedly result in numerous changes in agency heads and new gubernatorial initiatives.

***/2007/ In January 2006, Timothy Kaine, the former Democratic Lieutenant Governor was sworn in as Governor. Bill Bolling, a former Republican state senator was sworn in as Lieutenant Governor. Marilyn Tavenner was named Secretary of Health and Human Resources. Dr. Robert Stroube was reappointed as the State Health Commissioner. //2007//***

The Virginia Department of Health is mandated by the Code of Virginia to "administer and provide a comprehensive program of preventive, curative, restorative and environmental health services, educate the citizenry in health and environmental matters, develop and implement health resource plans, collect and preserve vital records and health statistics, assist in research, and abate hazards and nuisances to the health and environment, both emergency and otherwise, thereby improving the quality of life in the Commonwealth." In carrying out these responsibilities, VDH promulgates and enforces over 60 sets of regulations and manages over 70 federal and state grants. Organizationally VDH consists of a Central Office, 35 health districts, with numerous operational sites and hundreds of contractors. Three of the district offices, Arlington, Fairfax, and Richmond are independent with contractual relationships to the state system. See the Virginia Department of Health's Web site at http://www.vdh.virginia.gov/

***/2007/ In July 2006, Richmond Health Department will become part of the state health department system. //2007//***

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

Within the central office of VDH, the Maternal and Child Health Services Block Grant is managed by the Office of Family Health Services (OFHS). Dr. David Suttle is the OFHS director and reports directly to the Deputy Commissioner for Public Health, Dr. James Burns. Other offices under the direction of the Deputy Commissioner include the Office of Emergency Medical Services, the Office of Environmental Health Services, the Office of Drinking Water, and the Office of Epidemiology.

The administration of the Block Grant resides at the OFHS office level while divisions within the Office have specific responsibility for carrying out MCH programs. The divisions include Dental Health, Women's and Infants' Health, Chronic Disease Prevention and Control, Child and Adolescent Health, WIC and Community Nutrition and the Division of Injury and Violence Prevention. The CSHCN program resides within the Office's Division of Child and Adolescent Health. The OFHS mission and organizational placement within VDH remain the same as described in previous Maternal and Child Health Services Block Grant applications.

See attachment for the Virginia state government organizational chart. The Virginia Department of Health's organizational charts are available at http://www.vdh.virginia.gov/orgchart/orgchart.asp An OFHS organizational chart that includes all program elements of the Title V program is on file in the OFHS and is available upon request.

***An attachment is included in this section.***

## D. Other MCH Capacity

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

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

David E. Suttle, M.D. is Board Certified in Pediatrics with a specialty in adolescent medicine. Dr. Suttle has served in his current capacity as Director of the Office of Family Health Services since July 2002. Previously he served in the U.S. military in direct health care administration and health policy.

Janice M. Hicks, Ph.D. has served as the Policy and Assessment Director since 1997 and as the Office of Family Health Services' Senior Policy Analyst since 1994. She has over 20 years of experience in planning, evaluation and legislative analysis. Dr. Hicks also has experience in teaching college level courses in Sociology, Research Methods, Evaluation, Social Theory, Family, and Criminology/Juvenile Delinquency. She also serves as an adjunct faculty member in the Virginia Commonwealth University's Sociology Department. The Policy and Assessment Unit includes the grants coordinator (Robin Buskey), the State Systems Development Initiative (SSDI) Coordinator who also serves as the MCH Epidemiologist (Derek Chapman), the Behavior Risk Factor Surveillance System Coordinator (Susan Spain), the public relations coordinator (Charles Ford) and a senior health policy analyst (Kim Barnes) who continues to serve as the agency HIPAA compliance officer and the OFHS liaison to the Department of Medical Assistance Services on issues involving Medicaid and FAMIS.

Karen Day, D.D.S., M.S., M.P.H., has served in her current capacity as Director of the Division of Dental Health with the Virginia Department of Health (VDH) since 1996. Prior to this position with

VDH, she served as Community Water Fluoridation Coordinator for the Division for three years and as a public health dentist for fifteen years. Dr. Day has taught graduate and undergraduate courses at Virginia Commonwealth University including biology, oral epidemiology, principals of public health and public health dentistry.

Nancy R. Bullock, R.N., M.P.H., the CSHCN Program Director, has 38 years of experience in public health in Virginia. She served as a nurse consultant, program and division director at the state level and at the local level as a public health nurse and nurse manager. She has been the director of the CSHCN Program since 1991.

Joan Corder-Mabe, R.N.C., M.S., W.H.N.P., was selected as the Director for the Division of Women's and Infants' Health in 2001. Previously she served as the perinatal nurse consultant since 1992 and the Acting Director since 1998. She is responsible for programs including the Title X Family Planning, the Virginia Healthy Start Initiative, the CDC Breast and Cervical Cancer Early Detection Program, Partners in Prevention, the Resource Mothers Program, Women's Health, the Regional Perinatal Councils, and the Comprehensive Sickle Cell Program. She and the division staff also provide consultation and technical assistance to the local health departments serving perinatal clients.

Joanne S. Boise has served as Director of the Division of Child and Adolescent Health since June 2001. Prior to joining VDH, Ms. Boise spent fifteen years in the managed care industry working locally and nationally; she has held positions in health policy, HMO operations, quality improvement, utilization management, and network management. She holds an A.A.S. in Nursing (1979), B.A. in History (1976), and M.S.P.H. in Health Policy and Administration (1986).

Donna Seward, B.S., has served in her current capacity as the Director of the Division of WIC and Community Nutrition Services (DWCNS) since April 2000. She is responsible for the management of Virginia's WIC program. From 1976 to 2000 she served as the WIC Director at the local level in Texas. Her educational background is in health care management.

Erima S. Fobbs, B.Sc, M.P.H., is the Director of the Division of Injury and Violence Prevention (DIVP). Her M.P.H. includes a concentration on Epidemiology and Health Services Administration. Prior to becoming involved in injury prevention, she worked for one year as an evaluator on an AIDS education program targeted for minority communities. Her injury prevention career began in Canada in 1988 when, as the epidemiologist on a project at the University of Alberta, she prepared the first comprehensive report on injury epidemiology in Alberta and wrote a proposal leading to the permanent establishment and funding of the Alberta Injury Prevention Center. Her employment at the Virginia Department of Health began in 1994. Since that time she has developed a statewide injury and violence prevention program and directs staff in delivering services that include a resource information center, assessment, data analysis and reporting, state and community level prevention, training and education projects. She has also taught courses on the Epidemiology and Prevention of Intentional Injury as an adjunct assistant professor at MCV/VCU Department of Preventive Medicine and Public Health.

In the fall of 2004, OFHS contracted with the Virginia Commonwealth University's School of Public Health to hire a faculty level MCH epidemiologist. Derek Chapman, Ph.D. has been hired in this jointly appointed position that is supported by SSDI funds. Dr. Chapman previously served as the Director of Research at the Tennessee Department of Health and has a number of years of experience working with MCH data. He works closely with the division level epidemiologists to establish greater access to data including the development of linked data. He also works closely with the Behavior Risk Factor Surveillance System (BRFSS) Coordinator, the Director of the Center for Health Statistics and the Office of Information Management. The joint appointment of Dr. Chapman provides an opportunity for greater collaboration between the OFHS and the School of Public Health. It is anticipated that this arrangement will have benefits for both OFHS and the University through increased opportunities for grants, student internships, technical assistance and publications.

In April 2005 Susan Kennedy Spain, M.S. was hired to serve as the BRFSS Coordinator. She has fifteen years of experience in data analysis and project management. She previously was employed by the Virginia Commonwealth University's Survey Evaluation and Research Lab (SERL). She has expertise in survey development and will be an asset to the OFHS. She will be working closely with the MCH Epidemiologist to implement a routine surveillance system so that data will be routinely collected, analyzed and made available for use in program evaluation and decision making within the office.

***/2007/ Caroline Stampfel joined the Policy and Assessment Unit in September 2005. She has a 2-year fellowship sponsored by the Council of State and Territorial Epidemiologists (CSTE). Her work is focused primarily on MCH epidemiology. She received her MPH from Yale University in 2005. //2007//***

Family Involvement

OFHS provides a number of opportunities for family input into the MCH and CSHCN programs. A parent feedback survey is used to assess the services provided by Care Connection for Children centers, Bleeding Disorders Program, and the Child Development Clinics. Although the CSHCN Program has no parent with special needs children on staff, three Care Connection for Children centers do have contractual relationships with the coordinators for Virginia Family Voices, Parent-to-Parent, and Medical Home Plus. They provide outreach, support, mentorship and training to parents. They have assisted the Care Connection for Children centers in establishing their family-to-family support services. Two of the three centers now have contracts with families from their geographic service area to provide the support services. Parents from Family Voices and Parent-to-Parent provided input into Virginia's state CSHCN plan to meet the Healthy People 2010 goals. Parent focus groups have provided input for various MCH related programs including the Lead Program and Abstinence. Family representatives serve on the Regional Perinatal Councils, the Hemophilia Advisory Board, the Fetal Alcohol Spectrum Disorder Task Force, the Virginia Early Hearing Detection and Intervention Advisory Committee and its Parent Subcommittee, and the Virginia Lead Task Force. OFHS staff also participate in a number of organizations with families such as the Virginia Chapter of the Hemophilia Foundation, Spina Bifida Foundation, Cystic Fibrosis Foundation, Virginia SIDS Alliance, Virginia Parents Against Lead, and the Virginia Congress of Parents and Teachers. During 2005, CSHCN staff joined with parents and professionals from other state agencies and formed the Virginia Family Support Coalition which is committed to improving information and referral services for CSHCN and their families.

## E. State Agency Coordination

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

There are also ongoing opportunities to work with Virginia's health education programs and universities. For example, OFHS recently contracted with the Virginia Commonwealth University's (VCU) Department of Preventive Medicine and Community Health for the services of a faculty level MCH epidemiologist to work within the OFHS. VCU serves as the contractor for Virginia's

Behavior Risk Surveillance Survey (BRFSS) and also provides assistance with trainings, research and report writing and evaluations of programs such as the Teen Pregnancy Prevention Initiative and the Abstinence Education Initiative. Most recently, VCU completed a Women's Health Data Book and is currently completing a report on child hospitalizations. OFHS has also worked closely with the Center for Pediatric Research, Eastern Virginia Medical School (EVMS), in conducting surveys of perinatal providers on practice issues regarding perinatal depression, children's hospitalizations, and the development of a school health information system. Virginia Polytechnic Institute and State University (VPI&SU) also provided assistance in coalition building and program evaluation. The University of Virginia (UVA) recently provided assistance related to youth violence prevention activities.

***/2007/ The University of Virginia assisted in the development of the provider web-based training on perinatal depression. //2007//***

Currently OFHS contracts with Welligent (associated with EVMS) for the maintenance of client data systems including the Virginia Infant Screening and Infant Tracking System (VISITS), a web-based integrated database system that will track screening results for four programs and services: Virginia Newborn Hearing Screening Program, Virginia Congenital Anomalies Reporting and Education System (VaCARES), Early Hearing Detection and Intervention, and Infant and Toddler Connection (Part C of the Individuals with Disabilities Education Act (IDEA). The CSHCN Program, through a contractual agreement with EVMS/Welligent, implemented the Care Connection for Children System Users Network (CCC-SUN), a web-based database system. This software application is for the network of the six Care Connections for Children centers to document their services and report them to the CSHCN Program. Contracts with the tertiary care centers for genetic consultation/services and for specialized services for children with special health care needs are also maintained.

***/2007/ VDH has brought the Virginia Infant Screening and Tracking System as well as CCC-SUN in house under the Office of Information Management (OIM) for database management. Currently Welligent is contracted for programming services. Through a CDC grant funded project awarded in 2005, the Office of Information Management is redesigning VISITS, which will be integrated with the electronic birth certificate web-based system. The Virginia Child Health Information Systems Integration Project will include automatic and semi-automatic referrals to Infant and Toddler Connection (Part C of the Individuals with Disabilities Education Act (IDEA) and Care Connection for Children, and the project will examine the feasibility of linking VISITS with other child health databases, such as CCC-SUN and Lead Trax. //2007//***

The Department of Medical Assistance Services (DMAS) continues to bring the public and private sector together to address issues related to service delivery for mothers and children. The Managed Care Advisory Committee and its subgroup, the Managed Care Workgroup, continue to address problems with enrollment, access, and retention. The committee is comprised of representatives from the six contracted Medicaid managed care organizations, VDH Title V representatives, and the departments of Mental Health and Social Services. One of the significant accomplishments was the streamlining of eligibility determinations for pregnant woman. Through a contract with a private processing unit, a pregnant woman can now be enrolled and assigned a treating physician within 30 days to 45 days of application. Therefore, their access to prenatal services can now be accomplished during their first trimester.

Pursuant to legislation passed during the 2004 Session of the Virginia General Assembly, DMAS has brought together the public and private sector to address insurance coverage for children. The Child Health Insurance Advisory Committee (CHIPAC) has representation from state agencies, private industries, providers and consumers. The purpose of the group is to make policy recommendations concerning children's access to and utilization of health care services. Although in its infancy, this group has the support of senior management at DMAS and also members of the Virginia General Assembly.

An interagency agreement exists between VDH and DMAS for the coordination of Titles V and XIX services. The assignments of responsibilities as stated in the agreement are intended to result in improved use of state government resources and more effective service delivery by assuring that the provision of authorized Medicaid services is consistent with the statutory function and mission of VDH. The agreement has been modified to include a Business Associate Agreement for the purpose of data sharing. The current data sharing projects involve the exchange of blood-lead testing results, eligibility information and decedent information. In addition to the value of improved health status in the Commonwealth, these projects save the state approximately $1.2 million annually.

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

DMAS directs the EPSDT Program and collaborates with the VDH and DSS on specific components of the program. VDH interagency responsibilities include, when appropriate, (1) providing consultation on developing subsystem and data collection modifications and (2) collaborating on (a) modifying the Virginia EPSDT Periodicity, (b) developing screening standards and procedure guidelines for EPSDT providers, (c) developing materials to be included in the EPSDT Supplemental Medicaid Manual and other provider notices as may be required, (d) providing EPSDT educational activities targeted to local health departments, (e) implementing strategies that will increase the number of EPSDT screenings, and (f) making available current EPSDT program information brochures and other materials that are needed to communicate information to local health department patients. A web-based EPSDT training program is currently under development and will be marketed to Medicaid providers by DMAS.

***/2007/ The web-based curriculum on Bright Futures and EPSDT for health care providers and other child-serving professionals is now available at www.vcu-cme.org/bf //2007//***

In 1987, the Department of Medical Assistance Services, with the Departments of Health and Social Services, developed a plan for care coordination and other expanded services called Baby Care. The program services include outreach and care coordination for high-risk pregnant women and infants, education, counseling on nutrition, parenting and smoking cessation and follow-up and monitoring. With the advent of Medicaid Managed Care, the participating HMOs were allowed to develop proprietary Baby Care programs that met the objectives articulated in the 1987 regulations. These programs demonstrated significant improvements in birth outcomes. As the various programs were researched by DMAS, it has become evident that new Baby Care program guidance be established. This process is currently underway with an expected roll out date in early 2006.

***/2007/ The school health nurse specialist participated in numerous trainings with DMAS staff on Bright Futures, EPSDT, and childhood lead screening. //2007//***

A Memorandum of Understanding between VDH and the Virginia Department of Social Services covers the expectations related to the use of TANF funding to support the VDH Teen Pregnancy Prevention program, the Resource Mothers Sibling program (GEMS), Statutory Rape Awareness program and the Partners in Prevention program. The Title V program staff work closely with the DSS staff to ensure that the TANF funding addresses the needs of the MCH population.

The OFHS contracts with the six regional sites that make up the Statewide Human Services Information and Referral System, administered by the Virginia Department of Social Services, for

information and referral services for the MCH Helpline. The toll-free number is 1-800-230-6977. The system has been helping Virginians since 1974. This number also serves as the state number for the National Baby Line to provide information and referral for prenatal care. Data documenting maternal and child health related service calls are collected and reported to the OFHS quarterly as required by the contract. This information provides data for future needs assessments and program. Copies of the most recent contracts are on file in the OFHS.

***/2007/ During the past year the Statewide Human Services Information and Referral System implemented a "211" number that can be dialed from any location in the Commonwealth except the Northern Virginia Area. "211" access will be available in the Northern Virginia Area in the future. In 2005, over 44,000 calls relating to maternal and child health were received. //2007//***

Children with Special Health Care Needs

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

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

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

The Title V program has established and maintains ongoing interagency collaboration for systems building in some defined areas. The Title V program collaborates with DOE to develop and maintain guidelines for school health services for CSHCN, such as the First Aid Guide for School Emergencies (Revised 2003) and the Guidelines for Specialized Health Care Procedures (Revised 2004). VDH and the Virginia Chapter of the American Lung Association have established the Virginia Asthma Coalition to assess needs, share information, and collaborate on the use of available resources.

Other Collaborative Agreements

The Commissioner of the Department of Health serves on the Early Intervention Agencies Committee that was established in 1992 through Section 2.1-760-768 of the Code of Virginia to ensure the implementation of a comprehensive system of early intervention services for infants

and toddlers. A representative from the DCAH is an active participant on the Virginia Interagency Coordinating Council (VICC) and the Part C Interagency Management Team. At the local level, professional staff from the health departments and the Child Development Clinics serve on the local interagency coordinating councils.

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

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

Intra-agency and interagency collaboration will continue with the above mentioned agencies and others such as, WIC, the Office of Primary Care and Rural Health, Title X -- Federal Family Planning Program, the Commission on Youth, the Virginia Commission on Health Care, the VDH Office of Health Policy, the VDH Office of Minority Health, the Virginia Primary Care Association, and the Virginia Hospital and Health Care Foundation. In addition, Title V staff will continue to support community-based organizations that have been working to improve the health of the MCH population including organizations such as the Virginia Perinatal Association, the Virginia Association of School Nurses, the Virginia Chapter of the March of Dimes and numerous single disease oriented voluntary organizations.

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

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

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

A more comprehensive list of interagency work groups, advisory groups and other collaborative relationships is attached.

***An attachment is included in this section.***

## F. Health Systems Capacity Indicators

**Health Systems Capacity Indicator 01:** *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| Annual Objective and Performance Data | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|---|
| Annual Indicator | 49.1 | 38.6 | 42.2 | 36.6 | 33.2 |
| Numerator | 2269 | 1873 | 2072 | 1826 | |
| Denominator | 461982 | 485348 | 491229 | 498386 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

**Notes - 2005**
Data for 2005 not yet available. Entry is an estimate based on trend.

**Notes - 2004**
2004 Virginia hospital discharge data.

**Notes - 2003**
2003 Virginia Hospitals Discharge Data.

**Narrative:**
Asthma is considered an ambulatory sensitive condition for which hospitalizations can be largely prevented with consistent, available ambulatory care and adherence to treatment/self-care protocols. Hospital admissions may indicate access issues such as lack of insurance or few other options for service or the presence of social issues that may influence patient/family care such as homelessness or inconsistent caregivers. In 1998 39.7 /10,000 children were hospitalized for asthma. In 2002, the rate was 38.6/10,000 and in 2003 the rate was 43.5/10,000. The most recent rate (2004) is 36.6/10,000. The Virginia data do not appear to show a trend since the 1999 rate was 50/10,000 and the 2000 rate was 37/10,000. However, if hospitalizations for this condition had been prevented substantial saving would have resulted. The data does not present a complete picture of the impact of asthma since the visits to emergency rooms is not captured unless the visit results in hospitalization.

The Virginia Asthma Control Project (VACP) was created by the Virginia Department of Health in 2001 to reduce the increasing burden of asthma in the Commonwealth. The VACP is funded by the Centers for Disease Control and Prevention (CDC) and administered by the Office of Family Health Services' Division of Chronic Disease Control and Prevention. The goal of the VACP is to reduce the number of deaths, hospitalizations, emergency department visits, school or workdays missed, and limitations on activity due to asthma. The Virginia Asthma Coalition (VAC) consisting of seven regional coalitions works to improve asthma in the communities by promoting asthma awareness and prevention, asthma education, and the dissemination of asthma data. The VAC was created through collaboration between the Virginia Department of Health and the American Lung Assoication of Virginia and the Virginia Department of Education. The members include physicians, nurses, parents, health providers, governmental agencies, respiratory therapists and others who are concerned about controlling asthma.

Virginia's State Systems Development Initiative (SSDI) funds an MCH Epidemiologist who serves as the SSDI Project Director. A major focus of the grant is to develop an OFHS Data Mart that will facilitate easy access to data and will automatically update as new data are released. Future plans include the incorporation of Virgina's hospitalization data and will make access to asthma data easily accesible for program staff.

**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 Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| Annual Objective and Performance Data | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|---|
| Annual Indicator | 80.2 | 77.8 | 61.9 | 73.1 | 64 |
| Numerator | 28548 | 28885 | 44760 | 54980 | |
| Denominator | 35578 | 37135 | 72263 | 75209 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

**Notes - 2005**
2005 data not available at this time. Entry is an estimate based on trend.

**Notes - 2004**
NOTE: This population has more than doubled over the past few years due to increasing enrollment in Medicaid. In this context, a small decrease in EPSDT screens is not unexpected.

**Narrative:**
The Department of Medical Assistance Services (DMAS) has renewed its emphasis on maternal and child health services. Through agency reorganization, the department has established the Division of Maternal and Child Health that is devoted exclusively to the management of such services within the Medicaid and SCHIP populations. In FY 05, DMAS conducted statewide provider trainings on the EPSDT program and on the necessity to conduct proper screenings. DMAS also conducts quarterly case manager meetings throughout the state. These meetings provide a valuable forum to discuss services to children. In addition, a partnership between DMAS and the VDH Lead Safe Virginia Program allowed for the matching of blood lead test results with Medicaid recipients. Alert letters are now being sent to every child's primary care provider that had an elevated blood lead level. These letters serve as a physician reminder to conduct all other screenings as well.

VDH Title V staff continues to participate with the Children's Health Insurance Advisory Committee. This Committee is now under private sector leadership and has formalized its purpose and objectives concerning outreach, enrollment and service improvement. This committee's goal is to improve the system's capacity to serve Virginia's children.

A web-based curribulum on Bright Futures and EPSDT for health care providers and other child-serving professionals has been developed and is now available at www.vcu-cme.org/bf .

Virginia's State Systems Development Initiative (SSDI) funds an MCH Epidemiologist who serves as the SSDI Project Director. A major focus of the grant is to develop an OFHS Data Mart that will facilitate easy access to data and will automatically update as new data are released. Future plans include the implementation of an OFHS surveillance system that will include routinely available Medicaid/FAMIS data.

**Health Systems Capacity Indicator 03:** *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| Annual Objective and Performance Data | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|---|
| Annual Indicator | 54.1 | 72.1 | 52.3 | 55.1 | 54.2 |
| Numerator | 1025 | 991 | 2486 | 3170 | |
| Denominator | 1896 | 1374 | 4756 | 5750 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

**Notes - 2005**
2005 data not available at this time. Entry is an estimate based on trend.

**Narrative:**
The managed care marketplace in Virginia continues to expand. DMAS was able to contract with a new managed care organization (MCO) to provide an additional coverage option in northern Virginia. Also, three currently contracted MCOs have expanded their coverage areas within the Commonwealth. There is now a Medicaid MCO offering in 135 of the 160 existing cities/counties in Virginia. Through the DMAS/MCO contract, these organizations are required to report on their network strength and their ability to provide services to pregnant women and children. Although EPSDT services are not covered for the FAMIS population, well-child visits are. It is incumbent upon the MCOs to facilitate participation in these services as the number of well-child visits in the 1st 15 months of life and the number of childhood immunizations given in the 1st 2 years of life are reportable performance indicators.

A web-based curribulum on Bright Futures and EPSDT for health care providers and other child-serving professionals has been developed and is now available at www.vcu-cme.org/bf .

The VDH local health departments are participating providers in all Medicaid MCOs. We work collaboratively with the MCOs to help facilitate recipient entry into the health care system. Districts supply recipients with information on available primary care sites, location of bilingual practices, and instructions on screening periodicity. In addition, VDH has constructed an immunization registry for both public and private providers. The registry is designed to encourage and facilitate the proper delivery of necessary immunizations.

Virginia's State Systems Development Initiative (SSDI) funds an MCH Epidemiologist who serves as the SSDI Project Director. A major focus of the grant is to develop an OFHS Data Mart that will facilitate easy access to data and will automatically update as new data are released. Future plans include the implementation of an OFHS surveillance system that will include routinely available Medicaid/FAMIS data.

**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.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| Annual Objective and Performance Data | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|---|
| Annual Indicator | 80.5 | 80.8 | 80.1 | 79.6 | 79.4 |
| Numerator | 79382 | 79728 | 80174 | 82429 | |
| Denominator | 98567 | 98716 | 100038 | 103505 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

**Notes - 2005**
2005 data not yet available. Entry is an estimate based on trend.

**Notes - 2004**
2004 data from birth certificates.

**Notes - 2003**
Data from 2003 birth certificate data.

**Narrative:**
Birth certificate data are used to calculate the adequacy of prenatal care based on the Kotlechuck Index. The percentage of women receiving adequate prenatal care has remained constant with the exception of an increase to 86.2% in 2003. The 2003 data represents a calculation error.

The corrected 2003 data show that 80.1% of women received adequate prenatal care. In 2004, 79.6% of Virginia mothers received adequate prenatal care. Although almost 80% of received adequate care there are racial and ethnic disparities. In 2004, 84.4% of white non-Hispanic women had adequate prenatal care while 75.2% of black non-Hispanic and 64.2% of Hispanic women had adequate care.

The Virginia Department of Health continues to provide Title V funding to support local health departments' perinatal services. These services range from pregnancy testing and referral to prenatal care providers to direct prenatal care including case management. This year approximately $3.5 million will be provided to the local health departments for perinatal services. In addition, services to ensure adequate prenatal care are also provided by the Resource Mothers program, a home visiting program for pregnant teens, and the Virginia Healthy Start Initiative. The seven Regional Perinatal Councils conduct fetal infant mortality reviews (FIMR) and work on system issues that impact the delivery of prenatal care. In FY 05, the Regional Perinatal Councils trained a total of 17,446 professionals in obstetrical (355), neonatal (378) and other programs (184) totaling over 1461 program hours. Most were nurses (4,423) and respiratory therapists and consumers (10,509), while others were physicians (1,207), health educators (861), social workers (141), resource mothers (228), and nutritionists (77).

Virginia's State Systems Development Initiative (SSDI) funds an MCH Epidemiologist who serves as the SSDI Project Director. A major focus of the grant is to develop an OFHS Data Mart that will facilitate easy access to data and will automatically update as new data are released. Birth certificate data will be available to staff along with routine reports. In the future, provisional birth certificate data will be available so that staff will not have to wait for the official data.

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

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| **Annual Objective and Performance Data** | **2001** | **2002** | **2003** | **2004** | **2005** |
|---|---|---|---|---|---|
| Annual Indicator | 74.9 | 78.5 | 86.0 | 87.5 | 92.6 |
| Numerator | 357100 | 367315 | 407845 | 435993 | 469480 |
| Denominator | 477075 | 467712 | 474478 | 498315 | 506933 |
| Is the Data Provisional or Final? | | | | Final | Final |

**Notes - 2005**
Numerator = Number of Annual Unduplicated Recipients from Statistical Record of VA Medicaid Program FY2005 Edition, page 3-3, total for 0-20 yr old.

Denominator = Number of Annual Unduplicated Individulas Eligible for Medicaid Services from Statistical Record of VA Medicaid Program FY2005 Edition, page 2-12, total for 0-20 yr old + Number Estimated Eligible Uninsured Children in Virginia from www.signupnowva.org Child Health Insurance Program Enrollment Progress Report. Number is from December 1, 2005.

**Notes - 2004**
Numerator = Number of Annual Unduplicated Recipients from Statistical Record of VA Medicaid Program FY2005 Edition, page 3-3, total for 0-20 yr old.

Denominator = Number of Annual Unduplicated Individulas Eligible for Medicaid Services from Statistical Record of VA Medicaid Program FY2005 Edition, page 2-12, total for 0-20 yr old + Number Estimated Eligible Uninsured Children in Virginia from www.signupnowva.org Child Health Insurance Program Enrollment Progress Report. Number is from December 1, 2004.

**Notes - 2003**

Numerator = Annual unduplicated recipients receiving a service from Department of Medical Assistance Services (DMAS) FY 2003 Statistical Record HCFA 2082 series

Denominator = Medicaid enrolled (eligibles from page 2-12 FY 2003 DMAS Statistical Record + estimated eligible not enrolled for Medicaid.

**Narrative:**
DMAS undertook an aggressive campaign to enroll potential eligibles in both FAMIS and the rebranded Medicaid product, FAMIS Plus. FAMIS enrollment improved to where it is currently estimated that 92% of potential eligibles are enrolled. A strong network of community coalitions continues to work towards enrollment gains.

VDH provides an administrative practice management system for the local health departments. An additional feature was recently added to the system that facilitates the Medicaid eligibility process. VDH and DMAS collect similar demographic information on clients for each organization's business purposes. Now, the VDH information will automatically populate the Medicaid Enrollment form and therefore allow staff to deliver billable services on the day the client has presented. For example, applications for infants that present to the health department for postpartum follow-up, can immediately apply for Medicaid and if approved, coverage is retroactive for three months.

A web-based curribulum on Bright Futures and EPSDT for health care providers and other child-serving professionals has been developed and is now available at www.vcu-cme.org/bf .

**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.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| **Annual Objective and Performance Data** | **2001** | **2002** | **2003** | **2004** | **2005** |
|---|---|---|---|---|---|
| Annual Indicator | 31.2 | 26.6 | 24.9 | 32.8 | 29.7 |
| Numerator | 25693 | 22184 | 21909 | 30132 | |
| Denominator | 82452 | 83312 | 87816 | 91991 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

**Notes - 2005**
2005 data not available at this time. Entry is an estimate based on trend.

**Narrative:**
In 2004, 32.8 percent of EPSDT eligible children aged 6 through 9 years have received dental services during the year. This represents a small improvement over the 28.0 percent reported in 2000. One ongoing dental health care issue is the lack of Medicaid dental providers. This may be one factor in the low percent of EPSDT eligible children receiving dental care. During the past few months for profit dental practice franchises have opened in some areas of the state. These dental practices (Kool Smiles and Small Smiles) specifically target services to Medicaid eligible children. Depending on the success of these franchises, the percent of children receiving Medicaid reimbursed dental care should increase in areas where the services are available.

It is anticipated that recent changes in how dental services are administered by the Department of Medical Assistance Services (the Medicaid agency) willl also have an impact on the number of children receiving dental care. Prior to July 1, 2005, dental services were administered through the fee-for-service and MCO programs. Approximately 70% of children were enrolled in MCOs

and the remaining were enrolled in fee-for-service programs. The dentists complained that the program was administratively cumbersome. As a result, Medicaid/FAMIS dental services were carved out of the MCO programs and consolidated with the fee-for-service program and administered as a single statewide program. On July 1, 2005, the Smiles for Children program was implemented. Doral Dental USA, LLC was chosen to administer the Smiles for Children program. The new program also includes an overall increase in dental fees of 30%, as approved by the 2005 Virginia General Assembly and a member outreach and education component to increase children's dental utilization. Additionally, the Medicaid program actively recruits dentists. During the past year the numbr of Medicaid dental providers has increased from 620 to 810, a 31% increase.

Virginia participated along with 14 other states in the Center for Health Care Strategies Purchasing Institute: Best Practices for Oral Health Access program. The Institute, partially funded by the Robert Wood Johnson Foundation, took place in September 2005 in Philadelphia. David Suttle, MD and Karen Day, DDS for Virginia's Title V program participated as team members, along with representatives from the Medicaid agency.

Dr. Karen Day, director of the Virginia Department of Health's Division of Dental Health, participates on the state Dental Advisory Committee.

Beginning in state FY 2006, the Governor and General Assembly approved $325,000 for dental scholarships and loans to increase the number of dentists working in underserved areas of the state. The Virginia Department of Health's Division of Dental Health administers the dental scholarship and loan repayment program. In FY 2006, 17 scholarships and 7 loans were issued to dental students and practicing dentists. A requirement of the scholarship and loan programs is that the dentist must practice in an underserved area and agree to serve Medicaid patients. It is anticipated that the program requirements will increase the number of dentist serving Medicaid/FAMIS children.

Virginia's State Systems Development Initiative (SSDI) funds an MCH Epidemiologist who serves as the SSDI Project Director. A major focus of the grant is to develop an OFHS Data Mart that will facilitate easy access to data and will automatically update as new data are released. Future plans include the implementation of an OFHS surveillance system that will include routinely available Medicaid/FAMIS data.

**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.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| **Annual Objective and Performance Data** | **2001** | **2002** | **2003** | **2004** | **2005** |
|---|---|---|---|---|---|
| Annual Indicator | 4.6 | 4.4 | 3.3 | 2.6 | 2.8 |
| Numerator | 804 | 775 | 571 | 468 | 535 |
| Denominator | 17380 | 17620 | 17474 | 18020 | 18832 |
| Is the Data Provisional or Final? | | | | Final | Final |

**Narrative:**
In FY 05, 2.8 percent of Virginia's SSI beneficiaries less than 16 years old received rehabilitation services from the CSHCN Program. This is higher than the 2004 level of 2.6 percent. Over the last few years as the model of care for CSHCN with physical disabilities has transitioned from the provision of direct care in clinics to intensive care coordination, a broader range of children with varying financial and diagnoses is being served. The percent of SSI clients to total clients is

14.9% in the Care Connection for Children Centers and 10.7% in the Bleeding Disorders Program. Due to type of diagnoses served in the Child Development Clinics the percentage is much lower at 3.2%. All of these CSHCN programs continue to provide outreach to potentially eligible families and coordination of services for those who are eligible for SSI. This is a major component of the scope of services in the contracts with the local entities managing these programs.

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

| **INDICATOR #05** ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*** | **YEAR** | **DATA SOURCE** | **POPULATION** | | |
|---|---|---|---|---|---|
| | | | **MEDICAID** | **NON-MEDICAID** | **ALL** |
| Percent of low birth weight (< 2,500 grams) | 2004 | payment source from birth certificate | 10.5 | 7.5 | 8.2 |

**Narrative:**
The data source for expected payment source comes directly from the birth certificate data.

In 2004, 8.2% of all Virginia births were low birthweight with births covered by Medicaid having a higher percent of low birthweight births (10.5% as compared to 7.5% for non-Medicaid) and a higher rate of infant deaths (5.1 vs. 3.1 per 1000 live births). Also Medicaid births compared to non-Medicaid births had a lower percent of early entry into prenatal care (74.2% vs. 88.5%) and adequate prenatal care (71.1% vs. 82.8%).

The Virginia Department of Health continues to provide Title V funding to support local health departments' perinatal services. These services range from pregnancy testing and referral to prenatal care providers to direct prenatal care including case management. This year approximately $3.5 million will be provided to the local health departments for perinatal services. In addition, services to ensure adequate prenatal care are also provided by the Resource Mothers program, a home visiting program for pregnant teens, and the Virginia Healthy Start Initiative. The seven Regional Perinatal Councils conduct fetal infant mortality reviews (FIMR) and work on system issues that impact the delivery of prenatal care. In FY 05, the Regional Perinatal Councils trained a total of 17,446 professionals in obstetrical (355), neonatal (378) and other programs (184) totaling over 1461 program hours. Most were nurses (4,423) and respiratory therapists and consumers (10,509), while others were physicians (1,207), health educators (861), social workers (141), resource mothers (228), and nutritionists (77).

Virginia's State Systems Development Initiative (SSDI) funds an MCH Epidemiologist who serves as the SSDI Project Director. A major focus of the grant is to develop an OFHS Data Mart that will facilitate easy access to data and will automatically update as new data are released. Birth certificate data will be available to staff along with routine reports. In the future, provisional birth certificate data will be available so that staff will not have to wait for the official data.

### Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

| **INDICATOR #05** ***Comparison of health system capacity*** | **YEAR** | **DATA SOURCE** | **POPULATION** | | |
|---|---|---|---|---|---|
| | | | **MEDICAID** | **NON-MEDICAID** | **ALL** |

| ***indicators for Medicaid, non-Medicaid, and all MCH populations in the State*** | | | | | |
|---|---|---|---|---|---|
| Infant deaths per 1,000 live births | 2004 | payment source from birth certificate | 9.9 | 6.1 | 7.4 |

**Narrative:**
The data source for expected payment source comes directly from the birth certificate data.

In 2004, 8.2% of all Virginia births were low birthweight with births covered by Medicaid having a higher percent of low birthweight births (10.5% as compared to 7.5% for non-Medicaid) and a higher rate of infant deaths (9.9 vs. 6.1 per 1000 live births). Also Medicaid births compared to non-Medicaid births had a lower percent of early entry into prenatal care (74.2% vs. 88.5%) and adequate prenatal care (71.1% vs. 82.8%).

The Virginia Department of Health continues to provide Title V funding to support local health departments' perinatal services. These services range from pregnancy testing and referral to prenatal care providers to direct prenatal care including case management. This year approximately $3.5 million will be provided to the local health departments for perinatal services. In addition, services to ensure adequate prenatal care are also provided by the Resource Mothers program, a home visiting program for pregnant teens, and the Virginia Healthy Start Initiative. The seven Regional Perinatal Councils conduct fetal infant mortality reviews (FIMR) and work on system issues that impact the delivery of prenatal care. In FY 05, the Regional Perinatal Councils trained a total of 17,446 professionals in obstetrical (355), neonatal (378) and other programs (184) totaling over 1461 program hours. Most were nurses (4,423) and respiratory therapists and consumers (10,509), while others were physicians (1,207), health educators (861), social workers (141), resource mothers (228), and nutritionists (77).

On April 14, 2006 Virginia received CDC funding to support the implementation of the Pregnancy Risk Assessment Monitoring System (PRAMS). This surveillance system will provide data on such issues as intendedness of pregnancy, risk behaviors during pregnancy, early infant care such as sleeping position and breastfeeding, and postpartum depression. Data collection is expected to begin in April 2007.

Virginia's State Systems Development Initiative (SSDI) funds an MCH Epidemiologist who serves as the SSDI Project Director. A major focus of the grant is to develop an OFHS Data Mart that will facilitate easy access to data and will automatically update as new data are released. Birth certificate data will be available to staff along with routine reports. In the future, provisional birth certificate data will be available so that staff will not have to wait for the official data.

**Health Systems Capacity Indicator 05C:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

| **INDICATOR #05** ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*** | **YEAR** | **DATA SOURCE** | **POPULATION** | | |
|---|---|---|---|---|---|
| | | | **MEDICAID** | **NON-MEDICAID** | **ALL** |
| Percent of infants born to | 2004 | payment source | 74.2 | 88.5 | 84.8 |

| | | | | | |
|---|---|---|---|---|---|
| pregnant women receiving prenatal care beginning in the first trimester | | from birth certificate | | | |

**Narrative:**
The data source for this Health Systems Capacity Indicator is the expected payment source identified on the birth certificate. The percent of infants born to pregnant women receiving prenatal care beginning in the first trimester remains relatively unchanged from 2003. In 2004, 74.2% of Medicaid women entered prenatal care in the first trimester as compared to 88.5% of non-Medicaid women. Virginia implemented presumptive eligibility to decrease the wait for entry into care. Hispanic women, compared to both white non-Hispanic and black non-Hispanic, are less likely to enter prenatal care during the first trimester. In 2004, approximately 72% of Hispanic women received prenatal care beginning in the first trimester and 68% received adequate prenatal care. Immigration status may a role in early and adequate prenatal care and may impact the percent of Medicaid women who have early prenatal care. Further analysis on the impact of the presumptive eligibility and immigration status on early entry into prenatal care would be beneficial.

The Virginia Department of Health continues to provide Title V funding to support local health departments' perinatal services. These services range from pregnancy testing and referral to prenatal care providers to direct prenatal care including case management. This year approximately $3.5 million will be provided to the local health departments for perinatal services. In addition, services to ensure adequate prenatal care are also provided by the Resource Mothers program, a home visiting program for pregnant teens, and the Virginia Healthy Start Initiative. The seven Regional Perinatal Councils conduct fetal infant mortality reviews (FIMR) and work on system issues that impact the delivery of prenatal care. In FY 05, the Regional Perinatal Councils trained a total of 17,446 professionals in obstetrical (355), neonatal (378) and other programs (184) totaling over 1461 program hours. Most were nurses (4,423) and respiratory therapists and consumers (10,509), while others were physicians (1,207), health educators (861), social workers (141), resource mothers (228), and nutritionists (77).

Virginia's State Systems Development Initiative (SSDI) funds an MCH Epidemiologist who serves as the SSDI Project Director. A major focus of the grant is to develop an OFHS Data Mart that will facilitate easy access to data and will automatically update as new data are released. Birth certificate data will be available to staff along with routine reports. In the future, provisional birth certificate data will be available so that staff will not have to wait for the official data.

**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])*

| **INDICATOR #05** ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*** | **YEAR** | **DATA SOURCE** | **POPULATION** | | |
|---|---|---|---|---|---|
| | | | **MEDICAID** | **NON-MEDICAID** | **ALL** |
| Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to | 2004 | payment source from birth certificate | 71.1 | 82.8 | 80.1 |

| | | | | | |
|---|---|---|---|---|---|
| 80% [Kotelchuck Index]) | | | | | |

**Notes - 2007**
Missing information for method of payment caused the discrepancy between this and HSCI 04.

**Narrative:**
The data sources for this Health Systems Capacity Indicator are the expected payment source identified on the birth certificate and the adequacy of prenatal care as measured by the Kotelchuck Index. The overall percentage of women receiving adequate prenatal care has remained constant with the exception of an increase to 86.2% in 2003. The 2003 data represents a calculation error. The corrected 2003 data show that 80.1% of women received adequate prenatal care. This calculation error was also reflected in the 2003 data on the difference in Medicaid and non-Medicaid adequacy of care reported last year. In 2004, approximately 80% of Virginia mothers received adequate prenatal care. Although almost 80% of received adequate care there are racial and ethnic disparities. In 2004, 84.4% of white non-Hispanic women had adequate prenatal care while 75.2% of black non-Hispanic and 64.2% of Hispanic women had adequate care. There is also a difference in Medicaid and non-Medicaid with a lower percentage of Medicaid patients receiving adequate prenatal care (71.1% vs. 82.8% non-Medicaid births).

Virginia implemented presumptive eligibility to decrease the wait for entry into care which is one factor in determining the adequacy of prenatal care. Hispanic women, compared to both white non-Hispanic and black non-Hispanic, are less likely to enter prenatal care during the first trimester. In 2004, approximately 72% of Hispanic women received prenatal care beginning in the first trimester and 64% received adequate prenatal care. Immigration status may a play role in early and adequate prenatal care and may impact the percent of Medicaid women who have adequate prenatal care. Further analysis on the impact of the presumptive eligibility and immigration status on early entry into prenatal care and the adequacy of prenatal care would be beneficial.

The Virginia Department of Health continues to provide Title V funding to support local health departments' perinatal services. These services range from pregnancy testing and referral to prenatal care providers to direct prenatal care including case management. This year approximately $3.5 million will be provided to the local health departments for perinatal services. In addition, services to ensure adequate prenatal care are also provided by the Resource Mothers program, a home visiting program for pregnant teens, and the Virginia Healthy Start Initiative. The seven Regional Perinatal Councils conduct fetal infant mortality reviews (FIMR) and work on system issues that impact the delivery of prenatal care. In FY 05, the Regional Perinatal Councils trained a total of 17,446 professionals in obstetrical (355), neonatal (378) and other programs (184) totaling over 1461 program hours. Most were nurses (4,423) and respiratory therapists and consumers (10,509), while others were physicians (1,207), health educators (861), social workers (141), resource mothers (228), and nutritionists (77).

Virginia's State Systems Development Initiative (SSDI) funds an MCH Epidemiologist who serves as the SSDI Project Director. A major focus of the grant is to develop an OFHS Data Mart that will facilitate easy access to data and will automatically update as new data are released. Birth certificate data will be available to staff along with routine reports. In the future, provisional birth certificate data will be available so that staff will not have to wait for the official data.

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

| INDICATOR #06 | YEAR | PERCENT OF |
|---|---|---|

| **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.** | | **POVERTY LEVEL Medicaid** |
|---|---|---|
| Infants (0 to 1) | 2005 | 133 |
| **INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.** | **YEAR** | **PERCENT OF POVERTY LEVEL SCHIP** |
| Infants (0 to 1) | 2005 | 200 |

**Narrative:**
The percent of the federal poverty level for eligibility in Virginia's Medicaid programs for infants remains unchanged at 133% FPL.

The percent of the federal poverty level for eligibility in Virginia's SCHIP (FAMIS) program also remains unchanged at 200% FPL.

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

| **INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.** | **YEAR** | **PERCENT OF POVERTY LEVEL Medicaid** |
|---|---|---|
| Medicaid Children<br>(Age range 1 to 18)<br>(Age range to )<br>(Age range to ) | 2005 | 133 |
| **INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.** | **YEAR** | **PERCENT OF POVERTY LEVEL SCHIP** |
| Medicaid Children<br>(Age range 1 to 18)<br>(Age range to )<br>(Age range to ) | 2005 | 200 |

**Narrative:**
The percent of the federal poverty level for eligibility in Virginia's Medicaid programs for children remains unchanged at 133% FPL.

The percent of the federal poverty level for eligibility in Virginia's SCHIP (FAMIS) program also remains unchanged at 200% FPL.

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

| **INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.** | **YEAR** | **PERCENT OF POVERTY LEVEL Medicaid** |
|---|---|---|
| Pregnant Women | 2005 | 133 |
| **INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant** | **YEAR** | **PERCENT OF POVERTY LEVEL SCHIP** |

| | | |
|---|---|---|
| **women.** | | |
| Pregnant Women | 2005 | 166 |

**Narrative:**
The percent of the federal poverty level for eligibility in Virginia's Medicaid programs for pregnant women remains unchanged at 133% FPL.

The percent of the federal poverty level for eligibility in Virginia's SCHIP (FAMIS) program is 166% FPL.

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

| DATABASES OR SURVEYS | Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3) | Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N) |
|---|---|---|
| ANNUAL DATA LINKAGES<br>Annual linkage of infant birth and infant death certificates | 3 | Yes |
| Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files | 1 | No |
| Annual linkage of birth certificates and WIC eligibility files | 2 | Yes |
| Annual linkage of birth certificates and newborn screening files | 1 | No |
| REGISTRIES AND SURVEYS<br>Hospital discharge survey for at least 90% of in-State discharges | 1 | No |
| Annual birth defects surveillance system | 3 | Yes |
| Survey of recent mothers at least every two years (like PRAMS) | 1 | No |

**Notes - 2007**
Virginia's SSDI-funded MCH Epidemiologist has begun testing linkages between WIC program data and birth certificates. Historical birth data have already been loaded into a SQL Server Data Mart. WIC data will be extracted annually and linked to births. Variables to be physically "attached" to birth record data include WIC enrollment status of mother and infant at delivery, breastfeeding status, and BMI at each time measurement point in the WIC data.

Virginia received PRAMS funding effective April 14, 2006. Data collection will begin in 2007.

**Narrative:**
Virginia's State Systems Development Initiative (SSDI) funds the MCH Epidemiologist who serves as the SSDI Project Director. A major focus of the grant is to develop an OFHS Data Mart that will facilitate easy access to data and will automatically update as new data are released. The MCH Epidemiologist has made significant progress in increasing data availability and data linkages during the past year. The office has electronic access to birth certificate and infant death data and is able to link these data. There is also direct electronic access to the birth defects surveillance system. Direct access to WIC data is available and limited worke has begun to link WIC and birth certificate data. By the end of this year, it is expected that this linkage will be routine.

Currently, VDH has access to the Medicaid eligibility files for local health department clinics to determine Medicaid status. However, work continues on linking birth certificate data and Medicaid eligibility and paid claims data.

A linkage between the birth certificate and the newborn screening files does not currently exist, but is under development.

Hospital survey data are not available in Virginia. Virginia does routinely analyze the hospital discharge data to determine the reasons for hospitalizations as well as the related charges. Virginia is one of nine new PRAMS states effective April 14, 2006. During the first year of funding staff will be hired and the Virginia PRAMS protocol will be developed. Data collection will begin in April 2007. The PRAMS will address current data gaps on such areas as intendedness of pregnancy, risk behaviors during pregnancy, and postpartum depression.

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

| DATA SOURCES | Does your state participate in the YRBS survey? (Select 1 - 3) | Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N) |
|---|---|---|
| Youth Risk Behavior Survey (YRBS) | 1 | No |
| Youth Tobacco Survey | 2 | No |

**Notes - 2007**
As a state Virginia does not participate in the YRBS. Some individual school districts do survey students regarding risk behaviors.

The Youth Tobacco Survey was completed in 2001 and 2003. Findings from the 2005 survey are not available yet.

**Narrative:**
Virginia does not participate in the Youth Risk Behavior Survey (YRBS). Some school districts however, do conduct the YRBS or a partial YRBS-type survey. This limits the MCH program's ability to obtain data on a number of youth risk behaviors including obesity and the use of tobacco products. The Youth Tobacco Survey (YTS), was conducted in 2001, 2003 and 2005. The 2003 survey showed a 28 percent decrease in the number of high school students and a 45 percent decrease in the number of middle school students that report that they currently smoke. Findings

from the 2005 survey are not yet available.

The Virginia Tobacco Settlement Foundation (VTSF) funded 95 agencies to conduct prevention and/or smoking cessation programs throughout Virginia. The VTSF also released 3 additional television commericals and radio spots and trained a total of 500 high school students who will work with youth to increase awareness of smoking effects.

The Virginia Tobacco Use Control Project (TUCP)within the Virginia Department of Health is funded through a grant from the Centers for Disease Control and Prevention's Office on Smoking and Health. The TUCP provides training, information and materials to support the implementation of policies to help Virginians choose and maintain tobacco-free lifestyles. The TUCP works closely with coalitions, health districts and partner organizations to refuce youth tobacco use, increase cessation support, and increase clean indoor air.

The State Systems Development Initiative will work closely with the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, the Virginia Department of Education, the Virginia Tobacco Settlement Foundation and the Virginia Tobacco Use Control Project to obtain data on youth tobacco use.

# IV. Priorities, Performance and Program Activities

## A. Background and Overview

Virginia's Title V program continues to be challenged by changing economic, social, and political forces dramatically impacting the provision of health care. Although surveys have shown decreases in uninsured rates, rising health care costs and other market forces may slow those decreases particularly among lower income persons. Virginia's revised S-CHIP program, FAMIS, has been a major force in increasing the number of children who have insurance and access to health care. The changes in the FAMIS application process have also helped to identify and enroll more children in Medicaid, again increasing access to health care.

Managed care continues to be a major force in the health insurance area with half of all Medicaid recipients now under a managed care plan. The lack of providers has presented major problems in the Commonwealth. Like many other states, Virginia is experiencing what many people have referred to as a crisis in access to obstetrical care. The effects have been felt most in rural areas, but suburban and urban communities are also experiencing the effects. Several small community hospitals no longer provide obstetrical care and some obstetricians have stopped providing coverage for family practice physicians who have been delivering babies or have stopped providing supervision of certified nurse midwives. Some OB/GYNs have limited their practice to gynecology due to the prohibitive cost of malpractice insurance premiums. This has resulted in women having to travel further to the hospital or delivering in the emergency rooms or perhaps having inadequate prenatal care. The lack of dental providers also impacts children's access to dental care, especially for Medicaid children.

Communities continue to experience changing demographics with an influx of many new multicultural populations entering the state. Title V will prioritize efforts to address the needs of the most vulnerable populations. Market forces and recently enacted laws have forced public health, along with the Title V program, to reevaluate priorities, allocation of resources, and strategies used to achieve optimum health.

During the development of the 2006 Title V Block Grant application, the OFHS Management Team along with a number of our external partners, reviewed the Title V priorities, as well as needs assessment data that included the qualitative data from the key stakeholder interviews, focus groups, and the public hearings. The following reflects the priority areas that will be used to focus OFHS activities and resources during the coming years:

1. Exercise leadership in nurturing partnerships that promote systematic communication, coordination, shared resource allocation and education around health improvement efforts.

2. Enhance data collection and dissemination efforts to promote evidence-based decision making in planning, policy, evaluation, allocation and accountability.

3. Assess and develop strategies to address underinsurance for vulnerable populations to improve access to affordable, acceptable care.

4. Evaluate, coordinate and enhance provider education in risk assessment, documentation, intervention, treatment and referral consistent with evidence-based standards of care around health issues specific to women and children.

5. Advance a holistic continuum of care model for women's health services across the life-span toward improvements in health for women, their children and their families.

6. Expand availability, quality and utilization of medical homes for children.

7. Improve access to dental care, awareness of oral health, and application of new models in

dental health services.

8. Incorporate mental health into relevant preventive health efforts in MCH; participate in efforts to promote availability and quality of mental health services; and facilitate links between the mental health and health care communities.

9. Improve access to prenatal care including appropriate genetic assessment and breastfeeding support for all women across the state.

10. Apply socio-ecologic models to promote healthy weight by encouraging appropriate nutrition and safe physical activity efforts.

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

1. The percent of children and adolescents who have a specific source of ongoing primary care for coordination of their preventive and episodic health care.
2. Percent of children who are overweight or obese.
3. Percent of newborns screened for hearing loss who receive recommended follow-up services.
4. The unintentional injury hospitalization rate for children 1-14 per 100,000.
5. Percent of low-income children (ages 0-5) with dental caries.
6. The number of dental providers practicing in underserved areas.
7. The proportion of children (0-21) who receive genetic testing.
8. Percent of women reporting substance use during pregnancy.
9. Percent of women with a on-going source of primary care.

State Outcome Measure:
1. The black-white low birth weight ratio among singleton live births.

## B. State Priorities

As part of the 2005 Five-Year Needs Assessment, Virginia developed ten statewide priorities. The following shows the relationship between Virginia's maternal and child health (MCH) priorities and specific measures that are required elements of the annual block grant report: national performance measures (NPM), national outcome measures (OM), state performance measures (SPM), state outcome measures (SOM), health systems capacity indicators (HSCI), and health status indicators (HSI). The priorities are not ranked.

Priority # 1: Exercise leadership in nurturing partnerships that promote systematic communication, coordination, shared resource allocation and education around health improvement efforts.

The key stakeholders identified the need for increased and improved communication, leadership and improved planning, resource development and sharing. The key stakeholders also identified the need to increase collaborative activities to address identified community needs. An overall theme identified in the CAST-5 assessment was the need for a greater leadership role in developing stronger, collaborative intra-agency and interagency systems of care that are focused on and organized around serving similar populations.

One of the most vulnerable populations, CSHCN, remains as a major priority, receiving a large proportion of Title V funds. Improving identification of "at-risk" populations and assuring linkages with prevention, early intervention, and family support services can only be successfully accomplished through the development and nurturing of partnerships that promote systematic

communication, coordination, shared resource allocation and education around health improvement efforts.

NPM # 2, NPM # 5 and NPM # 7

Priority # 2: Enhance data collection and dissemination efforts to promote evidence-based decision making in planning, policy, evaluation, allocation and accountability.

Virginia will make enhancing data collection and dissemination a priority again this year. This year's needs assessment identified gaps in data for measuring health behaviors among pregnant women and adolescents specifically. The Virginia MCH program will continue to look for opportunities to partner with other agencies to collect data on youth risk behavior and will continue to advocate for Virginia's participation in the Youth Risk Behavior Surveillance System. Virginia plans to apply for funding for the Pregnancy Risk Assessment Monitoring System (PRAMS) when it is available. Both individual and organizational respondents to the needs assessment on-line survey indicated that the health department needed to ensure that health programs are working and needed to inform and educate the public and families about health issues and prevention. The key stakeholders expressed a desire for easily accessible data and the need to be informed about what data is available. The CAST-5 assessment identified the need for better data collection.

HSCI # 9a and 9b
Priority # 3: Assess and develop strategies to address underinsurance for vulnerable populations to improve access to affordable, acceptable care.

The key stakeholders indicated that there is a growing number of persons who are experiencing limited access to medical and dental care. The perinatal focus groups indicated that the greatest barrier for women receiving prenatal care was the lack of access to an affordable health care system in a timely manner. The on-line survey found that both individual and organizational representatives ranked the lack of health insurance coverage for children and women as the second major health issue. In 2004, 13 percent of Virginia women did not have health insurance. The percentage of children without health insurance in Virginia varies depending on the data source used, with a range between 7 percent and 14 percent. In addition, there is a growing concern about non-English speaking and immigrant women's and children's access to health related services, particularly linguistically and culturally appropriate services.

Additional efforts addressing this priority include referring patients to Medicaid and FAMIS and assisting CSHCN families in finding insurance (enabling services) and continuing to monitor the insurance status of the vulnerable populations (infrastructure building services). VDH participates in state level coalitions to define and measure underinsurance and consider policies to alleviate the problem.

NPM # 3, NPM # 4, NPM # 13, HSCI # 2, HSCI # 3, HSCI # 4, HSCI # 7A & 7B, SPM # 1, SPM # 2, SPM # 6, SPM # 9

Priority # 4: Evaluate, coordinate and enhance provider education in risk assessment, documentation, intervention, treatment and referral consistent with evidence-based standards of care around health issues specific to women and children.

In 2000-2002, unintentional injuries were the leading cause of deaths for persons aged 1 to 64. Unintentional injuries accounted for 52 percent of all deaths that occurred among persons aged 15 to 19. The majority of these deaths are preventable. In 2003, 57 intimate partner homicides occurred in Virginia. Nearly four of every five victims were women and three of the victims were children under the age of 18. There is also a need for continued efforts to promote healthy behaviors to reduce morbidity and mortality. Concerns relating to injury, violence, and obesity were identified in the needs assessment. The key stakeholders identified the need for expanded

prevention and education services for children relating to health issues, and the need for increased education for the prevention of risky behaviors among adolescents. The on-line survey identified obesity, domestic violence and child abuse and neglect as major health related issues. The public hearings identified the need to improve training of health professionals in screening for and identifying violence and sexual abuse. Potential activities to address this priority include continuing population-based prevention education and provider training on the identification of violence and appropriate documentation and referral.

NPM # 10, NPM # 14, NPM # 16, SPM # 1, SPM # 4, HSI # 3 a- c, HSI # 4 a-c, SPM # 2, SPM # 2, HSI # 8a, 8b

Priority # 5: Advance a holistic continuum of care model for women's health services across the life-span toward improvements in health for women, their children and their families.

Stakeholders in the priority setting meeting discussed the importance of extending the concept of "medical home" to women to ensure that they have an ongoing source of care. Although the Title V focus is on children and women of childbearing age, taking a life-span holistic approach recognizes the importance of overall health and the impact that may have on pregnancy. Activities related to this priority include educating women on the importance of total health, the prevention of chronic diseases for themselves and their children, and educating providers on the importance of using preventive guidelines. Other activities include the promotion of aggressive management of chronic diseases such as diabetes during and after pregnancy, and promoting preconceptual and interconceptual health, especially as it relates to their baby's health once pregnant.

SPM # 9

Priority # 6: Expand availability, quality and utilization of medical homes for children.

Having a medical home has been identified as an important way to ensure that children and especially CSHCN receive the comprehensive care that they need. In the medical home concept a physician provides primary care that is easily accessible, family centered, coordinated, and culturally appropriate. In 2003, 54.5 percent of Virginia CSHCN and 75 percent of children and adolescents received coordinated, ongoing, comprehensive care within a medical home. The key stakeholders and the public hearing participants identified the need for increased access to care and the need for coordinated and culturally-appropriate care. Some activities related to this priority include collaborating with other community agencies and state level groups to expand the availability of medical homes (infrastructure building services) and working with families to ensure that children are referred to a medical home (enabling services).

NPM # 3, SPM # 1

Priority # 7: Improve access to dental care, awareness of oral health, and application of new models in dental health services.

In 2000, the first Surgeon General's report on oral health identified a "silent epidemic" of dental and oral diseases that burdens some population groups. Oral diseases can place a major burden on low-income and underserved individuals in terms of pain, poor self-esteem, cost of treatment, and lost productivity from missed work or school days. Dental disease and access to dental care is a chronic problem among low-income populations in Virginia. In the public hearings, the need to increase access to dental services for women and children was identified. The lack of access to dental care was also a finding from the key stakeholder interviews and was identified as the most needed but not received service for children by respondents to the on-line survey. The Division of Dental Health's approach to this includes infrastructure building services such as oral health surveillance and recruitment of public health dentists. The Division also maintains a quality assurance program for public health dentists. Population-based services include dental

education, community water fluoridation, and the fluoride mouth rinse program. A number of local health departments provide clinical dental services.

NPM # 9 and SPM # 5, SPM # 6, HSCI # 7B

Priority # 8: Incorporate mental health into relevant preventive health efforts in MCH; participate in efforts to promote availability and quality of mental health services and facilitate links between the mental health and health care communities.

The public hearing participants identified the need for greater access to mental health services for women and children. The key stakeholders indicated that mental health and substance abuse services are in short supply, especially for low-income women and children. The perinatal focus groups identified women with mental health or substance abuse problems as one of the sub-populations not receiving appropriate prenatal care. Both the individual and organizational respondents to the on-line survey identified behavioral health issues as the third highest health issue for children, and depression and mental illness as the third highest issue for women. Some of the proposed approaches to address this issue included raising public awareness of the impact of mental health on overall health and the importance of viewing mental health from a public health perspective. Other approachs include partnering with mental health and strengthening our Title V programs in addressing mental health related issues such as perinatal depression, suicide, and eating disorders.

SPM # 8 and NPM # 15, NPM # 16

Priority # 9: Improve access to prenatal care including appropriate genetic assessment and breastfeeding support for all women across the state.

Overall, 85 percent of women begin prenatal care during the first trimester, however the rate varies by race and ethnicity. For example, in 2003, 71.1 percent of Hispanic women and 77.2 percent of Black women began prenatal care in the first trimester. Like many other states, Virginia is experiencing what many people have referred to as a crisis in access to obstetrical care. The effects have been felt most in rural areas. Several small community hospitals no longer provide obstetrical care and some obstetricians have stopped providing coverage for family practice physicians who have been delivering babies or have stopped providing supervision of certified nurse midwives. This has resulted in women having to travel further to the hospital or delivering their babies in emergency rooms. The key stakeholders identified access to obstetrical and other perinatal services as scarce for the generally low-income population and for rural and minority residents. The perinatal focus groups indicated that the availability of prenatal care varies from locality to locality and differs widely by demographic group and access to a payment source. The on-line survey respondents identified the lack of prenatal care as being one of the top five health issues for women. Some of the efforts will focus on educating targeted populations on the importance of prenatal care (population based services) and using lay home visitors and outreach activities to increase prenatal care (enabling services). Several National Performance Measures will be used to monitor progress in this priority area

NPM # 11, 15, 17, 18, OM # 1 -- 5, SOM # 1, HSI # 1a, 1b, 2a, 2b, 7a, 7b, SPM # 7, 8, 9, HSCI # 4

Priority # 10: Apply socio-ecologic models to promote healthy weight by encouraging appropriate nutrition and safe physical activity efforts.

Respondents to the on-line survey conducted as a part of the Title V Needs Assessment identified obesity/overweight as the top health issue for both children and women. Over the past decade, overweight/obesity has significantly increased in children living within the Commonwealth of Virginia. According to the National Survey of Children's Health in 2003, almost one-fourth (24 percent) of Virginia's children are overweight and 15 percent are at risk for being overweight.

Lack of regular physical activity, accessibility to calorie dense foods, larger portion sizes, family lifestyles and lack of interest in health and media messages contribute to the childhood overweight dilemma. In addition, many children live in areas that are not conducive to safe physical activity. This approach to the overweight issue includes population-based services such as public awareness and education and coordinating school and community based physical activity programs as well as an infrastructure level approach to monitor obesity data and policy development.

SPM # 2, NPM # 14

The state priorities for the 2007 Title V Block Grant Application will remain the same.

## 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** | **2001** | **2002** | **2003** | **2004** | **2005** |
|---|---|---|---|---|---|
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |
| Annual Indicator | 100.0 | 100.0 | 100.0 | 100.0 | 100 |
| Numerator | 87 | 103 | 111 | 99 | |
| Denominator | 87 | 103 | 111 | 99 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2006** | **2007** | **2008** | **2009** | **2010** |
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |

**Notes - 2005**
2005 data not yet available.

**Notes - 2003**
Appropriate follow-up = linked to appropriate specialist
Evidence = info from PCP or specialist, oral or written

**a. Last Year's Accomplishments**
During FY 05, the Virginia Newborn Screening Services (VNSS) Program screened all newborns born in the state for nine inborn errors of body chemistry: (1) phenylketonuria (PKU), (2) maple syrup urine disease, (3) homocystinuria, (4) biotinidase deficiency, (5) galactosemia, (6) congenital hypothyroidism, (7) congenital adrenal hyperplasia, (8) Medium Chain Acyl-CoA Dehydrogenase Deficiency (MCAD) and (9) hemoglobinopathies. VNSS followed up on over 15,000 abnormal results and assured that confirmed cases were appropriately referred for treatment (see Form 6 for data). In response to the state Joint Commission on Health Care's recommendation regarding expansion of the current panel of newborn screening conditions, the 2005 Virginia General Assembly mandated expansion to 28 disorders. The law directs screening to be consistent with the HRSA commissioned report from the American College of Medical Genetics. VDH secured a budget appropriation from Division of Consolidated Laboratories Services (DCLS) Enterprise funds (newborn screening kits revenue) to support program activities. To prepare for the March 2006 expansion, a workplan was developed to address provider education and training, parent education, promulgation of regulations governing VNSS, confirmatory testing, and provision of treatment services and assistance. In August 2005 vested parties across the state gathered to receive education, identify issues and form workgroups. Provider education and training materials, including fact sheets on expanded panel disorders and a revised healthcare practitioners' manual were developed. A revised brochure on screening, and fact sheets on new disorders were developed for parents. Other workgroups were formed to

address confirmatory testing needs, benefits available to diagnosed persons for metabolic formula, supplements, and low protein modified foods, and facilitating referrals to the state CSHCN program for care coordination and financial assistance services. Two new nursing positions were established to implement and operate the expanded panel.

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

**Table 4a, National Performance Measures Summary Sheet**

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

**b. Current Activities**

VNSS continues to (1) screen all infants for inborn errors of body chemistry and track and follow up all abnormal results; (2) administer the provision of special food products, including formulas, for the treatment of individuals with inborn errors of metabolism; and (3) maintain contracts for three metabolic treatment centers.

In anticipation of expansion, a DCAH team visited Florida Department of Health for technical assistance sponsored by MCHB. Emergency regulations were finalized and promulgated. Regional training for providers was given along with web-based seminars. In addition, other public relations activities included newsletter publications and press releases to educate providers and the public regarding expansion. Efforts to better integrate VNSS with the CSHCN

program continued. Procedures to assure all diagnosed individuals will be automatically referred to the Care Connection for Children Network for care coordination have been implemented. A workgroup developed plans to outline and modify assistance given for special foods. Children under age 21 who meet financial and other criteria may receive formula at no cost as well as access to funding for other medical needs covered under the CSHCN Pool of Funds. Adults meeting these same criteria may also receive the same formula benefit. Those not meeting the criteria who have no insurance coverage may purchase formula at cost through VDH. A reimbursement benefit for low protein modified foods and metabolic supplements was revamped for those meeting certain financial and other eligibility criteria. The reimbursement program is through a general fund state budget line item. In prior years, treatment assistance was mandated in Code and not means tested. Treatment assistance is now covered under the VNSS regulations to allow more program flexibility. Representatives from OFHS met with Northern Virginia providers to continue addressing service needs in that region. The two new nursing positions were filled and training was provided to ready for expansion.

Effective March 1, 2006, VNSS expanded screening to 28 conditions in accordance with emergency regulations promulgated. Educational materials for parents and providers continue to be disseminated through the web. The revised newborn screening brochure for parents is being distributed by the Division of Consolidated Laboratories with the filter paper kits to hospitals and providers. In addition, abbreviated newborn screening information will be added to the Governor's New Parent Kit provided to all new parents in the state. All parent materials have been or are in the process of being translated into Spanish.

**c. Plan for the Coming Year**

In FY 07, VNSS will continue to (1) ensure screening of all infants for this panel of inborn errors of body chemistry; (2) track and follow up on all abnormal results and assure that confirmed cases are referred into treatment in a timely manner; and (3) provide necessary education and technical assistance to providers. Newborn screening staff will continue to refer newly diagnosed children to the CCC network for care coordination. A team will continue to meet to evaluate needs related to newborn screening expansion. Efforts to better address needs in Northern Virginia will continue.

In addition, VNSS will continue to provide formula distribution, formula purchase, and reimbursement for low protein modified foods and supplements under a new model. Current clients will be evaluated and transitioned to care coordination services (if under age 21) and to be screened for applicable assistance programs.

Plans are in place to publish a comprehensive newborn screening data report, from 1966 through 2004. This report will be the first of its kind in sixteen years. Due to the increase in staff, this activity is now feasible. This will provide a complete report of diagnosed cases from program inception to expanded panel implementation. The goal is to produce a similar report biennially in the future. Additional educational resources will be developed to further newborn screening healthcare provider's knowledge and skills related to the panel of disorders and programmatic activities specific to newborn screening. The plan is to develop newborn screening training modules that will be accessible via the web. These specific modules will be developed in collaboration with a vendor to be determined.

**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 | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 60 | 60 | 60 |
| Annual Indicator | | 58.3 | 58.3 | 58.3 | 58.3 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2006** | **2007** | **2008** | **2009** | **2010** |
| Annual Performance Objective | 60 | 60 | 65 | 65 | 65 |

**Notes - 2005**
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

**Notes - 2004**
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

**Notes - 2003**
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

**a. Last Year's Accomplishments**
Each clinic in the Child Development Clinic network (CDC) surveyed parents to determine their level of satisfaction with care received. Response rates for the eleven CDCs ranged from 14 to 83 percent, with a statewide rate of 26%. Findings show an overall satisfaction rate of 95%.

Family Satisfaction Surveys were mailed to clients in Central Virginia Care Connection for Children (CCC) with a 36% response rate. The majority of the comments were very positive. 43% of the persons commenting specifically mentioned the helpfulness of their child's CCC care coordinator. Other CCC centers and Virginia Bleeding Disorders Program (VBDP) conducted less formal surveys with very positive comments from the families.

Family representatives continued to serve on the Virginia Early Hearing Detection and Intervention Program Advisory Board, the Hemophilia (Bleeding Disorders) Advisory Board, and the Virginia Genetics Advisory Committee. Three Care Connection for Children centers maintained family resource libraries. All centers maintained a close working relationship with Virginia coordinators for Family Voices and Parent--to-Parent. The coordinators and parents within these groups provided consultation and training to CCC centers' staff and clients. VBDP continues to host routine meetings of consumer advisory boards for three of the four Hemophilia Treatment Centers. One CDC developed an advisory group with participation of parents, a local pediatrician, school personnel, mental health workers, and social services workers.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Include family members and youth with special needs as members of committees and advisory boards of the CSHCN program. | | | | X |
| 2. Provide family-to-family support as a basic service of Care Connection for Children (CCC) centers. | | X | | |
| 3. Work with Va-INFO and other family organizations to enhance the ability of families to partner in decision-making. | | | | X |
| 4. Administer parent satisfaction surveys at CCC centers, Child Development Clinics (CDC), and the Virginia Bleeding Disorders | | | | X |

| | | | | |
|---|---|---|---|---|
| Program (VBDP). | | | | |
| 5. Monitor activities and outcomes; adjust CSHCN state plan for meeting HP 2010 goals as needed. | | | | X |
| 6. Review and make recommendations regarding proposed legislation or policies addressing CSHCN. | | | | X |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

The CDCs and VBDP continue to administer parent satisfaction surveys. VBDP continues to host routine meetings of consumer advisory boards for three of the four Hemophilia Treatment Centers.

In February 2006, a standardized Family Satisfaction Survey was conducted of clients receiving CCC services statewide. Approximately 2,400 surveys were mailed to active clients, using both an English and Spanish version. Response rates for the six CCCs ranged from 23 to 40 percent, with a statewide rate of 33%. Findings show an overall satisfaction rate of 92%. Of the remaining respondents, 5% reported that they are "not very satisfied" or "not at all satisfied" and 3% did not answer this question. Responses to questions regarding partnership with families were very positive. For example, high levels of agreement were found with the statements, "Staff from the Care Connection Center listen to what I have to say", "…are flexible in working around my schedule," and "…respect my culture and values."

Families continue to serve on advisory boards of the CSHCN Program and participate in CCC activities. All centers are increasing their efforts in their provision of family-to-family support services.

In FY 06 Family Voices of Virginia and Parent to Parent of Virginia were awarded a federal grant to create the Virginia Integrated Network of Family Organizations (VA-INFO) Center. This coalition of family organizations and local and state partners collaborates and educates on behalf of children and young adults with special needs and their families, and assists them to obtain timely access to information, resources, supports and services.

During FY 06, Advisory Committees were formed at the CCCs to increase family and community involvement in addressing issues relevant to the needs of the special needs population. The CSHCN program hosted a 2-day "Community Partners for Children and Youth Summit," to educate participants regarding Healthy People (HP) 2010 goals and seek broad stakeholder input into strategies for system improvement to meet 2010 outcomes for CSHCN and their families. Each of the CCC Advisory Committees sent six representatives to this Summit, including at least one parent and/or special needs youth/young adult.

To educate Summit participants and aid with coalition building, draft background briefs were developed for the "Community Partners" Summit, focusing on each of the six 2010 outcome areas for Children and Youth with Special Health Care Needs (CYSHCN). A draft background brief on Family Involvement in Decision-Making and Satisfaction with Services was written and presented to Summit participants for their input.

**c. Plan for the Coming Year**

Families will continue to serve on advisory boards of the CSHCN Program and participate as members of CCC teams. All six CCC centers will have viable family-to-family support services. CDCs, CCC centers and VBDP will survey families to determine their satisfaction with the services and make necessary changes to best meet identified needs. VBDP will continue to host

routine meetings of consumer advisory boards for three of the four Hemophilia Treatment Centers.

The background brief on Family Involvement will be finalized by a workgroup from the Summit and shared widely as a platform for action, individually in CSHCN staff's work with children, youth and their families and collectively in interagency councils and public/private coalitions. VDH will continue to partner with Va-INFO and other family organizations.

**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 | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 60 | 60 | 60 |
| Annual Indicator | | 54.5 | 54.5 | 54.5 | 54.5 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2006** | **2007** | **2008** | **2009** | **2010** |
| Annual Performance Objective | 60 | 60 | 60 | 60 | 60 |

**Notes - 2005**
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

**Notes - 2004**
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

**Notes - 2003**
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

**a. Last Year's Accomplishments**
In FY 05, 97 percent of Child Development Clinic network, 100 percent of Care Connection for Children network, and 90 percent of the Bleeding Disorder Program clients had a primary care provider.

All children seen for CDCs and CCC services were screened to determine if they had a primary care provider and if not, were informed of choices to obtain one. CDCs had the target to improve communications with the medical home by sending the clinic's final report to the medical home within fourteen days of the completion of the CDC team evaluation. The results ranged from 0 to 100 percent of the reports were mailed within fourteen days with a CDC network average of 57% and 76% within 30 days.

Sparked by participation in the national Medical Home Learning Collaborative, VDH implemented plans to spread the Medical Home concept across the state. Pivotal to these plans is a strong partnership forged with the Virginia Chapter of the American Academy of Pediatrics and Medical Home Plus to assist with this activity. Medical Home Plus (MHP) is a private, non-profit organization that provides services and support to parents of special needs children and technical assistance and training to primary care practices in the Medical Home model.

VDH contracted with MHP to spread Medical Home implementation across Virginia, beginning

with a Forum in FY 05, with follow-up technical assistance provided to participating primary care physician (PCP) practices in FY 06. In April 2005, a Medical Home Forum was held for CCC staff and interested PCP "teams." Based upon the national Medical Home Learning Collaborative model, each PCP team consists of a physician, a practice staff who performs care coordination duties, and a parent of a special needs child served by the practice.

A unique aspect of this event was a pre-Forum site visit to each of the practices registered for the Forum. The primary purpose of these visits was to inform as many practice staff as possible about the objectives of the Medical Home initiative and thereby, create more widespread momentum for change within the practice. It also provided an opportunity to address questions regarding expectations of the practice should they choose to continue their involvement in post-Forum technical assistance activities. Pre-forum site visits were well attended and highly successful in engaging a larger number of practice staff beyond the "team" that represented the PCP at the Forum. The visits also provided an excellent opportunity for educating practice staff about Title V services. Since the CCC Program Director for the region also participated in these visits, a relationship between the PCP and CCC was initiated. Thirteen PCP "teams" from three CCC regions chose to participate in follow-up technical assistance activities.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Collaborate with other community agencies to expand the availability of medical homes for CSHCN. | | | | X |
| 2. CCCs, CDCs, and the Bleeding Disorders Program work with families to ensure that children served are referred to a medical home. | | X | | |
| 3. Partner with state AAP, Medical Home Plus, and other organizations to provide training and technical assistance to primary care practices on the medical home concept. | | | | X |
| 4. Monitor activities and outcomes; adjust CSHCN state plan as needed. | | | | X |
| 5. Review and make recommendations regarding proposed legislation or policies addressing CSHCN. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

Through a contractual arrangement, Medical Home Plus continues to provide consultation and technical assistance to participating PCPs. Each of the 13 pediatric practices will receive a minimum of three onsite visits from a Medical Home consultant team to assist the practice team with needs assessment and development of plans to address practice needs, using tools and materials developed nationally such as the Medical Home Index. In addition, assistance is being provided through phone consultation, teleconferences, and shared resources through use of a shared electronic workspace (i.e., shared point portal). CCC Program Directors are active participants as members of the Medical Home consultant team. At the end of FY 06, evaluative data will be gathered to assess the impact of this initiative.

VDH is partnering with the Department of Medical Assistance Services (DMAS) to increase understanding of EPSDT services and improve communication with providers regarding Medicaid program and policy changes. The process includes conducting focus groups for both physicians

and case managers to assess barriers to serving the Medicaid child population, and the usefulness of DMAS training materials and other communication methods. DMAS also provided statewide training to medical providers to maximize reimbursement under EPSDT and is developing a series of Guidance Documents for providers to assist with the appropriate use of EPSDT services.

The CSHCN Program will continue to implement the plan for Virginia to meet HP 2010 outcomes for CSHCN and their families. The plan includes the use of the medical home concept as a measure of quality care. Specific activities have been designated and included in the VDH contractual arrangements with CCC centers and CDCs including the screening of all clients to determine if they have a primary care physician and if not, be informed of choices to obtain one.

As previously mentioned, draft background briefs were developed for the VDH-sponsored "Community Partners for Children and Youth Summit" to aid with state planning and coalition building. A draft background brief for Medical Home was written and presented to Summit participants for their input.

**c. Plan for the Coming Year**

The CSHCN Program will continue to implement the plan for Virginia to meet HP 2010 outcomes for CSHCN and their families. Work will continue to broaden stakeholder input into the Medical Home background brief and promote widespread adoption of the brief, for use in systems planning, advocacy and change. VDH will continue to partner with the state AAP, Medical Home Plus and other organizations to seek additional funding for continued spread of the medical home concept.

The Division of Child and Adolescent Health will continue participation in the New York Mid Atlantic Consortium for Genetic and Newborn Screening Services (NYMAC) to promote medical homes and a system of care for CSHCN identified through newborn screening. Efforts will continue to identify and proote helpful tools that primary and specialty care providers can use to better communicate with each other, and include the family as an active partner.

CCC centers, CDCs, and VBDP will continue to monitor the status and refer 100 percent of their clients without a medical home to resources.

**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** | **2001** | **2002** | **2003** | **2004** | **2005** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 67 | 68 | 70 |
| Annual Indicator | | 65.6 | 65.6 | 65.6 | 65.6 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2006** | **2007** | **2008** | **2009** | **2010** |
| Annual Performance Objective | 70 | 70 | 75 | 75 | 75 |

**Notes - 2005**

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

**Notes - 2004**
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

**Notes - 2003**
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

**a. Last Year's Accomplishments**
The CDCs and VBDP prepared their annual plans based on the HP 2010 outcomes for CSHCN and are contractually required to refer all eligible children without insurance to either Medicaid or FAMIS (SCHIP), and SSI and to follow-up with families to assure that the application is processed.

A major component of the CCC program is the provision of insurance case management to assist families to obtain, understand, and use health insurance. CCC staff participated in community groups to promote enrollment of uninsured children in public programs. CCC centers continued to refer all potentially eligible children to Medicaid, FAMIS, and SSI programs and follow-up with families to assure that the application is processed.

In FY 05, 97.4 percent of Child Development Clinic network, 92.5 percent of Care Connection for Children network, and 92 percent of the Bleeding Disorder Program clients had health insurance coverage. 10.1 percent of clients under age 16 years in all three programs also had SSI.

In FY 05, 338 clients (CCC:317 and VBDP:21) received financial assistance from the CSHCN Pool of Funds (POF). This Pool provides money to assist uninsured and underinsured clients. Covered services include durable medical equipment (DME), medications, diagnostic testing, therapies, hospitalizations, and dental orthodontic and prosthodontic appliances (for those with maxillofacial conditions). The POF was evaluated to identify areas of underinsurance and services not covered. Medications and durable medical equipment continue to be the most requested POF services.

The CSHCN Program continued work with DMAS to remove obstacles causing underinsurance of CSHCN on Medicaid and FAMIS such as making a seamless transition for special metabolic formula clients from the state system to community pharmacies. Updated manuals and videoconference training by DMAS was provided for CCC centers and CDCs.

The CSHCN Program collaborated with the Virginia Leadership Excellence in Neurodevelopmental Disabilities program to examine the issue of underinsurance using the CSHCN-SLAITS data. This analysis provided feedback on areas of incomplete coverage for CSHCN. An article entitled "Defining Underinsurance Among Children with Special Health Care Needs: A Virginia Sample" was published in the Maternal and Child Health Journal in June 2005.

The MCHIP CSHCN Health Insurance and Financing Grant worked to improve access to insurance benefits and services for CSHCN. Collaborating with the Virginia Chapter of the American Academy of Pediatrics and Medical Home Plus, the medical home concept was promoted among primary care providers. The Care Coordination Notebook was revised to include more resources. It serves as a training tool for the parent trainers and a "working" guidebook to maintain child's health care records.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Refer 100% of eligible children in the CCCs, CDCs, and the Bleeding Disorders Program to Medicaid, FAMIS, and SSI. | | X | | |
| 2. Provide health insurance case management as a basic service of the CCC centers and the Bleeding Disorders Program. | | X | | |
| 3. Continue the MCHIP/CSHCN Health Insurance and Financing Grant to improve access. | | | | X |
| 4. Monitor activities and outcomes; adjust the CSHCN state plan as needed. | | | | X |
| 5. Work with other agencies to identify issues and remove obstacles that cause underinsurance. | | | | X |
| 6. Provide financial assistance from the CSHCN Pool of Funds for the uninsured and underinsured clients of CCC and VBDP. | | X | | |
| 7. Review and make recommendations regarding proposed legislation or policies addressing CSHCN. | | | | X |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

CDCs, CCC centers, and VBDP continue to refer all potentially eligible children to Medicaid, FAMIS, and SSI programs and follow-up with families to assure that the application is processed. They also continue to provide annual plans based on the HP 2010 outcomes for CSHCN. Clients continue to receive financial assistance from the CSHCN Pool of Funds.

As mentioned in prior sections, draft background briefs on 2010 outcomes were developed for the March 2006 "Community Partners for Children and Youth Summit." A draft brief on Health Care Financing was developed and presented at the Summit.

The CSHCN Pool of Funds (POF) continues to be evaluated to identify areas of underinsurance and services/fees not covered by these funds. Guidelines for the POF have been modified to address some areas of underinsurance. Additional information from the CSHCN- SLAITS is being used as appropriate for this evaluation. The CSHCN Program continues to work with DMAS to identify issues and remove obstacles that cause underinsurance of CSHCN receiving Medicaid and FAMIS. Staff in CCC centers, VBDP, and CDCs continue to attend training providing updates on Medicaid, FAMIS Plus, and FAMIS policies and procedures.

The MCHIP CSHCN Health Insurance and Financing Grant continues to conduct project activities to improve access to comprehensive insurance benefits and services for CSHCN. Parent to Parent of Virginia has provided family education sessions in the third CCC pilot region to increase parents' knowledge of insurance programs, issues, and consumers' rights to appeal denial of benefits and services. The CSHCN Program has partnered with DMAS to increase knowledge of employers regarding public insurance programs, including FAMIS and the new FAMIS Select premium assistance program. Through a subcontract with the training organization SignUpNow, a series of eight workshops are being held across the state for human resources personnel from major employers in Virginia. The grant is also supporting a marketing campaign targeted to Spanish-speaking families by financing the development of and airtime for a Spanish radio advertisement for public insurance through FAMIS.

Grant activities also include collaborating with the MCHB Health Insurance grantee from Wisconsin to provide training to CCC staff, parent partners, and others on health benefits counseling. The goal of this training is to improve participants' skills related to the utilization of existing insurance resources to the maximum extent possible.

CSHCN staff participated with other MCHIP Health Insurance and Financing grantees to examine the issue of underinsurance. Parent outreach staff conducted outreach activities in the Hampton Roads CCC pilot region .

**c. Plan for the Coming Year**
CDCs, CCC centers, and VBDP will continue to refer all potentially eligible children to Medicaid, FAMIS, and SSI programs and follow-up with families to assure that the application is processed. They will continue to provide annual plans based on the HP 2010 outcomes for CSHCN.

The background brief on Health Care Financing will be more widely shared among stakeholder groups to foster shared strategies for improving financing of services and supports for the target population. Future Pool of Funds evaluation activities include assessing predictors regarding lifetime costs and cost-savings analyses.

A Spanish version of the Care Coordination Notebook will be developed and distributed. The final report on the MCHIP CSHCN Health Insurance and Financing Grant will be written, and products from the grant shared nationally.

Clients will continue to receive financial assistance from the CSHCN Pool of Funds and the funds will continue to be evaluated to identify areas of underinsurance and services/fees not covered by these funds. Work with DMAS will continue to identify issues and remove obstacles that cause underinsurance of CSHCN receiving Medicaid and FAMIS. Updated manuals and videoconference training by DMAS will be provided for CCC centers and CDCs.

**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 | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 82 | 82 | 83 |
| Annual Indicator | | 80.1 | 80.1 | 80.1 | 80.1 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2006** | **2007** | **2008** | **2009** | **2010** |
| Annual Performance Objective | 85 | 85 | 88 | 88 | 88 |

**Notes - 2005**
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

**Notes - 2004**
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

**Notes - 2003**
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

**a. Last Year's Accomplishments**

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

The network of eleven CDCs provided interdisciplinary evaluations of children suspected of having developmental disorders or emotional, behavioral, or psychosomatic problems. CDCs offered trainings/technical assistance to providers in the community; served as training sites for social work, nursing, or psychology students; provided services to foster care children; and offered field clinics or other specialty clinics to strengthen the community-based service system.

The VBDP supported a statewide network of comprehensive care centers for clients of all ages with inherited bleeding disorders and their families.

In FY 05, the CCC network served 4,160 clients. The VBDP served 243 clients (153 persons ages 0-21 90 persons 21 years and older). The CDC network provided multidisciplinary diagnostic evaluations, interpretative reports, and care coordination to 1,707 new clients. An additional 669 clients (new and follow-up) received initial assessments, consultation, treatment, and other follow-up services.

VBDP conducted a study of adults with hemophilia to identify the systems of care for adults currently being seen in the Commonwealth's comprehensive hemophilia treatment centers (HTCs) with the goal of outreach to this unserved or underserved population group. Findings include 1) 90 of the approximate 190 adults with hemophilia are served through the VBDP, 2) 165 of the 190 are receiving comprehensive care with 30% of them seen in HTCs outside of Virginia, 3) the top three barriers to providers making referrals to HTCs were providers believe they can provide adequate care in their local practices, clients prefer to have their care delivered locally, and clients can not get to HTCs due to transportation concerns. The Hemophilia Advisory Board considered the findings of the study of adults and endorsed the implementation of the study's recommendations.

In June 2005 the staff from all CDCs received training on clinical topics. In October 2004, coordinators from all CCC centers received training on transitioning of YSHCN to adult care. During FY 05, 6 CCC staff maintained their case management certification and four additional staff became Certified Case Managers. This brought the total to 10 certified care coordinators (31% of the staff).

During FY 05 VDH received an incentive award from the Champions for Progress Center at Utah State University for the project entitled "Building the Bridges for Partnerships". The objectives are for each CCC to establish and support a regional Advisory Committee for their center.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Provide leadership in planning, developing, and implementing efforts to improve services to CSHCN. | | | | X |
| 2. Provide care coordination for CSHCN from birth through twenty years of age in CCC and persons of all ages in VBDP. | | X | | |
| 3. Provide a system of services for people with bleeding disorders through the Bleeding Disorders Program. | X | | | |
| 4. Provide diagnostic and evaluation services for children from birth through twenty years of age through the Child Development Clinics. | X | | | |
| 5. Partner with others to coordinate care for children with behavioral programs through the Child Development Clinic | | X | | |

| | | | | |
|---|---|---|---|---|
| network. | | | | |
| 6. Monitor activities and outcomes; adjust the CSHCN state plan as needed. | | | | X |
| 7. Participate in statewide committees and interagency councils for CSHCN issues. | | | | X |
| 8. Provide training and technical assistance. | | | | X |
| 9. Establish a steering committee to foster the development of an alliance in Virginia committed to identification and promotion of strategies to achieve the HP 2010 outcomes. | | | | X |
| 10. Review and make recommendations regarding proposed legislation or policies addressing CSHCN. | | | | X |

**b. Current Activities**

In July 2005 training was conducted for all members of the CCC Inter-Center Work Group (CCC medical and program directors) to assist them in enhancing partnerships and developing advisory committees. By January 2006 all six CCCs had established their center's committee and held at least one committee meeting. In March 2006 VDH hosted the "Community Partners for Children and Youth Summit," to educate participants regarding HP 2010 goals and seek broad stakeholder input into strategies for system improvement to meet 2010 outcomes. Each of the CCC Advisory Committees sent six representatives to this Summit, including at least one parent and/or special needs youth/young adult. To educate Summit participants and aid with coalition building, draft background briefs were developed for the "Community Partners" Summit, focusing on each of the six 2010 outcome areas. They were presented to Summit participants for their input. One brief was entitled "Services for CYSHCN and their Families will be Organized in Ways that Families Can Use Them Easily".

CDCs continue to strengthen relationships with other community providers to coordinate services, reduce duplication of services, determine unmet needs, and assure that the children with the greatest need are served. Clinics continue to provide annual plans based on the HP 2010 outcomes for CSHCN.

The CCC centers continue in their mission to develop family-centered, culturally competent, and community-based systems of referral and care and to simplify access to these systems for families.

VBDP continues to provide leadership for the Hemophilia Advisory Board and the development of strategies to implement recommendations from the study of adult hemophiliacs. Several family outreach activities and health care professional trainings are planned.

**c. Plan for the Coming Year**

CDCs will continue to strengthen relationships with other community providers to coordinate services, reduce duplication of services, determine unmet needs, and assure that the children with the greatest need are served.

The CCC centers will continue in their mission to develop family-centered, culturally competent, and community-based systems of referral and care and to simplify access to these systems for families.

VBDP will continue to implement strategies from the study of adult hemophiliacs. Seminars planned include home infusion and coagulation update. Collaboration will continue with the Virginia Chapter of the National Hemophilia Foundation to facilitate training and networking events for clients. Consumer advisory boards will continue to be hosted.

The background brief on Services Organized in Ways that Families Can Use them Easily will be

more widely shared among stakeholder groups to foster shared strategies for improving financing of services and supports for the target population. A steering committee will be established to foster the development of an alliance in Virginia committed to identification and promotion of strategies to achieve the national outcomes.

**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** | **2001** | **2002** | **2003** | **2004** | **2005** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 5.8 | 5.8 | 6 |
| Annual Indicator | | 5.8 | 5.8 | 5.8 | 5.8 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2006** | **2007** | **2008** | **2009** | **2010** |
| Annual Performance Objective | 7 | 8 | 10 | 10 | 10 |

**Notes - 2005**
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

**Notes - 2004**
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

**Notes - 2003**
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

**a. Last Year's Accomplishments**
Virginia's plan to meet HP 2010 outcomes for CSHCN includes numerous activities to facilitate the development of a transition system for CSHCN; assure that youth with SHCN participate as decision-makers and as partners; have access to health insurance coverage; and have a medical home that is responsive to their needs. Specific activities have been included in their contractual arrangements with VDH. These include identification of all open cases of children age 14 years and above to prioritize the group for transition of health care, education, social, and employment needs. CCC and Bleeding Disorder Program are identifying "adolescent friendly" specialists to assist with the transitions.

CDCs focus on serving younger children (under age 10) to identify developmental, behavioral, and emotional problems as early as possible. Given a younger age group commonly served and the timeframe a child may be receiving services, the CDC role in providing transition services is limited. CDCs did work with their local school systems to identify the unmet needs of middle school students in special education to aid in their transition to high school. Adolescents were invited to participate in the interpretative interview of their evaluation findings and recommendations either with their parents or by having their own separate individual Interpretative Interview. Recommendations related to transition to adult life were included.

Training for the CCC care coordinators on transitioning clients from the pediatric to the adult health care system was conducted in the fall 2004. National experts and community-based providers presented at the training. The CSHCN Program developed standards of practice for CCC care coordinators in the provision of transition services. A Transition Tool Kit was

developed and one was provided to each CCC coordinator. The kit includes Transition Worksheets organized by aspects of transition to be used during encounters with the client and family. The worksheets help to identify the client's strengths and challenges during the transition process. It serves as a measure of progress toward transition over time. The worksheets are divided in five age groups between ages 14 and 21 years aiming toward a minimum of five transition encounters between the client, family, and care coordinator. The kit included a sample emergency information form for families to complete and provide to caregivers, emergency rooms, day care providers, etc. A transition resource library was developed for each CCC with documents related to the health, education, employment, transportation, recreation, legal, financial, health insurance, and housing aspects of transition.

The Bleeding Disorders Program enhanced its transition services to older children by using the CCC transition standards. It has developed educational packets for clients transitioning to adult care. It also piloted a transition checklist developed by the National Hemophilia Foundation.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Provide transition of services from pediatric to adult health care services in the CCCs, CDCs, and the Bleeding Disorders Program. | | X | | |
| 2. Monitor activities and outcomes; adjust the CSHCN state plan as needed. | | | | X |
| 3. Review and make recommendations regarding proposed legislation or policies addressing CSHCN. | | | | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

As previously mentioned, draft background briefs were developed for the VDH-sponsored "Community Partners for Children and Youth Summit" to aid with state planning and coalition building. A background brief for Adolescent Transition was written and presented to Summit participants for their input.

CDCs, CCC centers, and Bleeding Disorder Program continue to assist older children in the transition to adult care. Targeted activities in the plan for meeting this Healthy People 2010 goal include:

a) Investigate external funding sources to support the expansion of transitioning activities.

b) Facilitate interagency collaboration with the Department of Education, the Department of Rehabilitative Services, and the Department of Mental Health, Mental Retardation, and Substance Abuse Services to share resources and skills.

c) Collaborate with DMAS in their development of the Medicaid Buy-In Program for adults with disabilities.

CSHCN Program partnered with the Department of Education and Department of Rehabilitative Services in the planning and implementation of the state's 2006 Transition Forum.

VBDP participated in the development of a hemophilia comprehensive care clinic for adults at University of Virginia Medical Center. Previously, UVA has only had a pediatric clinic.

**c. Plan for the Coming Year**
The background brief on Adolescent Transition will be more widely shared among stakeholder groups to foster shared strategies for improving financing of services and supports for the target population.

CDCs, CCC centers, and VBDP will continue to assist older children in the transition to adult care.

The Division of Child and Adolescent Health participates with the New York Mid Atlantic Consortium for Genetic and Newborn Screening Services (NYMAC). This work group focusing on medical home will be participating with two other regional consortia on piloting transition initiatives. Virgina will take advantage of any opportunities that may come from this effort.

**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** | **2001** | **2002** | **2003** | **2004** | **2005** |
|---|---|---|---|---|---|
| Annual Performance Objective | 75 | 77 | 79 | 82 | 85 |
| Annual Indicator | 74.9 | 72 | 84 | 81 | 83 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2006** | **2007** | **2008** | **2009** | **2010** |
| Annual Performance Objective | 85 | 86 | 86 | 86 | 86 |

**Notes - 2005**
2005 data not yet available. Entry is an estimate based on trend.

**Notes - 2004**
National Immunization Program Data Calendar Year 2004 from CDC website.

**Notes - 2003**
National Immunization Program Data Calendar Year 2002 from CDC website

**a. Last Year's Accomplishments**
In FY 05, Title V supported activities related to increasing immunization rates focused on the provision of child care health consulting activities, including assessment. The Title V Early Childhood Project director, along with the lead state child care health consultant, oversaw Healthy Child Care Virginia (HCCV) training and technical support activities for public health nurses and other professionals serving as child care health consultants. Key consulting activities are to provide CASA immunization audits and help child care centers institute system changes to support all attendees reaching and maintaining up-to-date immunizations. The director provided consultation to the Department of Social Services to work with child care providers in developing their knowledge and ability to assure complete immunizations among child care attendees. A part-time contracted coordinator provided ongoing consultation and technical assistance to the

field. Eight health districts used Title V funds to support activities related to increasing immunization rates through assessment and child care health consultant activities.

Title V supported several state and local efforts to provide parents and caregivers with information about immunizations. The Governor's New Parent Kit initiated in 2004 was distributed throughout the state. The Kit contains a broad array of information related to infant and child care. In FY 05, 71,000 English and Spanish Kits were distributed reaching approximately eight out of ten new parents. VDH Resource Mothers, along with partners CHIP of Virginia and Healthy Families, led distribution efforts. The kit contains the Bright Futures Health Record and a customized Baby's First Year calendar highlighting immunizations needed for each month including stickers to put on dates received and the toll-free VDH Division of Immunization information line.

Title V funds support case management activities that help increase immunizations. Resource Mothers, a lay support program available in 87 communities, continued to assist teen parents in getting their infants properly immunized. In 2005, 87.8% of infants had up to date immunizations at age one. Roanoke health district used some of their Title V allocation to support their CHIP case management program for low-income children ages 0-5. In FY 05, 87% of Roanoke CHIP enrollees were up-to-date at age two for the basic series (4:3:1:3).

Other statewide activities administered and funded through other sources included provision of immunizations through all local health departments; development and implementation of local immunization action plans; collaboration with public and private sector partners such as WIC and Medicaid HMOs; and surveillance, CASA assessment and evaluation activities led by the VDH Division of Immunizations, Office of Epidemiology.

**Table 4a, National Performance Measures Summary Sheet**

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

**b. Current Activities**

Title V supported activities continue a major emphasis on working with child care providers to improve immunization rates and other health indicators. The Early Childhood Project director and part-time coordinator conducted two trainings in FY 05, increasing the number of child care health

consultants to over 200 statewide. With Title V funding, eleven health districts are conducting child care health consultant activities to improve immunization status in all tiers of child care. Districts review FY 05 CASA results to determine how they can work with local child care providers to improve rates within their areas. Education, training, and outreach activities for child care and Head Start staff to monitor immunization records are being conducted to assure that 80 percent of two-year-olds are adequately immunized.

Title V continues to partner with the Virginia Department of Social Services (DSS) in reaching child care providers. A quarterly Healthy Child Care newsletter is mailed to 10,000 child care providers throughout the state. Topics focus on timely issues including importance of immunizations and keeping children's medical records up-to-date, health insurance, disease prevention, mental-health and social-emotional competence, and working with children with special health care needs.

Since the statewide launch in FY 05, 103,000 Governor's New Parent Kits have been provided to community partners for distribution. The New Parent Kit, geared for parents or other primary care givers, contains several items providing immunization information and resources. Resource Mothers continue distributing these kits and provide support for teen parents to ensure their infants are adequately immunized.

VDH has partnered with Virginia Commonwealth University to provide a web-based training based on Bright Futures and EPSDT services in Virginia. The Virginia Chapter of the American Academy of Pediatrics served as a consultant to the project. Up to 7 hours of continuing medical education credits for physicians and 0.7 continuing education units can be earned. One of these modules focuses on required immunizations. This year, 659 registrants have used the site with 62 completing all 6 modules including the one addressing immunizations and 233 hours for CME have been awarded.

**c. Plan for the Coming Year**

The part-time child care health consultant will continue providing technical assistance to field staff through the end of the State Early Childhood Comprehensive Systems grant funding. To build sustainability, child care health consulting has been incorporated as a working committee under the VDH Nursing Council. Consultation and partnering with Project Immunize Virginia, the VDH Division of Immunization, Head Start Collaborative, and the DSS Divisions of Child Care Programs and Licensing will continue to assist with infrastructure building and quality enhancement activities.

In FY 07, nine local health districts -- Central Shenandoah, Central Virginia, Chesterfield, Hampton, Lord Fairfax, Norfolk, Peninsula, Piedmont, and Rappahannock -- plan to use some of their Title V allocation to support child care health and safety. Project Immunize Virginia subcommittee on Early Care and Education has developed an immunization tickler system for child care providers, to enhance their immunization rates. This tool is being piloted in the Tidewater area 2006 and 07.

A second round of Governor's New Parent Kits will be produced (100,000 English and 20,000 Spanish) and distributed statewide. The Kit will contain the Bright Futures Virginia Health Record which provides a tool to record immunizations. In addition, the Baby's First Year Calendar and the publication Caring for Your Baby also provide information about immunization schedules.

VDH will continue to partner with Virginia Commonwealth University to offer the Bright Futures web-based training which includes a module on immunizations. Professionals can earn continuing medical education/continuing education units for successful completion.

Other VDH non-Title V funded activities will continue to include provision of free immunizations

through local health departments, development and implementation of local immunization action plans; collaboration with public and private sector partners such as WIC and Medicaid HMOs; and surveillance, CASA assessment and evaluation activities led by the VDH Division of Immunizations. In addition, a statewide immunization registry authorized by the Code of Virginia is under development for eventual use by all pediatric providers.

**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** | **2001** | **2002** | **2003** | **2004** | **2005** |
|---|---|---|---|---|---|
| Annual Performance Objective | 21 | 20 | 19 | 19 | 19 |
| Annual Indicator | 21.0 | 18.9 | 17.4 | 17.5 | 15.1 |
| Numerator | 2906 | 2746 | 2570 | 2633 | |
| Denominator | 138386 | 144931 | 147701 | 150159 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2006** | **2007** | **2008** | **2009** | **2010** |
| Annual Performance Objective | 17 | 17 | 16 | 16 | 16 |

**Notes - 2005**
2005 data not available. Entry is an estimate based on trend.

**Notes - 2004**
Number of teen births from Vital Records 2004 data. Denominator from NCHS 2004 population estimates.

**Notes - 2003**
Number of teen births from Vital Records 2003 data. Denominator from NCHS 2003 population estimates.

**a. Last Year's Accomplishments**
The Teenage Pregnancy Prevention Initiative (TTPI), funded solely through Department of Social Services TANF funding, continued in seven health districts as mandated in state budget language since 1993. Teenage pregnancy prevention programs were staffed and monitored. Each program implemented curriculum identified as a best practice or effective program. Quarterly meetings were held for information dissemination, training, and networking. Staff worked in conjunction with VCU-SERL on the TPPI evaluation. A Master Evaluation Protocol (MEP) was used for collecting outcome data by each program. Since 1994, six of the seven districts have experienced declines in teenage pregnancy rates (ages 10-19). One health district has an artifact with induced termination data affecting its rate. All seven health districts have experienced 36 to 54% declines in birth rates for females ages 15-17. Under a state general fund allocation, 17 Better Beginnings Coalitions (BBCs) were funded and monitored. These coalitions worked to increase awareness and implement community approaches geared for prevention of teenage pregnancy through youth development, media, and other methodologies. The third annual evaluation conference was held to explore current trends in teenage pregnancy prevention programming and research with an emphasis on local level teenage pregnancy prevention activity and coalition building.

The CHATS (Collaborative on HIV/STD, Abstinence, Teenage Pregnancy, and Sexual and Reproductive Health) group met throughout the year and six regional stakeholder meetings to assist program providers in planning future integration efforts were conducted.

The Virginia Resource Mothers Program, started in 1986, continued providing lay home visiting

services to a total of 2,119 teens in 88 of 135 Virginia localities. Only 5.1% of Resource Mothers participants experienced a repeat pregnancy within the first year after birth versus an estimated 20% for the entire state.

VDH continues to administer the Virginia Abstinence Education Initiative using funding from the U.S. Administration on Children and Families which includes social marketing campaigns and abstinence-based education programs for school based youth. All health districts continue using Title X funding to provide family planning services.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Coordinate and oversee administration of teenage pregnancy prevention programming in seven health districts: Alexandria, Crater, Eastern Shore Norfol, Portsmouth, Richmond City and Roanoke City. | | | | X |
| 2. Fund Better Beginnings Coalitions (BBC) in 17 communities. | | X | | |
| 3. Evaluate teenage pregnancy prevention programs. | | | | X |
| 4. Support statewide train-the-trainer workshops to help parents talk with their children about sensitive topics including sexuality (e.g., "Can We Talk" curriculum and "Talk2Me Toolkit"). | | | | X |
| 5. Continue effort to integrate HIV, STD, and teen pregnancy prevention messages. | | | | X |
| 6. Develop the statewide adolescent sexual health plan. | | | | X |
| 7. Develop the skills and capacity of youth service providers to serve the target population through information networks. | | | | X |
| 8. Review and make recommendations regarding proposed legislation or policies addressing teens and their access to health care and other health related services. | | | | X |
| 9. Participate in CHATS and other collaboratives. | | | | X |
| 10. | | | | |

**b. Current Activities**

TPPI continues operations in the seven health districts specified by the Virginia General Assembly in 1993 and 1994. The program is funded entirely by DSS TANF funds as designated in the state budget. Quarterly meetings, convened in collaboration with the Virginia Abstinence Education Initiative, are held for information dissemination, training, and networking. Staff members are collaborating with VCU-SERL on the TPPI evaluation. The BBCs continue to develop increased awareness and implement community approaches to the prevention of teenage pregnancy through youth development, media, and other methodologies.

Information and promotion of the National Day to Prevent Teen Pregnancy on May 3, 2006 is being provided to all field programs and health districts. Health districts have also been provided with district specific fact pages regarding teenage pregnancy. A training day for program providers is scheduled for May 5, 2006.

The Divisions of Child & Adolescent Health, Women's and Infants' Health, and HIV/STD Prevention and others are collaborating to integrate teen pregnancy, abstinence, STD, and HIV prevention efforts wherever possible; this group meets bi-monthly. Programmatic areas currently involved are abstinence education, adolescent health, family life education, family planning, HIV/STD, resource mothers, juvenile justice, foster care services, and teenage pregnancy prevention. To date, this group continues to offer "Can We Talk" train-the-trainer sessions, designed to encourage parents to talk with their children, to local teams.

Resource Mothers continues to provide lay home visiting services to pregnant teenagers with the intent of preventing future pregnancies.

The Virginia Abstinence Education Initiative continues to conduct social marketing campaigns and support abstinence-based education programs for school-based youth. Over 30,000 "Talk 2 Me" toolkits have been provided to parents to assist them in discussing sexuality and all relationships with their children. Family Planning services continue to be provided in local health departments through Title X funding.

**c. Plan for the Coming Year**

The General Assembly appropriated level funding for the Teenage Pregnancy Prevention Initiative for FY07. Each TPPI program will be required to implement a curriculum identified as a best practice or effective program. Quarterly meetings will be held for information dissemination, training, and networking. Staff will continue to work in conjunction with VCU-SERL on the TPPI evaluation. Better Beginnings Coalitions (BBCs) will continue to be funded and monitored. BBCs work to increase awareness and implement community approaches geared toward the prevention of teenage pregnancy through youth development, media, and other methodologies. The development of a collaborative work plan will be continued to include an expansion of the agencies and programs participating.

In FY 07, Title V funds will not be used to support teenage pregnancy prevention programming at the health district level. Technical assistance, however, is provided to all health districts upon request. An evaluation conference will be held to explore current trends in teenage pregnancy prevention programming, and staff from health districts will be included along with funded program providers.

In conjunction with the National Campaign to Prevent Teen Pregnancy, Virginia has established a ten-year teen pregnancy reduction goal (Goal 2015) to reduce the pregnancy rate to 47.5 per 1000 females ages 15 -- 19. We plan to promote Goal 2015 and offer technical assistance to localities in an effort to assist them in 1) maintaining focus on the issue and 2) establishing local teen pregnancy reduction goals.

An expansion of the parent support and communications materials is still being planned to include a CD-Rom for talking with teens about sexually transmitted diseases and a Spanish version of the "Talk 2 Me - A Guide for Discussing Sexuality and Relationships with Your Kids." We are seeking funding for this effort. Web-based training modules will be developed for professionals interested in abstinence education, teenage pregnancy prevention, and related adolescent sexual health issues.

The Governor and the 2006 General Assembly supported a budget increase for the Resource Mothers porgram. As a result the existing Resource Mothers sites will be expanded in 2007 to increase capacity and quality of services.

**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 | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|---|
| Annual Performance Objective | 30 | 35 | 36 | 37 | 39 |

| | | | | | |
|---|---|---|---|---|---|
| Annual Indicator | 32 | 32 | 42.0 | 43.0 | 44.0 |
| Numerator | | | 856 | 876 | 897 |
| Denominator | | | 2038 | 2038 | 2038 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2006** | **2007** | **2008** | **2009** | **2010** |
| Annual Performance Objective | 39 | 39 | 40 | 40 | 40 |

**Notes - 2005**
Data is derived from a statewide needs assessment of school-age children in Virginia. This comprehensive study examined the oral health condition and needs of over 2,000 third-grade children from throughout the state.

**Notes - 2004**
Data is derived from a statewide needs assessment of school-age children in Virginia. This comprehensive study examined the oral health condition and needs of over 2,000 third-grade children from throughout the state.

**Notes - 2003**
Data is derived from a statewide needs assessment of school-age children in Virginia. This comprehensive study examined the oral health condition and needs of over 2,000 third-grade children from throughout the state.

**a. Last Year's Accomplishments**
The Division of Dental Health (DDH) supported local health department dental programs with Title V funds through providing a dentist to coordinate a quality assurance program, assist with recruitment for local health department dental programs and orient new dental staff. Last year, on-site quality assurance reviews were provided for dental programs in the following local health districts: Alexandria, Arlington, Danville, Allegheny, Roanoke and West Piedmont. VDH dental clinics served 24,763 individuals in 45,609 visits in FY 05. More than 182,000 clinical services, including 24,000 dental sealants, were provided for these patients at a value of more than $10 million dollars. Training was provided for 100 dental staff in 24 health districts regarding pediatric dentistry and other public health dental topics during a two-day meeting. Additionally, staff was trained regarding dental adhesive materials during a teleconference. Norfolk City, Roanoke City and Thomas Jefferson Health Districts used Title V funds to help support their dental programs.

Title V funds also provided materials for more than 47,000 children to participate in the school-based fluoride mouthrinse program. The VDH dental hygienist who oversees this program is funded by Title V and provided training to children, teachers, and nurses and conducted on-site reviews of half of the 211 participating schools in 50 counties statewide.

More than 5 million citizens consume water that has been optimally fluoridated. DDH provides oversight and monitors the systems for compliance in conjunction with the VDH Office of Drinking Water. In FY 05 the following communities had assistance with their programs including: Farmville, Three Springs, Isle of Wight, Nelson, Bluefield, Onancock, Castlewood/Dante. Additionally training was provided to water works operators through a teleconference.

Dental health education training was provided to 1,700 customers including Head Start programs, school nurses, and VDH dental staff. Additionally more than 31,000 citizens were educated regarding oral health. More than 150,000 VDH dental health brochures regarding dental sealants, flossing, brushing, oral health, well-being, nutrition, and dental health were utilized in these trainings/education sessions.

DDH hired an epidemiologist late in FY05 to assist with analysis and reporting of oral health data. Additionally, a Maternal and Early Child Oral Health Coordinator was hired funded partially with Title V to provide anticipatory guidance and fluoride varnish programs.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Five health districts are utilizing MCH funding to provide sealants. | X | | | |
| 2. A quality assurance program provides on site review of all health department dental programs that placed more than 19,000 sealants in FY 05 | | | | X |
| 3. Maintain data entry program to record the number of sealants placed. | | | | X |
| 4. Recruitment and orientation of new dentists. | | | | X |
| 5. Develop and distribute educational materials regarding dental sealants. | | | X | |
| 6. Train local public health dental staff on prevention including sealants. | | X | | |
| 7. Review and make recommendations regarding proposed legislation or policies addressing children's access to dental care. | | | | X |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

DDH partnered with the Virginia Head Start Collaboration Project, the Region III Head Start Program and the Association, of State and Territorial Dental Directors to hold an oral health summit September 2005, resulting in the development of a state oral health plan for Head Start. All Early Head Start Programs throughout the state are participating in the fluoride varnish program, which includes anticipatory guidance for parents, and screening and fluoride varnish for children. Head Start program directors have attended training. DDH is reaching out to Healthy Star, Resource Mothers, WIC and Regional Perinatal Councils with this program in FY06.

There have been increases in the number of children participating in the school fluoride rinse program from 45,000 to 47,000 this year. DDH hired 4 part time staff to assist with the oversight of the program (as one staff person was covering 50 counties) and one health district (Lenowisco) hired a full time dental hygienist to assist with the program. Increases in children participating have occurred in these areas including Lenowisco, Southside, Mount Rogers and Allegheny Health Districts.

Several data reports have been completed including a comprehensive report of Behavioral Risk Factor Surveillance System oral health data. Materials have been developed to meet the statewide Standards of Learning (SOL) for oral health and have been piloted in several health districts.

**c. Plan for the Coming Year**

There are plans to conduct a follow up state oral health survey of school children and planning will begin in FY 07. DDH will step up collaboration with programs and increase prevention services to children with special needs. VDH will continue to market the loan repayment program. VDH will be ordering several large dental vans for outreach of oral health services and DDH will assist in planning for the purchase and use of these vehicles.

**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** | **2001** | **2002** | **2003** | **2004** | **2005** |
|---|---|---|---|---|---|
| Annual Performance Objective | 2.5 | 2.1 | 2.1 | 2.1 | 2.1 |
| Annual Indicator | 2.1 | 2.7 | 2.7 | 1.9 | 2.2 |
| Numerator | 31 | 40 | 41 | 29 | |
| Denominator | 1453021 | 1482240 | 1496098 | 1497931 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2006** | **2007** | **2008** | **2009** | **2010** |
| Annual Performance Objective | 2.1 | 2.1 | 2 | 2 | 2 |

**Notes - 2005**
Data for 2005 not yet available. Entry is an estimate based on trend.

**Notes - 2004**
Data from Virginia hospitalization discharges, 2004.

**Notes - 2003**
Data from Virginia hospitalization discharges, 2003.

**a. Last Year's Accomplishments**
DIVP (formerly CIVP) coordinated the statewide observance of Child Passenger Safety Week. DIVP completed the transition of all of its child passenger safety trainers and technicians from an American Automobile Association (AAA) certification process to a new national certification process coordinated by the National Highway Traffic Safety Administration and SAFE KIDS worldwide. DIVP disseminated copies of a newly developed child passenger safety video to all maternity hospitals as part of a First Ride Safe Ride Campaign promoting hospital policies and practices that ensure safe transportation of newborns. DIVP coordinated radio public service announcements on the dangers of leaving children unattended in vehicles and included information on this issue in child passenger safety training and educational information. DIVP expanded the eligibility for its free low income child safety seats from one year of age to three years of age, initiated the provision of booster seats, and expanded the number of distribution sites to 130 in order to meet a growing demand with the growing resources of safety seats made available by additional traffic fines revenue. DIVP also coordinated bicycle helmet and bicycle safety trainings in conjunction with K-12 schools and pedestrian safety education activities as well.

**Table 4a, National Performance Measures Summary Sheet**

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

| | | | | |
|---|---|---|---|---|
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
DIVP staff are coordinating a variety of educational activities to observe the state's annual child passenger safety awareness week and Buckle Up America week. DIVP staff continue to coordinate a statewide child restraint distribution and education program which involves restraint dissemination to low income families, training on correct usage, and public awareness. DIVP staff are coordinating a statewide "window-cling" educational signage campaign in conjunction with law enforcement, child care providers and retailers across the state to raise awareness of hazards associated with children being left unattended in vehicles (e.g. trunk entrapment, hypo- and hyperthermia, and crashing/airbag injuries). DIVP staff continue to promote and disseminate bicycle helmets and coordinate bicycle and pedestrian safety awareness activities.

**c. Plan for the Coming Year**
DIVP staff will continue to disseminate child restraint devices and bicycle helmets and collaborate with state community and highway safety partners to implement a variety of strategies to involve Virginia's parents, youth and the general public in preventing injuries associated with motor vehicles.

**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** | **2001** | **2002** | **2003** | **2004** | **2005** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | |
| Annual Indicator | | | | | 39 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | | Final |
| | **2006** | **2007** | **2008** | **2009** | **2010** |
| Annual Performance Objective | 40 | 43 | 45 | 47 | 50 |

**Notes - 2005**
Data from CDC National Immunization Survey, 2005.

**a. Last Year's Accomplishments**
The Division of WIC & Community Nutrition Services (DWCNS) used the funding award from the United States Department of Agriculture to continue to develop the Breastfeeding Peer Counselor Program in Virginia. Materials were developed and all WIC Coordinators in the state were trained on the new peer counselor program using the Best Start Social Marketing's Loving Support Breastfeeding Curriculum.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Continue the Breastfeding advisory committee. | | | | X |
| 2. Continue the Breastfeeding Peer Counselor Program. | | X | | |

| | | | | |
|---|---|---|---|---|
| 3. Promote Breastfeeding during Breastfeeding Awareness Month. | | | X | |
| 4. Continue to distribute breastfeeding educational materials to WIC clients. | | | X | |
| 5. Review and make recommendations regarding proposed legislation or policies addressing breastfeeding. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

The Division of WIC & Community Nutrition Services is actively recruiting breastfeeding peer counselors to work in all 35 of health districts in Virginia. Currently, DWCNS has 30 of the 35 breastfeeding peer counselors hired. DWCNS is working through a temporary employment agency to hire and pay the peer counselors. District WIC Offices are using the Loving Support Breastfeeding Curriculum to train peer counselors. DWCNS is continuing to seek training opportunities as well as develop continuing education for the peer counselors in order to keep them abreast of the latest research in the field of lactation management.

A press release for Breastfeeding Awareness Month (August 2006) is being developed and will be available for local agencies.

In the Spring 2006 the Resource Mothers staff completed regional training to increase the number of women who breastfeed and the length of time for which they breastfeed. The predominantly African American population in Norfolk has been a major focus of the training. The Resource Mothers staff have found that there has been some shift in attitudes toward breastfeeding among younger African American women.

**c. Plan for the Coming Year**

VDH will now focus on establishing a State-wide Breastfeeding Advisory Committee. While the VBTF may well continue to exist independently, VDH will focus on creating a more permanent and representative Advisory Committee. The new committee will include specifically designated representatives of professional medical organizations (APA, ACOG, Virginia Hospital Association, etc.) and high level stakeholders with interest in breastfeeding from throughout the Commonwealth. Effort will be made to gain wider representation from other areas such as public education, workplace, insurance, day care centers, and research as well. The Breastfeeding Advisory Committee will build upon the works of the VBTF and establish a broad base with which to increase breastfeeding rates in the Commonwealth. In addition, the Committee will be actively involved in Obesity Prevention efforts in the Commonwealth through increased breastfeeding.

**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 | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|---|
| Annual Performance Objective | 95 | 98 | 100 | 100 | 100 |
| Annual Indicator | 95.1 | 97.2 | 96.2 | 97.3 | 98.1 |
| Numerator | 91849 | 94206 | 94601 | 99039 | 99359 |
| Denominator | 96535 | 96870 | 98328 | 101781 | 101243 |
| Is the Data Provisional or Final? | | | | Final | Final |

| | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |

**Notes - 2004**
Infants born in Virginia hospitals excludes home births

**Notes - 2003**
Data for 2002 are from the Virginia Early Hearing Detection and Intervention Program (numerator). The denominator is from the Virginia Center for Health Statistics (occurrent births) and equals the number of infants born in Virginia hospitals. Data for 2003 are not available at this time.

**a. Last Year's Accomplishments**
During FY 05, the Virginia Early Hearing Detection and Intervention (VEHDI) Program continued to administer the state's newborn hearing screening program as required by the Code of Virginia. VEHDI carried out the following activities: (1) distributed training materials to hospitals; (2) continued to submit quarterly reports to hospitals; (3) conducted WebEx training for hospital database users; (4) distributed a video (produced by National Center for Hearing Assessment and Management) to all birthing hospitals that explains the newborn hearing screening process to parents; and (5) produced and disseminated an annual report. The percentage of infants screened prior to hospital discharge has continued to rise to a high of 97.3% in 2004. The Pediatric Screening and Genetic Services (PSGS) unit received a 3-year CDC grant, which began 7/1/05, to enhance the VEHDI Program's capability for accurately ascertaining the disposition of every occurent birth for each step throughout the EHDI process and expand the integration of the program's tracking and surveillance system with other child health programs that identify children with special health care needs. Funds were used to establish the Virginia Child Health Information Systems Integration Project (VaCHISIP), managed by the PSGS Director, to redesign the Virginia Infant Screening and Infant Tracking System (VISITS) application. The current VISITS Web-based system contains the VEHDI Program, Virginia Congenital Anomalies Reporting and Education System (VaCARES), and At-Risk Referrals surveillance databases. VISITS II surveillance data will be used to guide and support child and adolescent health clinical and programmatic decisions. Plans are to electronically integrate and link together VISITS II with other child health information surveillance systems, such as Care Connection for Children SUN database. VISITS II is being integrated with the newly redesigned electronic birth certificate application by the VDH Office of Information Management (OIM). The redesign of the system is being led by a steering committee in consultation with various end user groups.

Furthermore, the VEHDI Program continued networking with other state programs in bordering states to explore reporting arrangements for resident newborns born in neighboring states.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Enhance, implement, and evaluate the Virginia Early Hearing Detection and Intervention Program. | | | | X |
| 2. Maintain and improve the Virginia Infant Screening and Infant Tracking System database. | | | | X |
| 3. Provid training and education opportunities for hospital staff. | | | | X |
| 4. Provide hospitals with quarterly updates on program strengths and areas of need. | | | | X |
| 5. Provide annual report to hospitals' CEO. | | | | X |
| 6. Monitor all newborn hearing screenings and ensure retesting | | | | X |

| | | | | |
|---|---|---|---|---|
| as needed. | | | | |
| 7. Monitor hearing screening for out of hospital births. | | | | X |
| 8. Collaborate with other states to track resident infants born in border states. | | | | X |
| 9. Review and make recommendations regarding proposed legislation or policies addressing newborn hearing screening and access to services. | | | | X |
| 10. | | | | |

**b. Current Activities**

During FY 06, the VEHDI Program continued to be administered as required by the Code of Virginia. Hospitals continued to screen all newborns for hearing loss prior to discharge and to report required data through VISITS, the Web-based integrated tracking and data management system. Ongoing program evaluation was conducted. Hospitals continued to receive quarterly reports on their screening and follow-up rates. In addition, the VEHDI Program continued technical assistance and training efforts for hospital staff, primary medical care providers, and audiologists to improve newborn hearing screening and reporting of screening and follow up.

The VEHDI Program continued networking with other state programs and bordering providers to facilitate reporting of resident infants born in neighboring states. PSGS applied for year 2 of the CDC grant, which, if awarded, will begin 7/1/06. During FY 06, the VEHDI Program continued those CDC grant-funded VaCHISIP activities that were initiated during FY 05, and continues implementing those activities throughout the remainder of FY 06. During FY 06 the following grant activities related to the system redesign were completed: VISITS II requirements documents, a VISITS-Electronic Birth Certificate (EBC) gaps analysis, and the initial project charter. The first VISITS II registration prototype is under development and will be based on the new EBC.

**c. Plan for the Coming Year**

In FY 07, the VEHDI Program will continue to be administered as required by the Code of Virginia. During FY 07, VEHDI staff will conduct quarterly teleconferences with hospital staff; and disseminate quarterly status reports and annual reports to hospital CEOs. An additional EHDI follow-up staff person will advocate for screening services for children not born in hospitals. Two VEHDI staff will be supported by Title V funding.

The VEHDI Program will continue to be involved in VaCHISIP collaborative activities, which include participating on Project Steering Committee and End User Groups. These groups will work with the Project Development Team to (1) identify, match, collect, and report standardized unduplicated individual identifiable data for every occurent birth via VISITS II; (2) improve VISITS II authenticated role-based Web access reporting efficiency, quality of data, and security; (3) develop an analytic plan to use VISITS II reports of unduplicated individual identifiable EHDI data to obtain outcome data; (4) improve the tracking and surveillance of program-targeted conditions (i.e., children with hearing loss, birth defects, risk for developmental delay) using VISITS II data; (5) disseminate timely and comprehensive data to healthcare professionals, policymakers, and other stakeholders; (6) improve Care Connection for Children and Lead-Safe Virginia case ascertainment; (7) complete a feasibility study on linkages with other statewide child health databases (e.g., Immunization Registry, WIC, and Medicaid); and (8) complete a VaCHISIP manuscript--which will include redesign processes, data reports utilization, and integration/linkages outcomes--and disseminate it to other state/territories, the CDC, and other federal and national agencies.

**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 | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|---|
| Annual Performance Objective | 7 | 6 | 5 | 5 | 5 |
| Annual Indicator | 7 | 4.9 | 6.4 | 6.4 | 6.4 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2006** | **2007** | **2008** | **2009** | **2010** |
| Annual Performance Objective | 5 | 5 | 5 | 5 | 5 |

**Notes - 2005**
Current survey data not available

**Notes - 2004**
Data not available at this time.

**Notes - 2003**
Data are from the SHADAC State Planning Grant 2004 study for children under age 18.

**a. Last Year's Accomplishments**
Collaborative efforts continued with state and local partners such as the Department of Medical Assistance (DMAS), the Department of Social Services (DSS), local health districts, school health personnel, the WIC program, Healthy Child Care Virginia (HCCV), and regional Care Connection for Children (CCC) centers for CSHCN to decease the percent of uninsured children with the continued emphasis on outreach to potential eligibles for Virginia's Children's Health Insurance Programs (FAMIS-Plus:Medicaid and FAMIS:SCHIP) known under the FAMIS umbrella. Outreach, information and application assistance continued among VDH programs where possible.

Title V staff served on the statewide Covering Kids and Families coalition and its task forces related to outreach and utilization of services. Increasing retention and utilization of health insurance as well as institutionalization of outreach and enrollment was a major focus of FY 05 activities. Title V staff served on the HRSA State Planning Grant (SPG) data workgroup. VDH staff participated in the state mandated Children's Health Insurance Program Advisory Committee.

VDH and DMAS partnered to launch the WebVISION-FAMIS application enhancement link. VDH's Office of Information Management developed this enhancement with Title V financial support. A link appears on the health department registration screen for potential eligible children. Activating the link populates a FAMIS application and gives users options to add data needed to complete the form. Patients may also complete the form while waiting for services. VDH staff faxed completed applications and available income verification to the DMAS Central Processing Units. Pilot testing of the application occurred in five health districts from May to August 2005. During the pilot, 225 applications were generated and 62 children were approved for health insurance coverage under the FAMIS programs umbrella.

During FY 05, Alexandria, Chesterfield, Cumberland Plateau, Norfolk, Richmond, Roanoke, and Virginia Beach used some of their Title V allocation to support outreach, referral, and enrollment efforts. One health district, Cumberland Plateau, used Project Connect grant funding as well to support these efforts. A total of 1,787 children were successfully enrolled in FAMIS programs.

Title V supported The Governor's New Parent Kit which was initiated in 2004 and distributed throughout the state. The Kit contains a broad array of information related to infant and child care.

In FY 05, 71,000 English and Spanish Kits were distributed reaching approximately eight out of ten new parents. The Kit contains information about FAMIS programs.

VDH continued efforts of the state Early Childhood Comprehensive Systems Grant (ECCS) from the MCHB for current planning activities. The Virginia ECCS completed an environmental scan and planning processes. A proposed work plan linking to Title V efforts was finalized.

**Table 4a, National Performance Measures Summary Sheet**

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

**b. Current Activities**

VDH continues collaborating with state and local partners. VDH programs are integrating outreach, education, and application assistance where feasible. Title V staff serve on the statewide CKF coalition and task forces. Title V staff also continue serving on the HRSA state planning grant. VDH participates in the state mandated Children's Health Insurance Advisory Committee.

The WebVISION-FAMIS application link was implemented statewide in September 2005. The link also integrates an application for pregnant women for Medicaid or the new FAMIS MOMS, a SCHIP program for pregnant women between 133 and 150% federal poverty level. To date in FY 06, half of the 35 health districts have had a successful applicant to FAMIS programs generated from the WebVISION-FAMIS link. A total of 836 children statewide have been enrolled in FAMIS programs in FY 06 from using the link.

In FY 06, eight health districts, Alexandria, Central Virginia, Chesterfield, Cumberland Plateau, Lenowisco, Norfolk, Roanoke, and Virginia Beach used Title V funding to support efforts to screen and help enroll children in FAMIS programs. These districts report successfully enrolling 1,176 children by the third quarter of FY 06. These numbers are not exclusive from the number enrolled through the Web-VISION process.

VDH and DMAS are working together to disseminate materials to local health districts related to the new marketing campaign for FAMIS programs. OFHS continues collaborating on HRSA State Planning Grant activities managed by the Office of Health Policy as appropriate.

Since the statewide launch in FY 05, 103,000 Governor's New Parent Kits have been provided to

community partners for distribution. Title V funds support this initiative and VDH is a major partner. The New Parent Kit, geared for parents or other primary care givers, contains information about state sponsored health insurance programs.

VECCS continues moving from planning to implementation with their state strategic plan. This blue print addresses cross-system issues and move from planning to implementation.

**c. Plan for the Coming Year**
VDH will continue to collaborate with both private and public sector partners on state and local levels. VDH will continue efforts to institutionalize outreach, education, application assistance for public health insurance programs. The Covering Kids and Family grant through Robert Wood Johnson has ended, however VDH will participate in any replacement efforts that may be developed. VDH will also continue participating in the state mandated Children's Health Insurance Advisory Committee.

The WebVISION-FAMIS application will continue to be supported. Districts will be provided feedback regarding applications and enrollee status through a data match and reporting system developed by the Office of Information Management Data Warehouse Team. VDH will continue collaborating with DMAS to possibly institute electronic signature and application submission as well as renewal applications. In addition, VDH will work with DMAS on ways to implement changes in application processes coming from the federal level. VDH and DMAS will collaborate on providing support and updates to state and local partners regarding Medicaid and S-CHIP policy and procedure changes.

OFHS will also participate as appropriate in HRSA State Planning Grant activities.

In FY 07, seven health districts, Alexandria, Cumberland Plateau, Lenowisco, Norfolk, Piedmont, Roanoke, and Virginia Beach will use part of their Title V allocation to screen and help enroll children in public health insurance programs.

A second round of Governor's New Parent Kits will be produced (100,000 English and 20,000 Spanish) and distributed statewide. The Kit will contain information about FAMIS state sponsored children's health insurance programs.

**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 | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | |
| Annual Indicator | | | | | 31.3 |
| Numerator | | | | | 27836 |
| Denominator | | | | | 88978 |
| Is the Data Provisional or Final? | | | | | Final |
| | **2006** | **2007** | **2008** | **2009** | **2010** |
| Annual Performance Objective | 30 | 30 | 30 | 29 | 29 |

**Notes - 2005**
Data from WICNet, 2005.

**a. Last Year's Accomplishments**

This is a new Performance measure and no accomplishments from last year to mention.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Continue to promote healthy eating/healthy weight to WIC families. | | | X | |
| 2. Provide educational materials on healthy weight to WIC families. | | | X | |
| 3. Require district health departments to address healthy weight in their WIC Service Plans. | | | | X |
| 4. Review and make recommendations regarding proposed legislation or policies addressing healthy lifestyles including nutrition and physical activity issues. | | | | X |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

The WIC Service Plan (WSP) is based on outcome funding principles. It is a document that all 35 local agencies must complete in order to obtain WIC funding. One of the mandatory goals is "Decrease the percentage of WIC children, ages 2 to 5, who are overweight (= or above the 95th percentile weight for height) by 5% of local agency baseline data (this year May 2005) utilizing the Many Faces of Nutrition Education curriculum (by Sept 30, 2006). Based on this goal each local agency must develop their own objectives that will help them meet this goal. They can develop as many as 3 objectives. WSP's are monitored on a monthly basis by a district liaison. Each local agency must complete a semi-annual and end of year progress report.

**c. Plan for the Coming Year**

Continue the development of WIC Service Plans that address overweight WIC children ages 2 to 5.

**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 | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | |
| Annual Indicator | | | | | 7.0 |
| Numerator | | | | | 7288 |
| Denominator | | | | | 103830 |
| Is the Data Provisional or Final? | | | | | Provisional |
| | **2006** | **2007** | **2008** | **2009** | **2010** |
| Annual Performance Objective | 6.5 | 6.4 | 6.3 | 6.2 | 6.1 |

**Notes - 2005**

Data from 2004 birth certificates. Data on smoking in third trimester is not available. Data are percent women reporting smoking throughout pregnancy from birth certificate data, 2004.

It is anticipated that Virginia will use the 2003 standard birth certificate in 2007. At that point, this measure can be computed directly.

**a. Last Year's Accomplishments**

In 2004, birth certificate data reveals that 7 percent of women smoked during pregnancy. There is currently no way to identify how many of these women smoked in the last three months of pregnancy. This is a new performance measure and the target for 2006 is 6.5%.

Section 54.1-2403.1 of the Code of Virginia requires licensed practitioners to routinely screen pregnant women for substance abuse, which includes smoking. They are also to counsel pregnant women with positive screens on the potential for poor outcomes and what avenues for treatment are available.

Thus, part of providing early and adequate prenatal care is asking women whether they smoke and if they do, encouraging them to stop smoking. WIC, many local health departments and the RPCs are making special efforts to reducing low weight births by providing pregnant women with early entry into care and adequate care, discouraging smoking, promoting good nutrition and increased physical activity. Local health departments served approximately 8,241 maternity patients (excluding teens) in FFY 03-04.

Case managers can play a major role in reducing smoking among pregnant women. VDH staff implemented a new training on advanced case management and repeated the one-day basic class for those who missed it last year. A case management manual will be printed and distributed to district staff.

The Virginia Healthy Start Initiative (VHSI) program provided case management services to 777 high-risk pregnant minority women, postpartum and interconceptional women, and infants in four communities (Norfolk, Portsmouth, Petersburg and Westmoreland County) who had high rates of low birth weights and infant mortality. LBW is associated with smoking. VHSI discourages women from smoking. In FY 05, 1.2 percent of infants born to VHSI clients were very low birth weight, an increase from the previous year (0.5 percent).

Southwest Virginia Regional Perinatal Council (RPC 1) continued to implement a smoking cessation program, "Breath Easy Baby!" in an effort to reduce low weight births. Women are enrolled during their pregnancy and encouraged to remain smoke-free postpartum. The June 2005 report stated that 154 women were smoke-free at three months postpartum, a quit rate of 52 percent.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Provide guidance to women in the family planning and prenatal clinics regarding the risk of smoking. | | X | | |
| 2. Provide cae management to pregnant women and refer them to smoking cessation programs. | X | | | |
| 3. Provide smoking cessation programs through some of VDH's programs. | X | X | | |
| 4. Implement a brief intervention curriculum to better screen and educate clients on substance use during pregnancy through the Va Healthy Start program | | X | | |
| 5. Review and make recommendations regarding proposed legislation or policies addressing smoking and the availability of cessation programs. | | | | X |

| | | | | |
|---|---|---|---|---|
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

All of the perinatal councils offer training to providers directly or indirectly related to reducing low weight and preterm births, many of which include smoking cessation. The RPCs are working to reduce low weight births and very low weight births by using the fetal infant mortality review (FIMR) process to identify recommendations that can be implemented to increase the referral process with local hospitals, health departments, OB offices, and regional agencies to the appropriate level of care. All RPCs are tracking the number of very low birth weight, fetal, and infant deaths for their region and assessing the appropriateness of care in their region's health care facilities.

VHSI staff assess for tobacco use during pregnancy and the interconceptional period, provide smoking cessation education and counseling to women who smoke, educate on the hazards of second hand smoke for infants and children and provide referrals to smoking cessation programs. In fact, data indicate that 7.2 percent of VHSI pregnant clients still smoked during the last 3 months of pregnancy.

Resource Mothers and BabyCare staff continue to receive information and training on identifying substance abuse, including smoking, depression and domestic violence, factors that may play a role in low weight births.

The Virginia Chapter of the March of Dimes awarded a grant to the SIDS Mid-Atlantic Alliance to provide up to eight regional one-day workshops for the Resource Mothers Program on Smoking Cessation using the 5As. These workshops were conducted from March through May.

Division staff continued their partnership with the March of Dimes (MOD) in educating the public and pregnant women themselves about risk factors for prematurity, small for gestational age and low weight births. March of Dimes provided materials for the Governor's New Parent Kit.

**c. Plan for the Coming Year**

Some local health departments and RPCs will focus their efforts on reducing low weight births by providing pregnant women with early entry into care and adequate care, and promoting good nutrition and smoking cessation.

VDH staff developed training on advanced case management and repeated the one-day basic class for those who missed it last year. A case management manual will be printed and distributed to VDH district staff.

The Resource Mothers Program will provide follow-up information to the SIDS Mid-Atlantic Alliance and the March of Dimes on the staff implementation of the 5As and on the teen client outcomes.

VHSI staff will continue to assess for tobacco use during pregnancy and the inter-conceptional period, provide smoking cessation education and counseling to women who smoke, educate on the hazards of second hand smoke for infants and children and provide referrals to smoking cessation programs.

**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 | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|---|
| Annual Performance Objective | 9.2 | 8.6 | 5.8 | 5.8 | 5.8 |
| Annual Indicator | 7.6 | 5.8 | 7.7 | 7.0 | 5.8 |
| Numerator | 37 | 29 | 39 | 36 | |
| Denominator | 484065 | 499862 | 508355 | 517261 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2006** | **2007** | **2008** | **2009** | **2010** |
| Annual Performance Objective | 5.4 | 5.4 | 5.2 | 5.2 | 5.2 |

**Notes - 2005**
Data for 2005 not yet available. Entry is an estimate based on trend.

**Notes - 2004**
2004 data from death certificates and 2004 NCHS population estimates.

**Notes - 2003**
Data from 2003 death certificates and 2003 NCHS population estimates.

**a. Last Year's Accomplishments**
DIVP provided gatekeeper training statewide on recognizing youth at risk for suicide for school staff and community providers. DIVP coordinated a website (www.preventsuicideva.org), and disseminated brochures, wallet cards and print materials to promote the new 1-800-273-TALK National Suicide Prevention Lifeline. DIVP coordinated statewide radio broadcasts of teen suicide prevention spots in May and September. DIVP collaborated with the Department of Education to provide copies of the State Board of Education Suicide Prevention Guidelines. DIVP applied for (and received) Garrett Lee Smith Memorial Act funding to continue public and professional awareness activities and provide coordinated suicide prevention activities in four high risk areas of the state. The VDH School Health Coordinator also participated in efforts addressing suicide prevention.

**Table 4a, National Performance Measures Summary Sheet**

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

| | | | | |
|---|---|---|---|---|
| 10. | | | | |

**b. Current Activities**
DIVP continues to coordinate statewide gatekeeper training and activities targeted at the public and providers to improve risk assessment and encourage/promote help seeking for suicidal youth. DIVP is also supplying start up materials and training for 200 schools to implement Signs of Suicide, an evidence-based secondary school suicide screening and prevention education program. DIVP is coordinating more comprehensive community based suicide prevention activities in four high risk areas of Virginia and promoting evidence-based middle and high school suicide prevention programs as part of a SAMHSA Cooperative Agreement funded through the Garrett Lee Smith Memorial Act. DIVP is closing out a multi-year CDC Cooperative Agreement that enabled widespread provider training on youth suicide prevention and included an evaluation component that indicated promising results of gatekeeper training on the QPR and ASIST models provided for school staff. The VDH School Health Coordinator also participated in efforts addressing suicide prevention.

**c. Plan for the Coming Year**
DIVP will continue to maintain a website and disseminate educational materials to improve recognition of youth suicide warning signs and encourage help seeking. DIVP will continue to coordinate gatekeeper training. DIVP will continue to manage community based youth suicide prevention/intervention activities and promote evidence based school suicide prevention programs as part of a SAMHSA cooperative agreement.

**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** | **2001** | **2002** | **2003** | **2004** | **2005** |
|---|---|---|---|---|---|
| Annual Performance Objective | 89 | 90 | 90 | 90 | 90 |
| Annual Indicator | 85.4 | 85.8 | 87.9 | 87.5 | 89.4 |
| Numerator | 1362 | 1418 | 1301 | 1222 | |
| Denominator | 1595 | 1653 | 1480 | 1396 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2006** | **2007** | **2008** | **2009** | **2010** |
| Annual Performance Objective | 91 | 91 | 91 | 91 | 91 |

**Notes - 2005**
2005 data not available at this time. Entry is an estimate based on trend.

**Notes - 2004**
2004 data from birth certificates and listing of Level III/IV facilities. Invalid birthweights and invalid hospital codes were excluded from the measure.

**Notes - 2003**
Only births with a valid facility ID were included in the denominator. Level III status is self designated; we do not have a standard statewide list of level III facilities. Current facility list derived from regional perinatal councils and VDH Center for Quality Health Care Services and Consumer Protection.

**a. Last Year's Accomplishments**
In Virginia, 87.5 percent of low weight births occurred at facilities for high-risk neonates in 2004, which is moving toward the target of 90 percent. Maternal and newborn transport data was reviewed by all regional perinatal councils to evaluate risk appropriate care for women and

infants. Recommendations are made to the hospitals and the RPCs coordinate and follow up with them to provide provider education and consultation, e.g., neonatal resuscitation, which can contribute to increasing very low birth weight births at level III hospitals.

VHSI continued the FIMR program in its four communities. Data from FIMR and Healthy Start clients was shared with the regional perinatal councils (RPCs) in order to examine existing infrastructure and barriers to health services.

The Northern Virginia Perinatal Council (RPC 5) began the Fetal Concerns Program to develop resources for health care providers and for the families expecting infants with a birth defect.

RPC 6 organized a maternal transport work group to improve access to care in areas without maternal and infant health providers. The group provided consultation on regional needs, resources and trends in health care for women and infants.

All RPCs provide the STABLE program which educates hospital providers on the safe and appropriate transport of high-risk maternity patients and/or their newborns.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Review maternal and newborn transport data (Regional Perinatal Councils) to evaluate risk appropriate care for women and infants | | | | X |
| 2. Recommend actions that hospitals can take to reduce infant deaths and coordinate and follow-up to provide education on areas needing improvement (RPCs) | | | | X |
| 3. Conduct fetal infant mortality reviews (RPCs) to identify barriers to care and make systems changes to address barriers. | | | | X |
| 4. Review and make recommendations regarding proposed legislation or policies addressing availability and access to appropriate care. | | | | X |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

RPCs are continuing the activities mentioned above.

Staff in local health departments and in the RM and VHSI programs conduct outreach to get pregnant women into prenatal care in the first trimester. In addition, the RM and VHSI programs participate in collaborative planning to increase the assessment of pregnant women for substance abuse and perinatal depression. Staff offer opportunities for developing the skills of private providers through training to serve low-income pregnant women and facilitate access to health insurance and community resources.

**c. Plan for the Coming Year**

The RPCs will continue maternal/newborn transport reviews and provide recommendations based on the reviews at each meeting with participating hospitals. They will continue FIMRs and implement recommendations that are provided by the case review team through their consortium. The Division of Women's and Infants' Health staff will also serve on the regulatory work group that will review the hospital neonatal regulations during the next year.

**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** | **2001** | **2002** | **2003** | **2004** | **2005** |
|---|---|---|---|---|---|
| Annual Performance Objective | 87 | 88 | 89 | 90 | 90 |
| Annual Indicator | 84.9 | 84.7 | 84.8 | 84.8 | 85 |
| Numerator | 83619 | 84085 | 85259 | 88054 | |
| Denominator | 98531 | 99235 | 100561 | 103830 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2006** | **2007** | **2008** | **2009** | **2010** |
| Annual Performance Objective | 91 | 91 | 91 | 91 | 91 |

**Notes - 2005**
Year 2005 data is not yet available. Entry is an estimate based on trend.

**Notes - 2004**
Data from 2004 birth certificates.

**Notes - 2003**
Data from 2003 birth certificates, Virginia Center for Health Statistics.

**a. Last Year's Accomplishments**
In 2004, Virginia had 84.8 percent of infants born to women who received prenatal care in the first trimester, with the target being 90 percent. 2005 data is not yet available. The Division of Women's and Infants' Health reviewed and managed 29 contracts with local health departments to provide maternity care. Eighty-two percent of local health districts provided prenatal care and are working to reduce perinatal mortality in some way.

In addition, the RPCs are working to increase the percentage of women receiving early prenatal care. RPC 1 certified eleven childbirth educators to provide prenatal education. RPC 3 conducts Community Voices program in which lay outreach workers are trained to educate community participants on the importance of prenatal care and adequate prenatal care. RPC 6 coordinates consultations with groups of concerned stakeholders in two communities seeking funding to improve access to health care for woman and infants. They developed obstetrical triage guidelines and maternal referral information forms.

Further, VHSI developed local strategies to address early entry into prenatal care and entry into VHSI services. Each local site implemented activities to increase awareness about the signs and symptoms of pregnancy and how to access prenatal care.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Review and manage contracts with local health departments and community organizations to provide early prenatal care | | | | X |

| | | | | |
|---|---|---|---|---|
| 2. Train childbirth educators/providers (through Community Voices) to more effectively provide prenatal education. | | X | | |
| 3. Educate providers on how to better serve low income women and link them to community resouces including health insurance. | | X | | |
| 4. Implement a work place education program to raise awareness of the importance of prenatal care. | | X | X | |
| 5. Educate public on the importance of early prenatal care | | | X | |
| 6. Provide education and training to providers on topics that support adequate prenatal care | | X | | |
| 7. Provide funding to district health departments to support prenatal care. | | X | | |
| 8. Review and make recommendations regarding proposed legislation or policies addressing access to care. | | | | X |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

Staff in local health departments and the RM and VHSI programs conduct outreach to get pregnant women into prenatal care in the first trimester. In addition, the RM and VHSI programs participate in collaborative planning to increase the assessment of pregnant women for substance abuse and perinatal depression. Staff also offer private providers opportunities to develop their skills through training to serve low-income pregnant women and facilitate access to medical insurance and community resources.

RPC 1 is certifying more childbirth educators by targeting the Comprehensive Health Investment Project (CHIP), RM, hospitals, obstetrical offices, and health departments.

RPC 2 is collaborating with the Henry County/Martinsville Health Department to track women with a positive pregnancy test until they are enrolled in prenatal care. The RPC will analyze and provide a report on the data. RPC 2 is also implementing the Community Voices project with lay health advisors to educate women about the importance of seeking early and adequate prenatal care.

RPC 3 is continuing the Beds and Britches Program, a prenatal care incentive project that encourages early prenatal care. RPC 7 staff are helping VHSI staff increase the number of women they serve. In Norfolk, the goal is to serve 94 clients.

Resource Mothers Program has the goal of early and regular prenatal care. Each local site's plan for enhancing first trimester enrollment is reviewed annually in relation to the local site's accomplishment the previous year and revisions to the site work plan are made accordingly. The enrollment activities and the birth outcomes are monitored. In addition, the program reports that this year 212 teens acknowledged that they smoked early in their pregnancies. By delivery 76 had stopped smoking and other young women reported decreases.

The three Virginia Health Start Initiative sites are implementing actionplans to improve first trimester entry into VHSI services and prenatal care services. Consumer members representing African American and Hispanic women are involved in the development and implementation of activities to educate women about the signs symptoms ofpregnancy and the need for early prenatal care.

**c. Plan for the Coming Year**

RPC 1 will be offering the Healthy Pregnancy Healthy Baby instructors course to certify 18 additional childbirth educators in the Southwest region by 2008.

RPC 2 will continue collaborating with a health department and with For the Children -- a nonprofit organization aimed at reducing risky behavior and assisting people with making positive choices -- to implement Community Voices. This program aims to increase community awareness on the disparities of African-American infant morbidity and mortality and the importance of early and adequate prenatal care.

RPC 3 will continue to increase the proportion of lay health advisors who understand the importance of early and adequate prenatal care so that they can educate their patients and maintain the Beds & Britches prenatal care incentive program.

RPC 4 worked with a local health department to incorporate Community Voices into their local health department. RPC 5 is exploring with community partners the development of a Fetal Concerns Program.

RPC 7 is planning to implement an education program for female employees who work at the Lillian Vernon Distribution Center.

The VHSI will establish referral systems with Medicaid eligibility workers, Community Health Centers, health department clinics and private physicians to assist with a woman's access to early prenatal care. The VHSI will continue to promote early prenatal care.

## D. State Performance Measures

**State Performance Measure 1:** *The percent of children and adolescents who have a specific source of ongoing primary care for coordination of their preventive and episodic health care.*

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

| **Annual Objective and Performance Data** | **2001** | **2002** | **2003** | **2004** | **2005** |
|---|---|---|---|---|---|
| Annual Performance Objective | 82 | 80 | 80 | 84 | 84 |
| Annual Indicator | 75 | 75 | 75 | 75 | |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | |
| | **2006** | **2007** | **2008** | **2009** | **2010** |
| Annual Performance Objective | 84 | 84 | 84 | 84 | 84 |

**Notes - 2005**
2005 Data not available.

**Notes - 2004**
2004 data not available

**Notes - 2003**
2002 Data are not available yet. Data cited from 2001 Virginia Children's Health Access Survey. Future data will be used from National Survey of Children's Health.

**a. Last Year's Accomplishments**
As referenced in NPM # 13, VDH continued with the SECCS planning grant from MCHB. As part of the environmental scan, VECCS assessed barriers related to obtaining medical homes, utilization of care systems, and other systems issues. Under the ECCS framework, partnerships have been explored which could improve capacity and process to ensure medical homes for

young children. The medical home work group completed the state strategic plan. Title V supported MCH staff collaborated on these efforts.

In FY 05, OFHS funded health district activities that promote access to medical homes. Alexandria, Chesterfield, Cumberland Plateau, Norfolk, Richmond City, Roanoke City, and Virginia Beach are among those districts conducting primary care clinics, case management, public education, and/or outreach to enroll children in health insurance and help the families to use insurance effectively.

Title V representatives served on multidisciplinary groups such as the Covering Kids and Families (CKF) Task Force on Values, Access, and Utilization of Services. VDH collaborated with the Virginia Chapter of American Academy of Pediatrics to promote the concept of Medical Home and worked with the Virginia Academy of Family Practice to promote this concept in practice. These groups formed partnerships and promoted messages regarding the importance of preventive care, increased ability to navigate systems of care, and monitoring use of services. As Virginia has experienced measurable success in increasing enrollment into public health insurance programs, the focus of these groups has moved towards a greater emphasis on access and use of medical services, including promotion of medical homes.

**Table 4b, State Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Fund local health districts to assist families in finding and utilizing a medical home. | | X | | |
| 2. Participate in initiatives and coalitions that aim to increase utilization of medical homes. | | | | X |
| 3. Continue surveillance, monitoring, and dissemination of data related to utilization of care. | | | | X |
| 4. Work with the AAP to promote the medical home concept for all children and adolescents. | | | | X |
| 5. Work with school nurses to promote the medical home concept to school children and their parents. | | | | X |
| 6. Collaborate with state Early Childhood Comprehensive Systems Project to implement a strategic plan for assurance of medical and dental homes. | | | | X |
| 7. Provide information to parents about the medical home conept through the Governor's New Parent Kit. | | X | | |
| 8. Review legislation and policies addressing health care access. | | | | X |
| 9. Continue participation in the New York Mid Atlantic Consortium for Genetic and Newborn Screening Services to promote medical homes for CSHCN. | | | | X |
| 10. | | | | |

**b. Current Activities**

In FY 06, OFHS is funding health districts that promote access to medical homes through case management, assistance with getting and using public health insurance programs, and in some districts provision of child health services for clients with no other resources. Alexandria, Central Virginia, Cumberland Plateau, Lenowisco, Norfolk, Roanoke, and Virginia Beach are using Title V funds in FY 06 to work on these goals.

VDH continued to participate in the Covering Kids and Families (CKF) Task Force on Values, Access, and Utilization of Services. VDH is collaborating with the Virginia Chapter of the American Academy of Pediatrics to promote the concept of Medical Home. Part of this

collaboration including working with Virginia Commonwealth University to develop the Bright Futures web-based training for continuing medical education/continuing education units. This web-course has a module on the concept of Medical Home. This year, 659 registrants have used the site with 62 completing all 6 modules including the one addressing Medical Home and 233 hours for CME have been awarded.

VDH programs such as Virginia Early Hearing Detection and Intervention, the Virginia Newborn Screening Services program and Care Connection for Children continue efforts to link newborns to medical homes as needed.

The Division of Child and Adolescent Heatlh participates with the New York Mid Atlantic Consortium for Genetic and Newborn Screening Services (NYMAC). The DCAH Director chairs a work group focused onpromoting medical home and a system of care for CSHCN identified through newborn screening. Efforts to date have centered on identifying and promoting helpful tools that primary and specialty care providers can use to better communicate with each other, and include the family as an active partner.

The VECCS project continues to make promotion of medical home a priority area in its strategic plan. Activities in the plan focus on expanding medical home trainings currently underway by Medical Home Plus, Inc. and the Virginia Chapter of the American Academy of Pediatrics. In addition, the plan addresses educating families about the concept of a medical home and what they should expect from a medical home provider.

**c. Plan for the Coming Year**
In FY07, OFHS will fund Alexandria, Cumberland Plateau, Lenowisco, Norfolk, Piedmont, Roanoke and Virginia Beach to promote access to Medical Homes.

VDH will continue to participate in state level partnerships that will be an outgrowth from the now ended Covering Kids and Families grant. VDH will continue its partnership with the Virginia Chapter of the American Academy of Pediatrics to promote the concept of the Medical Home. VDH will continue to sponsor and promote the Bright Futures web-site which contains information about the Medical Home concept and offers continuing education credits/units.

VDH will continue to support the Governor's New Parent Kit and plans to put information in the second round of Kits related to the concept of Medical Home.

VDH will continue to participate in NYMAC to promote medical homes and a system of care for CSHCN.

## State Performance Measure 2: *The percent of children who are overweight or obese.*

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

| Annual Objective and Performance Data | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|---|
| Annual Performance Objective | 17 | 17 | 16 | 15 | 14 |
| Annual Indicator | 17.4 | 17.4 | 17.4 | 31.3 | 31.3 |
| Numerator | | | | | 27836 |
| Denominator | | | | | 88978 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2006** | **2007** | **2008** | **2009** | **2010** |
| Annual Performance Objective | 14 | 14 | 14 | 14 | 14 |

**Notes - 2005**

Data from WICNet 2005. Beginning in 2004, overweight/obese was defined as at or above the 85th percentile. Previously, the 90th percentile was reported, so data prior to 2004 are not comparable current figures.

**Notes - 2004**
Data from WICNet 2005.

**Notes - 2003**
Data from fourth grade nutritional survey is not available for 2002 or 2003.

**a. Last Year's Accomplishments**
Development of the Eat Smart Virginia curriculum was completed. The pilot for this program was to be located within a faith based community, however; key staff assigned to manage this project relocated to another state. The pilot portion of this program is on hold until staff can be recruited and hired.

In November 2005, the Division of WIC & Community Nutrition Services convened a panel of experts in the field of public health to assist in the creation of the CHAMPION report. The report has been written and is now under formal review. The report highlights the opinions of all participants in the regional CHAMPION meetings and identifies common themes seen throughout the Commonwealth.

The Division of WIC and Community Nutrition Services launched the CHAMPION website. Through web-enabling, the site allows local organizations to share obesity prevention program information, data, and resources with other organizations and citizens across the state. The site also includes a searchable resource directory of physical activity and community nutrition programs and initiatives in the Commonwealth. The site also contains links to available grants and resources.

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Provide educational materials promoting healthy lifestyles. | | | X | |
| 2. Participate in coalitions and collaboratives aimed at policy and program development to promote healthy nutrition and adequate physical activity. | | | | X |
| 3. Support activities of Virginia Action for Healthy Kids to improve access to healthy foods and increased physical activity opportunities within schools. | | | | X |
| 4. Promote the "Eat Smart Virginia", an obesity prevention tool kit. | | | X | |
| 5. Collaborate with the Department of Education to maintain the website "Health Smart Virginia." | | X | | |
| 6. Fund and support local health district programs that address childhood obesity. | | X | | |
| 7. Review and make recommendations regarding policies/legislation addressing obesity. | | | | X |
| 8. Develop and distribute CHAMPION Report based on the regional meetings addressing prevention and control of obesity. | | | | X |
| 9. Develop and maintain a CHAMPION website. | | | X | |
| 10. | | | | |

**b. Current Activities**

The CHAMPION report is under formal review. Research is being conducted by Division staff as to the top common themes that were gathered during the regional CHAMPION meetings. Staff is looking nationally at programs that exist that are related to these themes to determine if they are science based and have been proven to affect behavior change.
The staff also continues to outreach with local community coalitions by providing technical assistance and support.

The Division of WIC and Community Nutrition Services is working with the Division of Child Care Development in the distribution of the After School Kits to after school providers.

In collaboration with the Governor's Office, the Division of Human Resource Management, and the Department for the Blind and Visually Impaired, the Division of WIC and Community Nutrition Services is providing technical assistance on all aspects, from the design, menu planning, marketing and promotion of the Virginia Department of Health's new café. The Division of WIC & Community Nutrition Services in collaboration with the Governor's Office has also submitted a grant application to the National Governor's Health States Grant Program which will focus on community and workplace wellness.

**c. Plan for the Coming Year**
The Governor's Office will release the CHAMPION Report to the public. The Division of WIC and Community Nutrition Services will convene an Advisory Committee which will assist in the writing of the State's Obesity Prevention Plan.

We will continue to provide outreach with local community coalitions by providing technical assistance and support.

The Division of WIC & Community Nutrition Services will continue to provide support to the Virginia Department of Health Café' in the form of nutritional labeling, and consumer education.

**State Performance Measure 3:** *The percent of newborns screened for hearing loss who receive recommended follow-up services.*

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

| **Annual Objective and Performance Data** | **2001** | **2002** | **2003** | **2004** | **2005** |
|---|---|---|---|---|---|
| Annual Performance Objective | 70 | 73 | 77 | 81 | 85 |
| Annual Indicator | 70.8 | 66.5 | 71.0 | 73.1 | 71.9 |
| Numerator | 2459 | 2098 | 2161 | 2139 | 2158 |
| Denominator | 3472 | 3156 | 3042 | 2927 | 3001 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2006** | **2007** | **2008** | **2009** | **2010** |
| Annual Performance Objective | 89 | 93 | 95 | 95 | 95 |

**Notes - 2005**
Data are from the Virginia Early Hearing Detection and Intervention Program.

**Notes - 2004**
Data are from the Virginia Early Hearing Detection and Intervention Program.

**Notes - 2003**

Data are from the Virginia Early Hearing Detection and Intervention Program. Database transition occurred in May 2002 from TONE to Virginia Infant Screening and Infant Tracking System (VISITS).

**a. Last Year's Accomplishments**

During FY 05, the VEHDI Program carried out the following activities with the help of funds from year four of a HRSA EHDI grant: (1) collaborated with the Part C Early Intervention System to track outcomes for those children with hearing loss who were referred to and received Part C services; (2) conducted two teleconferences for primary medical care providers on the role of the provider and early intervention and parent issues; (3) conducted Sensory Kids Impaired- Home Intervention (SKI-HI) training for early intervention providers on support and resources in natural environments for families with infants, toddlers, and preschoolers, age birth to five, who are deaf and hard of hearing; (4) conducted a workshop for audiologists with a focus on hands-on, skills-building; (5) initiated the establishment of a hearing aid loaner bank for children (to 18 years of age) that will be available when the child is first diagnosed; (6) disseminated the Parent Resource Guide video to audiologists and early intervention providers; and, (7) hired a follow up coordinator fluent in English and Spanish to increase capacity to follow up on the growing Hispanic population. In addition, PSGS was awarded a new 3-year HRSA EHDI grant, which began 9/1/05, to improve follow-up rates and reach EHDI goals of 1-3-6. The training activities, as well as the loaner bank, were supported by the funds from both the old and new grants.

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Administer statewide early hearing detection and intervention program. | | | X | |
| 2. Mail letters to parents and primary care providers regarding screening results and need for follow up. | X | | | |
| 3. Implement aggressive tracting activities for children lost to follow-up | X | | | |
| 4. Collaborate with Part C Early Intervention System to streamline referrals and document outcomes. | | | | X |
| 5. Provide parent to parent contact for families of children with hearing loss. | | X | | |
| 6. Provide training to increase capacity of Part C Early Intervention System to provide appropriate intervention services for children with hearing loss. | | | | X |
| 7. Maintain the Virginia Hearing Aid Loan Bank. | X | | | |
| 8. Review any proposed legislation and policies that address newborn hearing services. | | | | X |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

In FY 06, the VEHDI Program carried out the following activities: (1) continued training efforts for primary medical care providers with replication of the American Academy of Pediatrics teleconferences; (2) continued collaboration with CDC and four other states in a program evaluation project examining the issue of lost to follow up; (3) disseminated two early intervention videos focusing on best practices for family-centered approach in home visits and strategies and skills necessary to support parents' learning and the child's development to 40 local early intervention councils; (4) continued collaboration with the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Service (the lead agency for Part C) and the Virginia

Department of Education to establish a system for collecting outcome data for children with hearing loss across agencies; (5) maintained the hearing aid loan bank; and, (6) added a full-time staff person to assist with follow up activities, including tracking of children lost to follow up. In addition, PSGS will submit application for year two of the HRSA EHDI grant. Furthermore, VEHDI Program staff members participated in writing the 5-year CDC-funded birth defects surveillance and prevention grant, which began 3/1/05, to support VaCATPIP II. The project's EHDI follow-up-related activities include ensuring that the VISITS /Early Intervention Referral System is fully operational statewide.

**c. Plan for the Coming Year**
During FY 07, VEHDI Program staff will update the Parent Resource Guide. They will continue with training and education activities for primary care providers, audiologists, and early intervention providers. In addition VEHDI will collaborate with agency partners and members of the EHDI Advisory Committee to establish a statewide system of trained parent contacts for families of newly diagnosed infants and young children. A focus will remain on tracking Virginia newborns transferred out of state. As a part of an evaluation of the VEHDI program, a survey of parents with children with hearing loss is also planned. The VEHDI Program will continue to maintain the Hearing Aid Loaner Bank. Staff will continue collaboration with Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Service and the Virginia Department of Education to establish a system for collecting and sharing outcome data for children with hearing loss across agencies. Furthermore, PSGS will apply for the final year of the HRSA EHDI grant to improve follow up. Two VEHDI program staff members will be supported using Title V funding.

**State Performance Measure 4:** *The unintentional injury hospitalization rate for children aged 1-14 per 100,000.*

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

| **Annual Objective and Performance Data** | **2001** | **2002** | **2003** | **2004** | **2005** |
|---|---|---|---|---|---|
| Annual Performance Objective | 145 | 142.5 | 140 | 137.5 | 135 |
| Annual Indicator | 142.7 | 114.4 | 117.8 | 142.8 | 122.6 |
| Numerator | 1941 | 1580 | 1646 | 2139 | |
| Denominator | 1360313 | 1381105 | 1397075 | 1497931 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2006** | **2007** | **2008** | **2009** | **2010** |
| Annual Performance Objective | 132.5 | 130 | 130 | 130 | 130 |

**Notes - 2005**
2005 data not yet available. Entry is an estimate based on trend.

**Notes - 2004**
Data from Virginia Hospitalization Discharges 2004.

**Notes - 2003**
Data from 2003 Virginia hospital discharges.

**a. Last Year's Accomplishments**
DIVP resource center provided educational resources to numerous community groups to support local injury prevention projects. DIVP funded several local childhood injury prevention projects. A web based injury reporting system was finalized. An annual report on Virginia's injury deaths and

hospitalizations was produced and disseminated. DIVP aired a series of radio public service announcements addressing drowning, suffocation and leaving children unattended in vehicles.

**Table 4b, State Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Coordinate statewide educational activities relating to the prevention of unintentional injuries. | | | X | |
| 2. Provide funding and support for health districts' unintentional injury projects. | | X | | |
| 3. Develop and implement public awareness campaigns. | | | X | |
| 4. Disseminate safety devices (e.g. child restraints, gun locks, smoke alarms) | X | | | |
| 5. Review and make recommendations regarding proposed legislation or policies addressing unintentional injury issues. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

DIVP continues to provide training and consultation on injury prevention data and strategies, share prevention education resources and product safety recalls through list servers and mailouts from a resource center. DIVP is developing a state injury prevention plan in conjunction with a wide variety of state agencies and other injury stakeholders as part of a CDC cooperative agreement. In collaboration with the Department of Education, DIVP has produced and will shortly be disseminating and promoting a comprehensive school safety resource - SAFE SCHOOLS SAFE STUDENTS- Guidelines and Resources to Improve the Safety of Students in Virginia - to administrators, staff, and parent-teacher associations at all K-12 schools in Virginia.

**c. Plan for the Coming Year**

DIVP will continue to coordinate a wide variety of state-level, community-level and school based activities to prevent childhood injuries including provision of web and hardcopy resources, training, safety device dissemination and project support.

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

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | |
| Annual Indicator | | | | 23.2 | 22.2 |
| Numerator | | | | 3339 | 2763 |
| Denominator | | | | 14391 | 12456 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2006** | **2007** | **2008** | **2009** | **2010** |
| Annual Performance Objective | 12.5 | 12.4 | 12.3 | 12.2 | 12.1 |

**Notes - 2005**

Data is from the 2004-2005 Head Start Program and represents the percentage of Head Start children (ages 3-5) needing dental treatment. Data also is included from a 2005 VDH study of caries prevalence in Early Head Start children (ages 0-3).

**Notes - 2004**
Data is from the 2003-2004 Head Start Program and represents the percentage of Head Start children (ages 3-5) needing dental treatment. Data is not available for younger children for this year.

**a. Last Year's Accomplishments**
The Division of Dental Health (DDH) supported local health department dental programs with Title V funds through providing a dentist to coordinate a quality assurance program, assist with recruitments for local health department dental programs and orient new dental staff. Last year, on-site quality assurance reviews were provided for dental programs in the following local health districts: Alexandria, Arlington, Danville, Allegheny, Roanoke and West Piedmont. VDH dental clinics served 24,763 individuals in 45,609 visits in FY 05. More than 182,000 clinical services, including 24,000 dental sealants, were provided for these patients at a value of more than $10 million dollars. Training was provided for 100 dental staff in 24 health districts regarding pediatric dentistry and other public health dental topics during a two-day meeting. Additionally, staff was trained regarding dental adhesive materials during a teleconference. Norfolk City, Roanoke City and Thomas Jefferson Health Districts used Title V funds to help support their dental programs.

Title V funds also provided materials for more than 47,000 children to participate in the school-based fluoride mouthrinse program. The VDH dental hygienist who oversees this program is funded by Title V and provided training to children, teachers, and nurses and conducted on-site reviews of half of the 211 participating schools in 50 counties statewide.

More than 5 million citizens consume water that has been optimally fluoridated. DDH provides oversight and monitors the systems for compliance in conjunction with the VDH Office of Drinking Water. In FY 05 the following communities had assistance with their programs including: Farmville, Three Springs, Isle of Wight, Nelson, Bluefield, Onancock, Castlewood/Dante. Additionally training was provided to water works operators through a teleconference.

**Table 4b, State Performance Measures Summary Sheet**

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

**b. Current Activities**

There have been increases in the number of children participating in the school fluoride rinse program from 45,000 to 47,000 this year. DDH hired 4 part time staff to assist with the oversight of the program (as one staff person was covering 51 counties) and one health district (Lenowisco) hired a full time dental hygienist to assist with the program. Increases in children participating have occurred in these areas including Lenowisco, Southside, Mount Rogers and Allegheny Health Districts.

**c. Plan for the Coming Year**
There are plans to conduct a follow up state oral health survey of school children and planning will begin in FY 07. DDH will step up collaboration with programs and increase prevention services to children with special needs.

**State Performance Measure 6:** *The number of dental providers practicing in underserved areas.*

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

| Annual Objective and Performance Data | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | |
| Annual Indicator | | | | 0.3 | 0.3 |
| Numerator | | | | 1318 | 1318 |
| Denominator | | | | 4290110 | 4290110 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2006** | **2007** | **2008** | **2009** | **2010** |
| Annual Performance Objective | 0.4 | 0.5 | 0.6 | 0.7 | 0.8 |

**Notes - 2005**
Data is derived from a 2001 VDH assessment of dentally underserved areas in Virginia. The annual indicator represents the number of general dentists per 1,000 population, where the numerator is the number of general dentists in all dentally underserved areas and the denominator is the total population of all dentally underserved areas in Virginia. The statewide average dentist to population ratio is 1 dentist per 2,084 persons or 0.5 dentists per 1,000 persons. Areas of need are defined as those areas having a lower dentist to population ration than the statewide average. All areas of need are being reassessed in 2006.

**Notes - 2004**
Data is derived from a 2001 VDH study of dentally underserved areas in Virginia. The annual indicator represents the number of general dentists per 1,000 population, where the numerator is the number of general dentists in all dentally underserved areas and the denominator is the total population of all dentally underserved areas in Virginia. The statewide average dentist to population ratio is 1 dentist per 2,084 persons or 0.5 dentists per 1,000 persons. Areas of need are defined as those areas having a lower dentist to population ration than the statewide average.

**a. Last Year's Accomplishments**
The Virginia General Assembly increased the funding for the dental scholarship and loan repayment program from $25,000 GF to $325,000 GF in FY 2006. In addition, one time Title V funding was used to supplement the general fund dollars to increase the number of scholarships during FY 05.

**Table 4b, State Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Dental scholarship program for dental students. | | X | | |

| | | | | |
|---|---|---|---|---|
| 2. Provide dental loan repayment program for practicing dentists. | | X | | |
| 3. Collaborate with the Office of Health Policy on designation of dental Health Professions Shortage Areas. | | | | X |
| 4. Maintain collaboration with Virginia Commonwealth University's School of Dentistry. | | | | X |
| 5. Recruit dentists to serve in local health departments. | | | | X |
| 6. Analyze data on Medicaid patients seen in underserved areas. | | | | X |
| 7. Review and make recommendations regarding proposed legislation or policies addressing dental practice issues. | | | | X |
| 8. Continue to market the dentist loan repayment program. | | | | X |
| 9. Update the designation of dental areas of need. | | | | X |
| 10. | | | | |

**b. Current Activities**

Elizabeth Barrett, DDM, the staff person coordinating the dental scholarship and loan repayment program was hired in FY 06. The loan repayment program was started with development of contracts and advertising for participants. Areas of need are being updated through an analysis of state board figures and information from the dental association. Guidelines and contracts were drafted for the first dentists to enter the dentist loan repayment program. In FY 2006, 17 dental scholarships and 7 student loans were awarded. Each of these requires that the recipient practice in an underserved area and provide services to the Medicaid/FAMIS population.

Dr. Karen Day, the Director of the Division of Dental Health, serves on the Virginia Dental Advisory Committee.

Effective July 2005, the Department of Medical Assistance Services (DMAS), the Medicaid Agency implemented the Smiles for Children's program. The program, administered by Doral Dental USA, LLC. In planning the implementation of Smiles for Children, the DMAS conducted a survey of all licensed dental providers to determine their interest in being Medicaid/FAMIS providers. A number of providers who have never been participating providers or have been in the past but not currently indicated that they will consider participating with a single program administrator and an increase in fees. Seventy percent of providers who have been practicing over 3 years and have never been participating providers indicate that they will not participate in the future even if there is single program administrator and increased fees. Based on the survey results, DMAS recognizes that increasing provider participation in Smiles for Children will be a gradual process.

During the past few months for-profit dental practice franchises have opened in some areas of the state. These dental practicies (Kool Smiles and Small Smiles) specifically target services to Mediciad eligible children. Depending on the success of these franchises, the percent of children receiving Medicaid reimbursed dental care should increase in areas where the services are available.

**c. Plan for the Coming Year**

Efforts to market the dentist loan repayment program will continue during the next year.

Karen Day, DSS, the director of VDH's Division of Dental Health will continue to serve on the Virginia Dental Advisory Committee. This committee will continue to monitor the provider participation in the Smiles for Children program and the percent of eligible children receiving Medicaid/FAMIS dental services.

**State Performance Measure 7:** *The proportion of children (0-21 years) who receive genetic testing.*

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

| Annual Objective and Performance Data | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | |
| Annual Indicator | | | | 28.7 | |
| Numerator | | | | 2560 | |
| Denominator | | | | 8913 | |
| Is the Data Provisional or Final? | | | | Provisional | |
| | **2006** | **2007** | **2008** | **2009** | **2010** |
| Annual Performance Objective | 32 | 35 | 38 | 41 | 44 |

**Notes - 2005**
2005 data not yet available

**Notes - 2004**
Data for the numerator are from three contracted genetic centers and include all children seen under age 21 (both new and follow up)

Data from denominator are from birth defects cases mandated to be reported through Virginia Congenital Anomalies and Reporting System. These are only children (up to age 2) hospitalized with certain defects as mandated in the Code of Virginia.

These data are provisional as the measurement parameters are being refined.

**a. Last Year's Accomplishments**
This is a new performance measure adopted in the FY 06 application.

**Table 4b, State Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Maintain contracts with genetic centers to assure genetic services are available to all children and families in Virginia. | | | | X |
| 2. Mail letters to parents identified through the Virginia Congenital Anomalies and Reporting System to increase knowledge regarding available resources. | X | | | |
| 3. Support the Virginia Genetics Advisory Committee and its activities. | | | | X |
| 4. Redesign and maintain the Virginia Infant Tracking and Infant Screening web-based data system to provide better surveillance of genetic screening and results. | | | | X |
| 5. Strengthen referral systems to ensure that all children and families are referred for genetic testing and counseling when appropriate. | | | | X |
| 6. Develop family genetic history tool to help families identify their risk for genetic inherited disorders. | | X | | |
| 7. Review and make recommendations regarding proposed legislation or policies addressing genetic testing. | | | | X |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
The Pediatric Screening and Genetic Services (PSGS) unit of Division of Child and Adolescent Health (DCAH) contracts with 3 genetic/metabolic treatment centers to assure that genetic services are available to all children and their families in the state. Contractual relationships exist with Eastern Virginia Medical School and the Departments of Genetics at University of Virginia and Virginia Commonwealth University. DCAH also contracts with the Genetics and IVF Institute for genetic services in the Northern Virginia area.

OFHS also supports the Virginia Genetics Advisory Committee chaired by a geneticist from Virginia Commonwealth University. Their purpose is to advise the Virginia Genetics Program on planning, implementing, and evaluation services related to maternal and child health. This group has several subcommittees including a parent involvement workgroup.

The Advisory Committee is currently examining results from a state genetic needs assessment. The assessment describes the current status of genetic services in the state, assesses current and emerging practices/gaps, and solicits participant input. The assessment involved surveying genetics providers and key stakeholders, consumer focus groups, and a survey of the general public. Strengths identified include that existing services are generally of high quality and availability is important to citizens. Needs were identified in providing family-centered culturally competent services, funding and coverage for genetic services, and limited knowledge of available services among non-genetic health care providers. Other issues included the on-going need for attention to the ethical, legal, and social implications of genetics and to have improved linkages between different genetic services and databases as well as other medical specialties.

Along with newborn screening services expansion, efforts are being made to better facilitate referrals for families whose children have genetic disorders to Part C (Early Intervention) and Care Connection for Children.

PSGS in consultation with Virginia Genetics Advisory Committee is developing a family genetic history tool to help families identify their risk for genetic inherited disorders.

The Virginia Early Hearing Detection and Intervention Program (VEHDI) received CDC grant funding (VA-CHISP) to help redesign the surveillance database which is used to track infants and children diagnosed with genetic and heritable disorders, including birth defects mandated in Code to be reported. This redesign will allow for more timely identification of unduplicated birth defects cases. The Virginia Congenital Anomalies Reporting and Education System will then resume parent contact letters which includes a Parent Resource Center brochure discussing available genetic services. Another CDC grant, CATPIP II is providing for improved birth defects case identification which will improve referrals to needed services including genetics

**c. Plan for the Coming Year**
PSGS will continue contracting with three genetic/metabolic treatment centers to assure that genetic services are available to all children and their families in the state. Contractual relationships will continue with Eastern Virginia Medical School, the Departments of Genetics at University of Virginia and Virginia Commonwealth University, and the Genetics and IVF Institute.

In FY 07, the Virginia Genetics Advisory Committee will focus efforts on provider education regarding genetic services as identified in the needs assessment. The Committee and PSGS will continue efforts to develop and disseminate the family genetic history tool.

Strengthening referral systems will continue to be a focus so that all children and families with identified genetic disorders will have access to case management services and assistance with obtaining genetic services and coverage.

The VaCHISP grant will proceed with the redesign of VISITS II. Upon completion, family contact

for those infants and children diagnosed with certain birth defects as mandated in the Code of Virginia will receive contact and information about genetic services. The Electronic Birth Certificate will provide better contact information to reach families.

**State Performance Measure 8:** *The percent of women reporting substance use during pregnancy.*

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

| **Annual Objective and Performance Data** | **2001** | **2002** | **2003** | **2004** | **2005** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | |
| Annual Indicator | | | 7.3 | 7.0 | 6.7 |
| Numerator | | | 7942 | 7789 | |
| Denominator | | | 108354 | 111239 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2006** | **2007** | **2008** | **2009** | **2010** |
| Annual Performance Objective | 6.6 | 6.3 | 6 | 5.7 | 5.4 |

**Notes - 2005**
2005 data is not yet available. Entry is an estimate based on trend.

**Notes - 2004**
Data from 2004 birth certificates.

**Notes - 2003**
Data from 2003 birth certificates.

**a. Last Year's Accomplishments**
In 2004, birth certificate data reveals that 7 percent of women reported using substances during pregnancy and the target is 6.6. This is a new state performance measure. See information in national performance measure 15 for information on accomplishments related to smoking cessation. In addition, the Fetal Alcohol Syndrome Disorder (FASD) Task Force formed this year to discuss strategies for Virginia and one recommendation was to bring an expert to Virginia to education providers. On January 12, 2006 Dan Duboskey, from the U. S. Department of Health and Human Services, shared his insight and knowledge about FASD with area health care providers.

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Develop routine data reporting to monitor substance use through PRAMS and develop strategies for reducing abuse. | | | | X |
| 2. Participate in the Fetal Alcohol Syndrome Disorder Task Force to develop strategies to reduce substance use during pregnancy. | | | | X |
| 3. Continue to promote smoking cessation through the regional perinatal councils, Healthy Start and other VDH sponsored programs. | | X | X | |
| 4. Collaborate with DMAS to update and improve screening of substance use during pregnancy for women in Babycare. | | X | | X |
| 5. Participate in an interagency task force to explore ways to | | X | | X |

| | | | | |
|---|---|---|---|---|
| train providers in screening and referral of substance abusers. | | | | |
| 6. Review and make recommendations regarding proposed legislation or policies addressing substance use treatment services for women. | | | | X |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
See information in national performance measure 15 for information on accomplishments related to smoking cessation.

The Virginia Health Start Initiative uses culturally appropriate screening tools for substance use and perinatal depression that have been validated for use with multiple racial/ethnic groups. Education materials used with the clients are field-tested by consumer members representing the African American and Hispanic communities.

Virginia successfully applied for the CDC funded Pregnancy Risk Assessment Monitoring System (PRAMS) grant and was awarded funding in April. This surveillance system will provide additional data on smoking and alcohol use during pregnancy. Virginia is currently working on the implementation of this system and will consider additional questions related to other substance use. Data from PRAMS will not be available until 2008.

**c. Plan for the Coming Year**
In spite of the state requirement that screening for substance abuse and referral be conducted, there is no systematic way of collecting accurate data other than the birth certificate, which is very limited. VDH will consider including additional questions regarding substance use in future PRAMS questionnaires.

In addition, an interagency task force, comprised of DMHMRSAS, VDSS, DMAS and VDH will be exploring ways to train providers in screening and referral across the state, e.g., incorporate training for substance abuse into the new web-based training on perinatal depression.

VHSI is implementing a brief intervention curriculum to assist with screening and education regarding substance use during pregnancy. The primary focus is on tobacco and alcohol use. When these substances are identified then additional questions will be asked regarding illicit substances. For women identified as using substances other than tobacco or alcohol, the VHSI refers to Project Link and local Community Service Boards for services.

DWIH will be working with DMAS to update and improve the risk screen providers complete on pregnant women for BabyCare which may lead to provider and managed care training for case managers next year.

The regional perinatal councils will be required to include substance abuse in their performance plan for FY 07.

**State Performance Measure 9:** *The percent of women with an ongoing source of primary care.*

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

| Annual Objective and Performance Data | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | |
| Annual Indicator | | | 88.6 | 86.8 | 90.5 |
| Numerator | | | 2494343 | 2513554 | 2999 |
| Denominator | | | 2813758 | 2895257 | 3314 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2006** | **2007** | **2008** | **2009** | **2010** |
| Annual Performance Objective | 90 | 91 | 92 | 93 | 94 |

**Notes - 2005**
2005 Provisional Unweighted BRFSS data. NOTE: the numerator and denominator are substantially smaller than the weighted numbers reported in prior years.

**Notes - 2004**
2004 Final Weighted BRFSS data.

**Notes - 2003**
2003 Final Weighted BRFSS data.

**a. Last Year's Accomplishments**
This is a new state performance measure. The baseline, using BRFSS data, is 86.8% in 2004.

VDH provided case management services through Resource Mothers and VHSI. In addition, the family planning waiver was renewed at DMAS that will allow access to a medical provider for two years after delivery.

**Table 4b, State Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Provide case management services through Resource Mothers and the Virginia Healthy Start Initiative | | X | | |
| 2. Strengthen connections with local health care providers through program outreach activities. | | X | | X |
| 3. Improve the referral systems of local health departments and community agencies via the Virginia Healthy Start Initiative | | | X | X |
| 4. Review and make recommendations regarding proposed legislation or policies addressing women's access to care. | | | | X |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
VDH will continue these case management activities. The VHSI provided case management services to 443 pregnant and interconceptional women in FY06. Staff connect women to sources of health care, assist with application to insurance carriers and setting up appointments.

In March 2006 a Women's Health meeting for OFHS staff and key related health department staff was held. The purpose of the meeting was to promote the importance of women's health across the lifespan and to develop a draft plan on innovative ways to accomplish this. Technical

assistance support for this meeting was provided by MCHB. Dawn Misra, Ph.D. from the University of Michigan's School of Public Health facilitated this meeting.

**c. Plan for the Coming Year**

The OFHS is promoting women's health across the lifespan and access to primary and obstetrical care is an important part of this. In the coming year OFHS will actively support National Women's Health Week, the Wear Red campaign to raise awareness about heart disease in women and will encourage screening for breast and cervical cancer and other diseases. In addition a draft plan to implement a broader view of women's health will be developed.

VHSI will strengthen connections with local health care providers through program outreach activities. Referral systems will be strengthened with health department programs that serve women, such as family planning and women's health clinics, in the three VHSI sites.

## E. Health Status Indicators

In the past, there has not been a sustained and coordinated maternal and child health surveillance effort in Virginia due in large part to the lack of long-term resources and full-time positions dedicated to surveillance activities. As a result, MCH surveillance activities related to health status indicators tended to be specific to a particular division and done through contractual arrangements using one-time funds. Over the past five years, however, leadership in the Office of Family Health Services has made a strong commitment to improving MCH surveillance capacity through the use of Title V, State Systems Development Initiative (SSDI), and other funding.

Using SSDI funds, Virginia has made significant improvements in MCH surveillance capacity in the past two years. In October 2004, a Ph.D. level MCH Epidemiologist was hired with SSDI funds via a contract with the Department of Epidemiology and Community Health within Virginia Commonwealth University's (VCU) emerging School of Public Health. In order to lead and direct MCH surveillance activities across all OFHS division, this position was placed at the office level in the Policy and Assessment Unit.

Improvements in access to health status indicators updated on a regular and timely basis have occurred since the hiring of the MCH Epidemiologist. A Memorandum of Agreement (MOA) with Vital Records and the Center for Health Statistics grants all OFHS staff access to complete statistical data files on birth, death, fetal death, linked birth-infant death and intentional terminations of pregnancy. With assistance from the CSTE Fellow, the MCH Epidemiologist established the OFHS Data Mart through which all OFHS staff may now access cleaned and standardized 1995-2004 vital records data and 1996-2004 hospital discharge data. Protocols are also in place to automatically append new data as it becomes available. Provisional data (monthly births and deaths; quarterly hospital discharges) and Census data are expected to be included in the OFHS Data Mart by the end of 2006. The Data Mart will enable OFHS staff with easy access to the health status indicators for use in program planning and evaluation. An office wide surveillance system is being developed that will establish systematic reporting and review of health status indicators.

Currently the OFHS Division of Women's and Infants' Health uses data for Health Status Indicators # 01A, 01B, 02A, 02B, 07A and 07B. This information is available from the Center for Health Statistics which also provides county/city data for local planning and evaluation efforts. The data provides a basis for developing plans and resource allocations for such initiatives as Healthy Start, Resource Mothers, and the educational programs offered by the Regional Perinatal Councils.

The OFHS Division of Injury and Violence Prevention is responsible for addressing Health Status Indicators # 03A, 03B, 04A, 04B and 04C. The division uses these data to target education and prevention efforts and to evaluate these efforts. The primary source of information for planning and policy development is the hospital discharge database.

Health Status Indicators # 05A and 05B are primarily monitored by the Office of Epidemiology's Division of Disease Prevention. This information is used to target education, prevention, and testing efforts to appropriate subpopulations and geographic areas. The OFHS Family Planning Program (Title X) located in the Division of Women's and Infants' Health coordinates planning and services with the Division of Disease Prevention.

The demographic data (Health Status Indicators # 06A, 06B, 08A, 08B, 09A, 09B, 10, 11, and 12) are used primarily for long-range planning. Child death statistics are used by the Child Fatality Review Team (funded by Title V) located in the Virginia Department of Health's Office of the Chief Medical Examiner. The team makes recommendations for policy and procedures to prevent child deaths. The Regional Perinatal Council's FIMR teams use data on fetal and infant deaths to develop strategies for addressing the causes of deaths within communities across the state. Data on enrollment in WIC, Medicaid and SCHIP inform outreach efforts. Data on households headed by a single parent, TANF, foster home care, enrollment in food stamp programs, juvenile crime arrests and high school drop-out rates are not used specifically for MCH programs. Poverty statistics inform planning for most human service programs for Virginia families.

## F. Other Program Activities

DIVP is coordinating a state child and adolescent violence prevention planning process (ESCAPE) funded with a grant from the Centers for Disease Control. DIVP is partnering with the Department of Education and the Department of Criminal Justice Services and the Center for School-Community Collaboration at the Virginia Commonwealth University on school staff development related to bullying prevention. As part of this project, an initial set of materials will be provided to up to 100 schools to enable them to have a staff committee complete the training necessary to implement bullying prevention programs based on the evidence-based Olweus model. DIVP is coordinating RADAR, a statewide medical outreach initiative to improve assessment and referral of victims of domestic violence and to promote the development of model hospital domestic violence assessment and response policies. DIVP also continues to coordinate general, teen and male outreach projects aimed at preventing sexual violence as part of a CDC Rape Prevention Education Cooperative Agreement.

In FY 05, all seven Regional Perinatal Councils trained a total of 17,446 professionals in obstetrical (355), neonatal (378) and other programs (184) totaling 1461.69 program hours. Most were nurses (4,423) and respiratory therapists and consumers (10,509), while others were physicians (1,207), health educators (861), social workers (141), resource mothers (228), and nutritionists (77).

The Virginia Department of Health's Early Childhood Health Program in collaboration with the Emergency Preparedness and Response Program developed It Pays to Prepare, an emergency preparedness guide for use by child care providers. It was paired with the First Aid Guide for School Emergencies to help child care providers manage emergencies. The guidelines and flip charts have been distributed to 20,000 child care providers throughout Virginia. Funds from 2006 are being used to reprint the guide.

A second initiative in partnership with the Virginia Department of Social Services is the development of a statewide medication administration program for unlicensed personnel who work in the child care industry. Effective June 1, 2007, any child care provider who chooses to administer medication, with the exception of over-the-counter topical ointments, sunscreen and

topically applied insect repellant, to children in a child day program, must successfully complete a medication administration training (MAT) developed or approved by the Department of Social Services in consultation with the Department of Health and the Board of Nursing and taught by an RN, LPN, physician, or pharmacist.

Virginia was awarded a Pregnancy Risk Assessment Monitoring System (PRAMS) grant effective April 14, 2006. Implementation work has begun in order to be operational by April 2007. A PRAMS advisory committee made up of key perinatal stakeholders has been established and will have their first meeting in August. PRAMS will partially fund a coordinator and a data analyst. The Title V Block grant will provide the remaining funds for these positions. The actual daily operations will be performed by the Virginia Commonwealth University's Survey Research and Evaluation Laboratory (SERL). SERL is also the contractor for the Virginia Behavior Risk Factor Surveillance System (BRFSS). The PRAMS data on such areas as intendedness of pregnancy, postpartum depression and risk behaviors during pregnancy will fill a major data gap and will assist Virginia in targeting perinatal services, evaluating programs and allocating resources.

The Virginia Alliance of Information and Referral Systems (VAIRS), the Virginia Statewide Information and Referral System and the Virginia Department of Social Services has partnered to implement 2-1-1 VIRGINIA, an easy to remember and universally recognizable number to help connect indiviuals and families in need to appropriate community-based services. On February 10, 2006, 2-1-1 VIRGINIA became available to all people in Virginia except those located in the Northern Virginia area. It is anticipated that Northern Virginia will have access to the system in 2007. Northern Virginia residents can continue to dial 1-800-230-6977 which was the previous statewide number. The Virginia Title V program will continue to use this information and referral network as the MCH HelpLine and work the organization to ensure that information on MCH services are available. The website for 2-1-1 VIRGINIA is www.211virginia.org See attached 2-1-1 Virginia brochure.

## G. Technical Assistance

General Systems Capacity

1. Technical assistance in how to establish and work effectively with advisory groups. Much of our MCH work includes the participation of advisory groups. The identification of advisory group members and the role of the advisory group are extremely important in obtaining input into identifying priorities, targeting resources, identifying promising programs, developing policies, and evaluating program outcomes. New England Serve recently provided this training for our CSHCN program. We are requesting that they provide a similar training for the remaining MCH program staff.

2. Financial/Grant Monitoring Systems. Identify states with proven practices in Title V financial/grant monitoring systems. A Virginia team would make site visits to determine how the best practices may be included in an updated Virginia system. Virginia is considering improvements to the Title V financial/grant monitoring system and also has a number of new financial/grants administration staff that would benefit from other states experience.

Data-Related Issues

1. Data Linking. Seek Assistance from a state that has successfully linked data such as birth records, death records and Medicaid files to provide guidance to Virginia's efforts. Examples of the consultant state's assistance could include lessons learned and examples of how the linked data is currently used. (This also supports Virginia's SSDI efforts)

# V. Budget Narrative

## A. Expenditures

State fund expenditures for Maternal and Child Health Services listed on Form 3 show a negative variance from that budgeted. This is due to state budget cuts. However, Virginia met the required match and exceeded this with program income. Form 4: Expenditures for pregnant women served exceeds that budgeted by $219,772.72. The expended amount is based on the actual visits while the budgeted amount is an estimate based on the prior year's visits. The amount expended for infants again increased in FY2005 due to the increased funding to support screening activities and visits. Expenditures for services to Children 1 to 22 falls short of the budgeted amount by $743,227.30. This is the result of the vacancy of several key positions providing such services during this reporting period. This is also true for Children with Special Health Care Needs (CSHCN) and Others. Additionally, Form 5 shows that Direct Health Care has a variance from the budgeted amount. This reflects a continuing decrease in the provision of direct clinical services in the local health departments (LHD) as well as reasons identified above. Virginia continues to emphasize health education and translation services geared toward pregnant women, infants and children. Additionally, Virginia has been moving toward population-based services as opposed to direct provision of care. Form 5 indicates significant variation in expenditures by types of service. The rationale behind this is discussed above. Also, a concerted effort to secure reimbursement through other sources (Medicaid, commercial insurance, etc.) for direct service provision has proven extremely effective. Infrastructure building expenditures fall below that budgeted due to prior year activities that resulted in enhanced infrastructure.

## B. Budget

The Title V block grant budget provides funds for maternal and child health (MCH) services, primary care for children and adolescents, and preventive and maintenance services to CSHCN. Preventive and primary care services include policy and procedural oversight, nutrition services, LHD agreements, pharmacy and laboratory testing, Regional Perinatal Coordinating Councils (RPCC), Fetal/Infant Mortality Review, Newborn screening/follow up, and reducing health problems and risk factors. Other services provided are promotion of health and provision of comprehensive health services, assessment, management of secondary and tertiary care, injury prevention, Child Care Nurse Consultant, Medical Home/Access to Care, Resource Mothers (RM), primary care, school health, family planning (under age 22), teen pregnancy prevention, maternal health (under age 22), laboratory testing, pharmacy, sickle cell services, and dental health.Population services include policy and procedural oversight concerning women's services, agreements with LHD for family planning services, laboratory testing and pharmacy services.Services for CSHCN include family-centered, community-based coordinated care for persons from birth through age 20 who have or are at risk for disabilities, handicapping conditions, chronic illnesses and conditions or health related educational or behavioral problems, and development of community-based systems of care for such children and families. Administrative costs are incurred by the Virginia Department of Health (VDH) in administering grants by individuals other than those solely supporting the grant. As in previous years, the FY07 budget does not include administrative costs. VDH's definition of administrative costs includes management and policy direction, accounting and budgeting services, personnel services, and support services for supplies, equipment, etc.Virginia budgets 30% or more of MCH funding for preventive and primary care services for children. At least 30% is also budgeted for CSHCN. $4,892,912.10 (45% of total funds; 36% of federal funds) is used for preventive and primary care services for children (including infants) and adolescents; $9,909,357.00 (38% of total funds; 36% of federal funds) is for CSHCN. The remaining funds will be used for pregnant women, mothers, and non-pregnant women over 21 years. State funds provided for FY07 for MCH exceed the fiscal year 1989 level. Between October 1988 and September 30, 1989 (FY89), $8,718,003 in state funds for Title V services was expended; the FY07 state allocation, including program income, is $13,293,841. This exceeds the 4:3 requirement by $3,901,096.75. During FY89,

$9,033,260 in federal fund was expended and Virginia overmatched the 4:3 requirement by $1,943,058. State funds expended in 1989 included all funds used for the Title V match and overmatch for all Title V-funded units and for childhood immunization. Title V funds are used to carry out the purposes of this title and the following activities previously conducted under the Consolidated Health Programs: Lead poisoning prevention and Genetics. Virginia did not receive Sudden Infant Death Syndrome (SIDS) funds; however, the Division of Women's and Infants' Health provides information to families of SIDS infants. Based on the State's previous use of funds under this title, a reasonable proportion of allotted funds will be used to carry out the purposes described in Section 501(a)(1)(A) - (D). The total budget is estimated to be $25,817,500. Title V funds ($15,908,143) will be used for preventive and primary care services for pregnant women, non-pregnant women of child bearing age, mothers, infants, children and adolescents. These funds will be used for family planning, LHD prenatal and child health services, genetic testing/counseling/ pharmacy and education, RPCCs, primary care, injury prevention, and local programs to reduce infant mortality. These services meet Section 501(a)(1)(A) and (B). Title V funds ($9,909,357) will be used for CSHCN, meeting purposes in Section (a)(1)(C) and (D). Additional federal funds CDC programs totaling $11,376,006. Funds for Healthy Start are $1,050,000; SSDI, $100,000; CISS, $126,000; and Abstinence Education, $841,329. Another source of MCH targeted funding is the Women, Infants, and Children (WIC) nutrition program estimated to be $86,651,057. In FY07, $7,752,084 in "other" federal funds includes: Department of Medical Assistance Services for RM ($447,500). Title X provides $4,527,671; Department of Social Services provides Temporary Assistance to Needy Families funding totaling $1,979,300 (Teen Pregnancy Prevention, Partners in Prevention, etc.); Maternal and Child Health Bureau additional funds include Universal Hearing Screening totaling $397,613. SAMSHA funds Youth Suicide Prevention at $400,000. Nearly $44 million in state and local funds and revenues are used for MCH services. Lead Screening Services have been relocated to the Office of Environmental Health.There are no known unobligated balances for the state fiscal year ending June 30, 2006. Funds will be used to enhance population-based services and infrastructure activities and to support innovative research-based pilot projects.

## 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.