

STATE TITLE V BLOCK GRANT NARRATIVE

STATE: VA

APPLICATION YEAR: 2005

I. General Requirements

[A. Letter of Transmittal](#)

[B. Face Sheet](#)

[C. Assurances and Certifications](#)

[D. Table of Contents](#)

[E. Public Input](#)

II. Needs Assessment

III. State Overview

[A. Overview](#)

[B. Agency Capacity](#)

[C. Organizational Structure](#)

[D. Other MCH Capacity](#)

[E. State Agency Coordination](#)

[F. Health Systems Capacity Indicators](#)

IV. Priorities, Performance and Program Activities

[A. Background and Overview](#)

[B. State Priorities](#)

[C. National Performance Measures](#)

[D. State Performance Measures](#)

[E. Other Program Activities](#)

[F. Technical Assistance](#)

V. Budget Narrative

[A. Expenditures](#)

[B. Budget](#)

VI. Reporting Forms-General Information

VII. Performance and Outcome Measure Detail Sheets

VIII. Glossary

IX. Technical Notes

X. Appendices and State Supporting documents

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to 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

The required federal Assurances and Certifications regarding non-construction program, debarment and suspension, drug free work place, lobbying, program fraud, and tobacco smoke are available for inspection in the state MCH program's central office located in the Office of Family Health Services, Virginia Department of Health, 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; published June, 2003; expires May 31, 2006.

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. Over the past years, the OFHS Family and Community Health Advisory Committee has provided input into the identification of MCH needs. The opportunity for public comment was publicized on the OFHS web site (www.vahealth.org), on the Commonwealth Calendar website, the Virginia Register and through direct notification of numerous stakeholders including the 35 district health departments. After transmittal to MCHB, the application will be available on the OFHS website and upon request for public review and comment. The OFHS also will continue to seek opportunities during FY 05 to present an overview of Virginia's Maternal and Child Health programs funded by Title V at various meetings with interested parties. (See attached Request for Public Input.)

Plans are currently under development for public hearings in the 5 health planning areas prior to the completion of the 2006 MCH Needs Assessment. Interviews will also be held with key stakeholders and the OFHS advisory groups will be given an opportunity for input into the needs assessment process.

II. NEEDS ASSESSMENT

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

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 Virginia Department of Health (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.state.va.us for a state map showing local health districts.)

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. Difficult terrain, lack of medical services and transportation issues pose barriers to health care for 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. However, more than three-fourths of the state population lives within metropolitan areas, according to the U.S. Census.

According to Census 2000, Virginia ranks as the 12th most populated state with 7,078,515 residents. This is a 14.4 percent increase from 1990. 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 1,738,262 residents under age 18, the 14th highest child population in the country. This number represents a 16 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 28 percent of the population and women of childbearing age make up approximately 24 percent of the population. According to Census 2000, 6.5 percent of residents of the Commonwealth are under age 5 and 20.8 percent are 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. Virginia ranks as having the 16th largest Hispanic population and the 9th largest Asian population in the country. The Census 2000 shows a continuing trend in racial and ethnic diversity in the state. The Virginia population in 2000 was 4.7 percent Hispanic compared to 2.6 in 1990, 3.7 percent Asian compared to 2.5 in 1990, and 19.6 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 1990 U.S. Census, three-fourths of state residents had achieved at least a high school diploma or equivalency. The Census 2000 report on educational attainment indicates that the percentage of high school graduates or higher had risen to 81.5 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 Census 2000 data, approximately 30 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 than the total state figure of high school graduates. According to data published by Annie E. Casey Foundation, 8 percent of teens ages 16-19 were high school dropouts. While the national percentage has declined from 10 percent in 1990 to 9 percent in 2000, the Virginia

percentage was unchanged in the last decade.

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 has recently 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 2003 was 4.1 percent, which is the same as March 2002. Virginia's unemployment rate remains significantly lower than the national rate of 6.2 percent in March 2003. The unemployment rate differs across the state. Fairfax city, at 2.0 percent, had the lowest unemployment rate. Martinsville, which had plant closings in 2002, had a rate of 13.9 percent and Dickenson County had a rate of 14.5 percent. Seven additional counties had double-digit unemployment rates in 2003.

The current poverty rate in Virginia is below the U.S. figure of 12.4 percent. In 1999, 7 percent of Virginia's families were living at or below the Federal Poverty Level as compared to 9.2 percent nationally. Based on 1999 data, Virginia ranks 47th, having the 3rd lowest statewide poverty rate in the country. The median household income in 1999 was \$46,677 compared to \$41,994 nationally. 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 2000 only 35 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 childcare 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 1999, approximately 10 percent of Virginia's children were without health insurance and approximately 25 percent of children in poverty were without health insurance. However, estimates of uninsured children in Virginia range between 7 percent and 14 percent. While the percentage of children living at or below 200 percent FPL has decreased since 1990, the proportion of uninsured children in this cohort has steadily increased and was estimated to be as high as 28.5 percent according to Current Population Survey data for 1998-2000 three year averages.

Health Status Indicators

Specific health status indicators highlight some of the challenges that Virginia faces. Unintentional injuries took the lives of 2,415 Virginians in 2002, 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 2002, 414 people were homicide victims in Virginia (down from 491 in 2001). Of the 414 homicides, the majority was by firearms and explosives. Approximately 21 percent of all the deaths in 15-19 year-olds were classified as homicides in 2002. Homicide disproportionately affects the young African American male. During the next year The Center for Injury and Violence Prevention (CIVP) will continue their youth violence prevention program and will work with the Department of Education to address the youth violence issue. Thirty-seven youth ages 10 -- 19 died from self-inflicted injuries in 2002. The CIVP will continue their suicide prevention activities during FY 05.

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 2002, the rate was

7.3 per 1,000 live births. However, there continues to be an increasing disparity between the rates for white and for African American infants. In 2002, the rate for white infants was 5.6/1,000 as compared to 14.5/1,000 for African American infants. The African American infant mortality rate increased from 12.4/1,000 live births in 2000. There was a slight decrease from the 15.1/1,000 in 2001. 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.

Of Virginia women having a live birth in 2002, 84.7 percent received early prenatal care. During the same period, approximately 1 percent of women 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 mothers of African American and other races in Virginia has not significantly changed from 1995 through 2002. 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.

Low birth weight is an indicator of limited access to health care and a major predictor of infant mortality. In 2002, 7.8 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.

Pregnancy rates for teens decreased over the past five years from 34.1 per 1000 females in 1998 to 27.6 in 2002. However, the black teen 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.

Public Health Infrastructure: The Turning Point Initiative

In 1998, the Virginia Department of Health, in partnership with the Virginia Hospital and Healthcare Association, was awarded a Turning Point grant from the Robert Wood Johnson and W.K. Kellogg foundations. Virginia's Turning Point has four major goals: to obtain community input on the roles and responsibilities for public health agencies; to improve decision makers' understanding of and value for the contributions that public health and its partners make to create and sustain healthy communities; to develop, collect, analyze, and share health-related data that support information-based decisions for Virginia communities; and to ensure that the public health work force has the skills needed in the future.

During the first two years of the Turning Point Initiative, activities focused on obtaining community feedback on the future roles and responsibilities of public health. This resulted in the development of a web site, group presentations, a statewide telephone survey, key informant discussion groups and regional forums. From this feedback it was determined that the most critical needs for Virginia public health relate to information and education, and changing the "ownership" of public health so that every sector, public and private, works together to invest in the future of public health. As a result, the two overarching recommendations are to launch a Community Health Improvement Plan and create a Center for Community Health.

Virginia was awarded funding from Robert Wood Johnson Foundation to implement the four-year Turning Point Community Health Improvement plan. The plan includes performing community health needs assessments, assessing the economics of prevention, and promoting public health awareness. The creation of a Center for Healthy Communities with public/private governance and leadership has greatly increased the opportunity for public health research and has created an independent voice for public health issues. The Center is working to study the costs, benefits and long term implications of health policy decisions related to public health by facilitating collaborative efforts between public health and its partners.

Virginia's Turning Point partners engaged a consultant to inventory community health needs assessment activities around the Commonwealth. An online database documents where community

assessments have been completed and assesses the comprehensive nature of the activity. The Virginia Center for Healthy Communities has also developed a web-based health data tool called the Virginia Atlas of Community Health. The Atlas includes zip code level mapping of various population, economic, and health indicators. The Atlas is available to the public free of charge and is an easy-to-use resource for communities to utilize in assessing local needs and forming a community health improvement action plan. The Atlas can also be used to identify and measure progress toward community health improvement goals.

Virginia has also developed a web site that provides tools and resources for community health improvement activities. The web site includes community health indicators; advice on implementing community health improvement programs; effective program research; and community health news and information.

In addition, Turning Point will continue to focus on the provision of training to VDH staff and community partners in developing effective public awareness and social marketing strategies. In 2001, Turning Point sponsored a prevention effectiveness training for VDH staff. A poster has been developed to promote the use of social marketing concepts, and Virginia Turning Point collaborated with other Turning Point states to produce a Social Marketing 101 course and a tool to be used in planning social marketing interventions: CDCynergy -- Social Marketing Edition. Virginia is sending four individuals to a Train-the-Trainer course on CDCynergy -- Social Marketing Edition so that VDH staff and community partners throughout Virginia can have access to training on this tool. Turning Point is also providing free training around the state on how to use the Atlas and how to conduct community health needs assessments.

Turning Point has held three Business Roundtables on Health. The first highlighted a variety of Richmond area business leaders discussing workplace wellness initiatives and their impact on employee morale and productivity. The second, also held in Richmond, featured three speakers addressing the issue of rising healthcare costs and the ways that employers can impact them. The third, held in Chesapeake, brought together several local business leaders to participate in a panel discussion around the fiscal and physical rewards of wellness programs; the event also featured keynote speaker Congressman Randy Forbes.

Turning Point is also working on a current research project ranking the health status of Virginia localities and comparing them to the state average. Researchers from Virginia Commonwealth University and the University of Virginia are consultants on the project. In addition, Turning Point is also dedicated to working with businesses to improve Virginia's overall health status. A worksite-based diabetes prevention project is being implemented with the Wytheville-Wythe-Bland Chamber of Commerce. The project team also includes representatives from the local health department and local hospital. The program focuses on small employers that belong to the Chamber of Commerce, and it encourages them to schedule free on-site diabetes screenings for their employees. Nurses and health educators will counsel employees about their risk for diabetes and will also provide them educational materials appropriate for their diabetes risk status.

Access to Health Care

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 has 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. The Virginia Department of Health (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. Title V staff served on the Outreach Oversight Committee required by law. At this time the FAMIS Outreach Plan included specific strategies for improving outreach and enrollment in localities having less than statewide average enrollment and enrolling children of former TANF recipients.

Work continued on the FAMIS implementation during 2001. DMAS and DSS staff worked closely to determine the requirements and design of the FAMIS application and to develop an automated FAMIS eligibility determination system. The FAMIS benefit package was designed to be similar to the enhanced package provided to State employees under Key Advantage. It included well child and preventive services, mental health and substance abuse services, dental and vision services. DMAS also worked with current health plans to encourage participation in FAMIS. An Outreach Oversight Committee composed of representatives from community-based organizations engaged in outreach activities, social services eligibility workers, business associations, the provider community; and health plans and consumers was active. DMAS also created several internal teams to assist the Outreach Oversight Committee. Title V staff served on numerous subcommittees of the Outreach Oversight Committee. A Community-Based Organization (CBO) Outreach Committee traveled throughout the state and to North Carolina to meet with local DSS representatives, advocacy, and community-based organizations to identify "best practices" that address the barriers to outreach and enrollment. In addition, DMAS surveyed 55 local DSS offices in the Central and Tidewater areas to solicit feedback on enrollment barriers and "best practices" and mailed letters to 6,250 former TANF recipients to obtain information on barriers to enrollment.

A toll-free information number (1-866-87FAMIS) was made available and included a language service for translations. Brochures were developed in English, Spanish, Vietnamese, Farsi, and subsequent ones in Korean, Arabic, and Russian. The FAMIS application forms are in both English and Spanish. DMAS contracted with the Virginia Health Care Foundation (VHCF) to fund community organizations to provide outreach. They expect to continue funding for 6 or 7 of the original 12 Project Connect grantees. An RFP was issued on July 23, 2001. DMAS had a one-year contract with SignUpNow, a project of the Virginia Coalition for Children's Health to provide training for community service providers to help them to understand FAMIS and the application process so that they can better assist their clients. The SignUpNow project continues to provide outreach services to DMAS.

Despite these efforts Virginia lagged behind other states in enrollment. Administrative difficulties in administering two separate programs produced problems for both DMAS and recipients. Families

could have children in both programs causing the family to navigate two different service systems with different reporting requirements, different applications, different benefits and different cost-sharing requirements. To remedy many of the administrative problems, a number of changes were undertaken in 2002. To prevent families from having different children enrolled in both programs at the same time, a Medicaid expansion SCHIP program was added for children between the ages of six and eighteen in families with incomes up to 133 percent of FPL. Renewed marketing and outreach efforts accompanied a new, common application with common income verification procedures. Families were allowed to apply for either program at a DSS office or through a central processing center. Once they had applied, both Medicaid and FAMIS used the same verification procedures so eligibility determination was seamless and did not require any additional documentation. In addition, FAMIS eliminated premiums.

The effect of these changes was pronounced. From September 2002 to September 2003 the percentage of eligible children enrolled in Medicaid and FAMIS increased from 72 percent to 86 percent.

In addition, 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 grew 25 percent between September 2002 and February 2004, increasing from 297,030 at the time of the reorganization to 370,752 covered children in February of 2004. It is thought that currently 90 percent of estimated eligibles are enrolled.

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 work closely with these staff and offer assistance in program design and outreach.

Currently, VDH is working closely with DMAS on eligibility issues. VDH is incorporating the FAMIS/FAMIS Plus application into its Web Vision system (computer system for local health district operations). At a minimum, VDH staff would be able to assist an eligible recipient with the application. If approved by DMAS, VDH may also be approved for income determination purposes therefore being able to facilitate enrollment of eligible recipients immediately.

VDH continues to work with DMAS on various other issues. For example, the Commonwealth of Virginia was awarded a federal Medicaid Infrastructure Grant effective January 1, 2002 to develop infrastructures that support the gainful employment of people with disabilities by targeting improvements to the state's Medicaid Program. A Medicaid Buy-In program, as proposed, would allow working people with disabilities to pay a premium to participate in the State's Medicaid program as though they were purchasing private health care coverage. State agencies in Virginia initiated a collaborative effort by involving consumers, providers and advocates in the development of a Medicaid Buy-In option. During the 2003 Session of the Virginia General Assembly, legislation was passed requiring the Department of Medical Assistance Services to seek a waiver from the Centers for Medicaid and Medicare Services to establish a Medicaid Buy-In Program. Eligible individuals will include those with incomes at or below 175 percent of the federal poverty level. This bill also requires that the waiver be developed by October 2003 in order that the fiscal impact of the program be considered in the development of the 2004-2006 biennial budget. This effort has renewed legislative interest as a result of the Olmstead decision.

The Virginia Children with Special Health Care Needs Program has provided support to the development of this initiative. Many of the children served through the Care Connection for Children (CCC) network are able to be employed as they age out of the program, but are at income levels that cannot sustain the premium cost of private insurance.

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 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, WIC recipient information for FAMIS outreach purposes, and the sharing of foster child enrollment for immediate case assessment and intervention services. The implementation of this law has become the project of both the Secretary's Council on HIPAA Compliance and the Secretary's Council on Audit and Control. 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.

In 1996, mandatory managed care enrollment in a contracted HMO began in seven Tidewater cities. The next expansion occurred in 1997 to include an additional six cities and counties in the surrounding Tidewater area. Beginning April 1, 1999, approximately 69,000 Medicaid recipients and CMSIP enrollees in 33 localities were transitioned into the Medallion II program in the Central Virginia Region. This area consists of the Richmond metropolitan area, Eastern Shore and the Southwest Tidewater areas. Effective October 1, 2000, Medallion II expanded to include managed care eligible Medicaid recipients and CMSIP enrollees residing in nine additional localities including the City of

Fredericksburg, Caroline, Cumberland, King George, Lunenburg, Mecklenburg, Spotsylvania, Stafford, and Westmoreland County. In July 2001, Medallion II expanded to cover the remainder of the state with the exception of the Bristol area in the far southwest portion. Currently seven MCOs serve 103 localities through the Medallion II expansion. There are no participating MCOs in 33 localities. Recipients in these areas receive services through the Medallion I (Primary Care Case Management) model. Effective July 1, 2002 the MCOs have additional program and reporting responsibilities resulting from refinements in their contract with DMAS. Upon request, VDH provided input on the content of the contract. Contractual emphasis was placed on issues related to maternity, birth outcomes and children with special health care needs. All participating MCOs must 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. Also, special programming requirements were added in order to guarantee access to multidisciplinary practitioners for children with special health care needs. The MCOs must now establish a medical home for these children, ensure direct access to specialty services, maintain intensive case management services, and provide reimbursement for services rendered from a non-participating provider when needed. In addition, the workgroup known as the Prenatal, Infants, Children, and Special Needs (PICS) was convened to continue to bring representatives from state agencies and the private sector together to discuss issues related to the care of these populations. The primary goals are to share information and work collaboratively to improve access to prenatal care, address issues of children with special needs, and provide a forum for developing solutions.

Current discussions with DMAS involve the redesign of the 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. DMAS recognizes that the central component of BabyCare, intensive nurse case management, is of value to high-risk women. They have agreed to work 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.

The local health districts continue to be essential participants in the MCO delivery system. As the expansion network provider contracts were negotiated from central office, the OFHS managed care policy analyst played 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. As their service capacity has become intertwined with the Care Connection for Children network, we have been able to initiate negotiations with MCOs to provide reimbursement to the network for supplying the contractual functions defined above for children with special health care needs. The local health districts are network providers for all Medicaid HMOs with the exception of one small plan.

State Health Agency 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 Virginia Department of Health such as the Office of Minority Health, the Office of Health Policy, and the Division of STD/AIDS within the Office of Epidemiology. These collaborative relationships along with continued assessment of the health status of Virginians

provide the basis for the establishment of MCH Priorities.

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. The overall health status of Virginia's families has continued to improve in the past five years as evidenced by declining mortality rates, most noted in infants and children. Deaths due to low weight births, congenital anomalies, and unintentional injuries have decreased. Health status, however, remains unequal with variations seen by race, income, age, insurance coverage, and residency. These variations continue to present challenges. During the next year, the Title V efforts will continue to be focused on improving data systems, analysis and reporting capacity, reducing racial disparities, increasing quality health services, improving access to quality health services, and improving identification of at-risk populations and assuring linkage with prevention, early intervention and family support services. In addition, this year Title V efforts will continue to focus on three specific health outcome areas: reducing childhood obesity, reducing dental disease among children and adolescents, and reducing mortality and morbidity from injury and violence. The Title V funded programs will continue to promote the overall health of women, infants and children, reduce injury and violence, and promote healthy lifestyles to enable all Virginia residents to reach and maintain their optimum level of health and well-being throughout their life.

More detailed MCH-related health status indicators were reported in the FY 2001 Needs Assessment. In addition, other emerging health trends, problems, gaps and barriers were also identified in the Needs Assessment Section.

B. AGENCY CAPACITY

The Office of Family Health Services (OFHS) within the Virginia Department of Health (VDH) is organized to address the specific needs of the Title V target populations which include women and infants, children, adolescents and children with special health care needs. Donald R. Stern, M.D., M.P.H. was named as director of the OFHS in 1997. He previously served as the director in OFHS in 1993 and then as the Acting State Health Commissioner and the Deputy Commissioner for Health Programs.

/2003/ In October 2002, Dr. Stern became the Rappahannock District Health Director. Janice Hicks, Ph.D. is currently serving as the Acting OFHS Director. It is expected that a new OFHS director will be hired in the very near future.

/2004/ David Suttle, M.D. was named OFHS Director in July 2002.

Two of the divisions within the OFHS address the specific target populations, and the other two divisions and one center address specific program areas relating to chronic disease, nutrition, dental health and injury and violence prevention. At the office level, the Policy and Assessment Unit, formerly the Research and Analysis Team, (see Section D. Other MCH Capacity for a discussion of the Unit's activities) and the Business Unit provide support for the entire office. William Bulluck was appointed OFHS Business Manager in the fall of 1999, following the resignation of Joan Martin. The following describes the OFHS Divisions and the Center for Injury and Violence Prevention:

Division of Child and Adolescent Health (DCAH)

The DCAH provides leadership in planning, developing and implementing efforts to improve the health of children and adolescents in Virginia, including services for children with special health care needs (CSHCN). Services include assessment of child and adolescent health issues, identifying resources, informing the public about child and adolescent health issues, providing assistance to state policy makers, developing programs and information systems, and providing clinical consultation and education activities. The specific program areas addressed by the DCAH include adolescent health and pregnancy prevention, child development services, children with special health care needs, lead

poisoning prevention, fatherhood, early childhood health, school health, primary care and quality assurance, and speech and hearing services including the newborn hearing screening program. The Division is also responsible for administering the Virginia Abstinence Education Initiative. A major component of the DCAH is the services for children with special health care needs. This component consists of the Child Development Services Program and the Children's Specialty Services Program (CSS). The Child Development Services Program ensures the availability and accessibility of comprehensive developmental services to children and adolescents through a network of 11 child development clinics. The CSS Program currently provides specialty medical and surgical care to medically indigent children with special health care needs through clinics in six regional centers and 28 communities statewide. Nancy Bullock, R.N., M.P.H. is the CSHCN program director. Cecilia E. Barbosa, M.P.H., M.C.R.P. is the Division Director.

/2002/ Cecilia Barbosa resigned in December 2000. Nancy Ford, the DCAH School Health Nurse Consultant, served as Acting DCAH Director until June 2001. The new DCAH director is Joanne S. Boise, M.S.P.H. Steve Conley, Adolescent Health/Teen Pregnancy Prevention Coordinator resigned during the year. This position is currently being recruited.

/2003/ The Children's Specialty Services (CSS), renamed Care Connection for Children in 2002, has started to transition its structure and focus. Six regional centers, affiliated with hospitals offering pediatric specialty services will provide culturally competent services, care coordination and family-to-family support services to all families of children with special health care needs. In addition, some centers will provide clinic services and each site will have funds to provide specialty medical and surgical care to medically indigent children. Nancy Ford, previously the School Health Nurse Consultant, now heads the newly formed Pediatric Screening and Genetic Services Unit (PSGS) in the division. This unit includes the Virginia Genetics Program which consists of Virginia Congenital Anomalies (VaCARES) and the Virginia Newborn Screening Services, which were transferred from the Division of Women's and Infants' Health (DWIH). In addition, PSGS includes the Virginia Newborn Hearing Screening program. Molly Carpenter, Policy Analyst, resigned and has been replaced by Susan Tlusty. Carol Pollock was recently hired to serve as the School-Age and Adolescent Health Nurse Consultant. The Right Choices for Youth Program was transferred from the Office of Health Policy to the DCAH. Brian Ambrose is the program coordinator. Ryan Ehrensberger is currently the Teen Pregnancy Prevention Initiative Coordinator. This was a position previously held by Steve Conley. Ron Clark continues to coordinate the Virginia Fatherhood program.

/2004/ Gale Grant, as the Adolescent Sexual Health Program Manager, oversees both Abstinence Education and Teen Pregnancy Prevention programs. Clayton Pape, the director of the Virginia Childhood Lead Poisoning Prevention Program, recently resigned. Nancy Van Voorhis is currently the acting director.

/2005/ Nancy Van Voorhis was named as the director of the Virginia Childhood Lead Poisoning Prevention Program. The Fatherhood program and the Right Choices for Youth program have been eliminated due to TANF funding limitations //2005//

Division of Women's and Infants' Health (DWIH)

The DWIH provides procedural and policy oversight for Women's and Infants' Health. Services include assessment of Women and Infant's Health issues, identifying resources, informing the public about health issues impacting women and infants, providing assistance to state policy makers, developing programs and information systems, and providing clinical consultation and education activities. The specific program areas addressed by the DWIH include reproductive health, maternity and perinatal health, the Resource Mothers Program, the Regional Perinatal Councils, fetal, infant and maternal fatality reviews, genetics and newborn screening, neonatal/infant health, breast and cervical cancer detection, and the Partners in Prevention initiative to reduce nonmarital births. The DWIH also administers the Virginia Healthy Start Initiative and the Title X-Family Planning Grant. Joan Corder-Mabe, R.N.C., M.S., W.H.N.P. is continuing as the Acting Division Director until a permanent director can be recruited.

/2003/ Joan Corder-Mabe was named the division director. Her former position, perinatal nurse consultant, is in the final stages of recruitment and hiring. The Director of the Breast and Cervical Cancer Early Detection Program (BCCEDP), Audrey Butler, retired at the end of 2001 and Gail Clavet is serving as the acting director. This position is currently in recruitment. Rene Hannah, the Healthy Start Coordinator, also resigned in 2001. This position will be in recruitment by mid-summer. The Virginia Newborn Screening Program and the Virginia Genetics Program were transferred to the Division of Child and Adolescent Health.

/2004/ Kathy Heise, a former WIC nutrition manager, is currently the BCCEDP coordinator. John Mkandawire, M.S.W, M.P.H. is currently the Healthy Start Director. Theresa Taylor, BSN, MPH was recently hired to serve as the Perinatal Nurse Consultant.

/2005/ John Mkandawire, Healthy Start Director, resigned. Linda Foster, M.P.H., R.D., formerly a state nutrition coordinator, was named as the new director. //2005//

Division of Dental Health (DDH)

The DDH provides leadership in planning, developing and implementing a coordinated oral disease prevention and education program to promote optimal oral health for all Virginians and a primary care program to assure access to dental care for special populations. The specific program areas addressed by the DDH include community water fluoridation, school fluoride mouth rinse, dental sealants, baby bottle tooth decay prevention, school-based community dental health education, and clinical dental services provided through local health departments. Karen C. Day, D.D.S., M.P.H. is the Division Director.

/2003/ The Dental Division is currently fully staffed. The staffing now includes a part time dentist providing quality assurance monitoring of local public health dental clinics and a part time dentist providing epidemiological expertise.

/2004/ The dental epidemiologist position is currently vacant.

/2005/ Recruitment for the dental epidemiologist continues. //2005//

Center for Injury and Violence Prevention (CIVP)

The CIVP was established at the office level in 1998. The injury prevention initiative was formerly located in the Division of Child and Adolescent Health (DCAH) and focused on unintentional childhood injuries. The establishment of the Center expands the injury prevention focus to include intentional injuries and broadens the target population to include adults. The Sexual Assault Program, previously located in the Division of Women and Infant's Health, is also administered by the CIVP. The CIVP programs include youth violence prevention, fire and fall safety, child car seat safety restraints and motor vehicle safety, playground safety and suicide prevention. Erima Fobbs, M.P.H., formerly the Injury Prevention Director in DCAH, continues to serve as the CIVP director.

/2002/ Erima Fobbs resigned in April 2001. Rebecca Odor, the CIVP Sexual Assault Program Coordinator, is currently serving as the Acting CIVP Director. The Director's position is currently being recruited.

/2003/ Erima Fobbs returned in September 2001 as the CIVP Director.

Division of Chronic Disease Prevention and Nutrition (DCDPN)

/2003/ This division was split into two divisions: The Division of Chronic Disease Prevention and Control and the Division of WIC and Community Nutrition.

The Division of Chronic Disease Prevention and Nutrition (DCDPN) provides leadership in planning, developing and implementing efforts to reduce the morbidity and mortality of chronic diseases and improving the nutritional status of Virginians. The division seeks a variety of funding sources to pay for chronic disease interventions, coordinates and facilitates statewide activities that seek to prevent

chronic diseases, seeks opportunities to assist local communities in establishing chronic disease prevention programs, and provides resources, guidance and support for chronic disease projects initiated by other agencies. The Tobacco Use Control Program is also a component of the division. This program manages the Virginia component of the Centers For Disease Control (CDC) National Tobacco Use Prevention Project. The DCDPN also provides nutrition-related services such as assessment of prenatal, infant, and child nutrition, identifying resources, informing the public about nutritional issues, providing assistance to state policy makers, developing nutritional programs, and providing clinical consultation and professional education activities. Nutritionists from the division continue to provide technical assistance to the other divisions. Other specific nutrition-related projects include the Childhood Obesity Project, the nutritional component of the Virginia Healthy Start Initiative, the Folic Acid Awareness Campaign, Osteoporosis Education Campaign, and the Five a Day for Better Health Campaign. The Division also administers The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Donna Seward, B.S. was recently appointed as the Division Director. She has approximately 24 years of public health management experience and most recently served as the WIC Director in El Paso, Texas.

/2003/ During this year restructuring resulted in the establishment of a separate Division of Chronic Disease Prevention and Control (DCDPC). Ramona Schaeffer is currently the DCDPC Acting Director. The permanent director is currently in recruit. The new division includes a focus on cancer, tobacco control, asthma, diabetes, arthritis, and cardiovascular disease. The DCDPN was renamed the Division of WIC and Community Nutrition. Donna Seward continues to serve as the Director. The major project during this past year has been the implementation of WICNet, a new information system. The implementation will be complete in August.

/2005/ Karen Feagin is serving as the Policy Analyst for the Division of WIC and Community Nutrition. //2005//

/2005/ In FY 04 the OFHS requested technical assistance to complete a CAST-V assessment of the office's MCH capacity. The request was approved and in September 2004, a representative from Johns Hopkins University will assist OFHS in completing the assessment. //2005//

/2004/ Ramona Schaeffer was named director of the Division of Chronic Disease Prevention and Control. During the past year, the Virginia Cancer Registry was relocated from the Office of Epidemiology to the Division of Chronic Disease Prevention and Control. The Division of WIC and Community Nutrition completed the implementation of WICNet. An Integrated Project Team (IPT) was established to determine the nutritional support needs of each of the OFHS divisions and make recommendations on how the needs could be met. The OFHS director is currently considering their recommendations.

Additional OFHS Activities:

Office of Family Health Services Strategic Plan

In the past few months the OFHS Management Team, consisting of the OFHS Director, the Division Directors, the CIVP Director, the Business Manager, and the Senior Policy Analyst, has been involved in developing the OFHS strategic plan. Following the development of the plan, each division and the CIVP developed their operational plan for SFY 01. The following are the OFHS strategic goals that will guide our activities, including our grant related activities, over the next year:

1. Improve health outcomes by strengthening families.
2. Improve the quality of clinical, preventive and community-based services.
3. Develop the capacity to meet customers' needs for accurate, reliable, timely and relevant public health information and assure its use in decision-making.
4. Improve access to health services and health insurance.
5. Improve identification of "at risk" populations and assure linkage with prevention and early intervention.
6. Reduce (racial/ethnic) minority disparities in health status.

7. Promote healthy behaviors.

In order to enhance the effectiveness and efficiency of OFHS, the Management Team has committed to a strategic planning process that includes a yearly review and update of the plan. The OFHS Strategic Plan will provide direction for all OFHS work and resource plans and allocations. In addition, the OFHS Management Team is currently assessing the organizational structure of the office to ensure that the organizational structure maximizes our ability to accomplish the OFHS goals.

/2002/ The OFHS Management Team reviewed the SFY 01 Strategic Plan and reprioritized some of the OFHS efforts. The following strategic goals will guide our activities, including our grant related activities, over the next year:

1. Develop the capacity to meet customers' needs for reliable, accurate, timely and relevant public health information and assure its use for decision-making.
2. Reduce racial and ethnic minority disparities in health status.
3. Enhance the effectiveness and efficiency of OFHS performance.
4. Improve the quality of clinical, preventive and community-based services.
5. Improve access to clinical, preventive, and community-based health services.
6. Improve health outcomes by strengthening families.

/2003/ The OFHS Management Team reviewed the SFY 02 Strategic Plan and refined and reprioritized some of the OFHS efforts. The following mission and strategic goals will guide our activities, including our grant related activities, over the next year:

The Mission of the Office of Family Health Services is to provide the leadership, expertise and resources that enable all Virginia residents to reach and maintain their optimum level of health and well being throughout their life.

1. Establish the Office as a reliable resource for objective, evidence-based, relevant public health information including program outcome evaluation and health status indicators.
2. Enable our partners to deliver the highest quality of care, including clinical, preventive and community-based services.
3. Enhance the availability, affordability and acceptability of health care services.
4. Improve health outcomes by addressing significant causes of morbidity and mortality in Virginia.

/2005/ The mission and goals remain the same. //2005//

Grant Allocations to the District Health Departments

In 1998, an advisory committee made up of district health department staff was established to develop recommendations for new allocation methodologies for the funds from four federal grants that support district health department services (MCH, Preventive Health and Health Services (PHHS) block grant, Title X-Family Planning, and WIC). The field advisory committee provided their new allocation recommendations to the OFHS management team. The Title V allocations for perinatal and child health were previously awarded based on a historical funding pattern and did not reflect changing demographics. The new methodology shifts to a needs-based methodology over time. Last year (1999) was the first year the new methodology was used. The districts received 80 percent of previous year's funding, plus 20 percent based on the district's proportion of the poverty births (200 percent FPL). This year the districts will receive 60 percent of the original funding, plus 40 percent

based on the district's proportion of poverty births. The funding for the Child Development Clinics will remain the same for the next year.

/2002/ For FY 02, the districts will receive 40 percent of their original Title V funding plus 60 percent based on the district's proportion of poverty births. During FY 02, the district health directors will establish an advisory committee to review the current Title V funding of the Child Development Clinics and make recommendations regarding future funding and management. The district health directors will also establish committees to review the current allocation methodologies for Title V, PHHS, Family Planning and WIC funding. OFHS staff will provide support to these committees. Recommendations will be presented to OFHS by early 2002.

/2003/ For FY 03, the districts will receive 60 percent of their original Title V funding plus 40 percent based on the district's proportion of poverty births. During FY 02, an Allocation Task Force was formed to make recommendations on the funding methodology to the districts. The recommendation was made to continue the funding methodology in place.

/2004/ For FY 04, the districts' Title V funding was based entirely on their proportion of poverty births as determined by Census 2000 data. This resulted in some significant changes in the amount some districts received. The formula was adjusted slightly for the current year to reduce the loss that some districts would experience.

/2005/ In FY 05, the districts' Title V funding continues to be based entirely on their proportion of poverty births as determined by Census 2000 data. Unlike FY 04, the formula was not adjusted to reduce the loss/gain that some districts experienced. This resulted in some fairly significant changes in the amount some districts received in FY 05. The investor targets that districts may choose to address with their funding remained the same as in 2004. It is anticipated that the outcome funding approach will be revisited during the next year and the investor targets will change to reflect the needs identified by the MCH Needs Assessment. In addition, the district allocation methodology will be reviewed during the next year. //2005//

In FY 2000, the OFHS implemented a new district application process for MCH and PHHS funds. A joint application was developed for MCH and PHHS to encourage and enable the districts to assess the needs of the community and fund priority programs based on community needs and the funding source requirements. This gave the districts more flexibility to target specific maternal and child health needs with both MCH and PHHS funds if they chose. The districts are required to develop a plan that is then reviewed by OFHS staff. All plans must be approved prior to the awarding of funds to the district. The joint application process will continue this year with additional accountability requirements. The OFHS program staff assigned to the district will present a summary of the district's performance to the OFHS Management Team. Districts that do not meet agreed upon performance measures this year will not receive funding in the third year. Future plans include the continued refinement of standardized site monitoring and performance measure reporting by the districts.

/2002/ The joint application process has continued. In April, a grant guidance package was sent to all districts requesting plans for the use of MCH, PHHS, Title X and WIC funds. Plans were submitted in early May and reviewed by OFHS staff. OFHS staff assignments for the MCH plan reviews were based on the districts' programmatic plans. The OFHS program staff will continue to provide technical assistance to the districts during the year and will review the two required progress reports submitted by the districts. The newly hired grants coordinator, Robin Buskey, will work with OFHS staff and the districts to increase the level of accountability for the federal funds made available to the districts. The long-term goal is to develop and implement an outcome-based funding approach. This will require training for OFHS staff and district staff.

/2003/ For FY 03, OFHS decided to discontinue use of the combined application process. Districts now apply for each of the four grants (MCH, Preventive Health and Health Services (PHHS) block grant, Title X-Family Planning, and WIC) in a separate application package. In October 2001, John LaRocca, an external consultant from the Rensselaerville Institute provided an overview of an

outcome funding approach. In February 2002, OFHS contracted with the Rensselaerville Institute to provide training to management and central office program staff to gain a better understanding of and develop tools toward implementing a results-based funding approach with the local health districts and OFHS programs. In March 2002, local health district directors and nurse managers received an overview of the results-based funding approach. In April 2002, district guidance for FY 03 MCH, PHHS and WIC funding was developed and distributed to local health districts. This guidance incorporated the principles of outcome funding. OFHS developed and provided investor targets for which the state seeks results with its Title V funds. Title V targets are measurable and coincide with identified MCH Priority Needs. In this new model, districts propose targets to be achieved with their customer populations which will lead to accomplishment of the investor target. A major emphasis is placed on identifying key customer behaviors which will result from activities and strategies. OFHS held workshops to provide local health district staff with technical assistance and guidance in completing the FY 03 results-based application. Future plans for FY 03 include the provision of train-the-trainer sessions in the fall. OFHS is looking to expand this model to other programs.

//2005/ A number of OFHS programs, including the Teen Pregnancy Prevention Initiative, Partners in Prevention and WIC, have incorporated the outcome funding approach. //2005//

/2004/ Train-the-trainer sessions were held during the year. Additional potential programs have been identified for future outcome funding implementation. The trainers will develop a plan for training other program staff in the implementation of outcome funding during the coming year. Additional training may be scheduled for district health department staff.

OFHS Family and Community Health Advisory Committee

The new OFHS Family and Community Health Advisory Committee met for the first time in September to learn about the Title V and Preventive Health and Health Services grant so that they can advise the department in the coming years. The committee also met in March to review Virginia's health status assessment and provide recommendations for the MCH and PHHS grant applications. Committee members represent different geographical regions, major players among the health professions, medical schools, parents of CSHCN, and those groups concerned with the populations served by the grants. The committee has the following purposes:

- 1) Make recommendations to the State Health Commissioner through the OFHS about critical public health issues related to healthy families and communities.
- 2) Review and comment on the health status issues being addressed by the OFHS with input on targeted population groups and ideas for obtaining impact to improve health outcomes.
- 3) Provide input on public health issues that should be considered by OFHS in developing program priorities to reduce morbidity and mortality of selected populations.
- 4) Review and comment on the State's PHHS Annual Plan and the MCH block grant application and to assist in gathering public comment on these documents.

/2002/ - The OFHS Family and Community Health Advisory Committee reviewed data from the needs assessment and reviewed the OFHS Title V and PHHS priorities. In June-July 2001, the committee members reviewed and commented on the 2002 Title V plan.

/2003/ The OFHS Family and Community Health Advisory Committee were provided an opportunity to review and comment on the 2003 Title V plan.

/2004/ Plans for the coming year include reevaluating the purpose and composition of the committee to ensure that the committee's effectiveness is maximized. This will include recommendations on the role of the committee in conducting public hearings planned as a part of the FY 06 MCH needs assessment process.

//2005/ During the next year, the OFHS Family and Community Health Advisory Committee will participate in the process of setting the state MCH priorities based on the needs identified in the needs assessment. //2005//

C. ORGANIZATIONAL STRUCTURE

The VDH is mandated by the Code of Virginia to "administer and provide a comprehensive program of preventive, curative, restorative and environmental health services, educate the citizenry in health and environmental matters, develop and implement health resource plans, collect and preserve vital records and health statistics, assist in research, and abate hazards and nuisances to the health and environment, both emergency and otherwise, thereby improving the quality of life in the Commonwealth." In carrying out these responsibilities, VDH 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 website at www.vdh.state.va.us).

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). The OFHS mission and organizational placement within VDH remain the same as described in previous Maternal and Child Health Services Block Grant applications.

Governor James S. Gilmore, III is in the third year of his term. Claude A. Allen, appointed by Governor Gilmore in 1998, continues to serve as the Secretary of Health and Human Resources. E. Anne Peterson, M.D., M.P.H. formerly the Acting State Health Commissioner was officially appointed to the position in late 1999. The position of Deputy Commissioner for Policy and Health Care Delivery, formerly held by Clydette L. Powell, M.D., M.P.H., is currently vacant. Robert Stroube, M.D., M.P.H. is currently the Acting Deputy for Health Programs.

/2002/ Governor Gilmore is currently in the last year of his term. Secretary Allen was recently appointed to serve as Deputy to the Secretary of Health and Human Services, Tommy Thompson. Louis F. Rossiter has been appointed to serve as Virginia's Secretary of Health and Human Resources. He formerly served as the Deputy Secretary of Health and Human Resources. President Bush recently announced his intent to nominate Dr. Peterson for Assistant Administrator of the Bureau of Global Health in the U.S. Agency for International Development (USAID). In January 2001, Eileen Mannix, formerly a member of the OFHS staff and more recently a New York local health director, was named as the Director of the Office of Health Policy. This position was formerly held by Clydette L. Powell, M.D., M.P.H.

/2003/ Mark R. Warner was sworn in as Virginia's Governor in January 2002. He becomes 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 has 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. Currently James Burns, M.D., M.P.H. serves as the Acting Deputy Commissioner for Public Health Programs. Rene Cabral-Daniels has been named as the director of the Office of Health Policy. She replaces Eileen Mannix.

/2004/ James Burns, M.D., M.P.H. was named Deputy Commissioner for Public Health Programs.

The Virginia State Government Organizational Chart is available at www.commonwealth.state.va.us.

D. OTHER MCH CAPACITY

Thirty-six and a half full-time equivalent positions (FTEs) in the OFHS are responsible for administering the Title V supported programs.

Senior level MCH staff includes 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.

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 15 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 all of the 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, 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 15 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 Center for Injury and Violence Prevention (CIVP). 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 assistant professor at MCV/VCU Department of Preventive Medicine and Public Health.

Carol Pollock, R.N., M.S.N., F.N.P., serves as the VDH School Nurse Consultant and State Adolescent Health Coordinator with the Division of Child and Adolescent Health. She also is co-chair for the Bright Futures Virginia project. She is the VDH school health liaison with the Virginia Department of Education and is involved with a statewide task force to address childhood obesity issues. Additional activities include working with schools to address asthma and diabetes management within the schools and providing developmental screening and depression screening workshops to public health employees and school nurses throughout Virginia. She previously was the Nurse Manager with the Children with Special Health Care Needs program at VDH. Prior to joining the state, she worked as a nurse practitioner in the Richmond area.

Policy and Assessment Unit:

The Policy and Assessment Unit, formerly the Research and Analysis Team, is located at the office level. The unit consists of a senior policy analyst, who serves as the director, a managed care policy analyst, an epidemiologist/senior statistical analyst, a health systems analyst who serves as the State Systems Development Initiative (SSDI) Coordinator, and a public relations specialist. Recruitment for a grants management specialist is currently underway. This new position will coordinate the PHHS grant activities, provide technical assistance to OFHS staff and the district staff on grant writing and performance measure development and monitoring. Individual staff within the unit also has responsibility for managing the Title V block grant, the PHHS block grant, the SSDI grant, the Behavior Risk Factor Surveillance System (BRFSS), the MultiCultural Health Task Force, the Managed Care Team, the Web Development Team and the Data and Information Team. The Unit also organizes various statistical analysis training sessions for staff. Future plans include employing a MCH epidemiologist and an evaluation specialist.

/2002/ Robin Buskey, the Grants Coordinator, was hired in March 2001. Kimberly Carswell, the statistical analyst and BRFSS Coordinator, resigned in March and this position is currently being recruited. Over the next few months, the managed care policy analyst, Kim Barnes, will be working half-time in the Commissioner's office to assist the district health departments to develop and market their services to managed care organizations. The OFHS FY 2002 Strategic Plan's top priority is to increase data capacity and assure its use in decision-making. A doctoral-level epidemiologist is currently being recruited.

/2003/ Gerges Seifen was hired in 2001 to serve as an OFHS epidemiologist and BRFSS Coordinator. He also serves as the MCH Data Contact. Kimberly Barnes continues to work closely with the district health departments to market their services to managed care organizations. She is also involved with data sharing efforts between VDH and the Department of Medical Assistance Services, (DMAS) the Medicaid agency. We were not successful in recruiting a doctoral-level epidemiologist.

/2004/ Kim Barnes, the managed care policy analyst has been actively involved in ensuring agency HIPAA compliance. She serves as the OFHS Privacy Officer and provided HIPAA training to all Care Connection for Children center managers. Each manager was provided with the Privacy Rule citation concerning public healthcare oversight authority that enables the program director to have access to all health information maintained in the data system.

/2004/ Dawn Bishop, the SSDI Coordinator, resigned in July 2002 to relocate to New York. Cecilia Barbosa is currently serving as the coordinator. One of her duties during the next year is to provide an assessment of OFHS's surveillance capacity to ensure that data is available, analyzed and monitored routinely, and is in a format that is useful for decision making. A specific emphasis will be placed on racial and ethnic health disparity data. The SSDI grant beginning in FY 04 will include support for a MCH epidemiologist and routine analysis of MCH data for the Title V application. In the future the MCH epidemiologist will serve as the state data contact person.

/2005/ OFHS has contracted with the Virginia Commonwealth University's Department of Preventive Medicine and Community Health to hire a faculty level epidemiologist to reside in the OFHS. The position is currently under recruitment. OFHS has also applied for a Centers for Disease Control and Prevention (CDC) MCH Epidemiologist placement. Virginia is one of three states being considered for the placement.

Kim Barnes, the managed care analyst, has continued to serve as the agency HIPAA compliance officer. She has conducted a number of trainings on HIPAA compliance and provides technical assistance to the district health departments on issues relating to HIPAA compliance. She also coordinated a statewide training on the new Medicare drug discount card for human services providers. She is currently coordinating an update of the MOA between VDH and the Medicaid agency. She continues to serve as a liaison to the Department of Medical Assistance Services (DMAS) on issues involving Medicaid and FAMIS.

Gerges Seifen, the BRFSS Coordinator resigned in June 2004 to enter a medical residency program in New York. The position is currently being advertised. //2005//

OFHS provides a number of opportunities for family input into the MCH and CSHCN programs. A parent satisfaction survey is used to assess the services provided by Care Connection for Children, Bleeding Disorders Program, and the Child Development Clinics. The CSHCN Program has no parent with special needs children on staff. The program does have contractual relationships with two Virginia coordinators for Family Voices and Parent-to-Parent. They provide outreach, support, mentorship, and training to parents. They also assist the Care Connection for Children centers in establishing their family-to-family support services. They provide training to health professionals to enhance families partnering in decision making. They provide training and monitoring of the primary care practices involved in establishing the medical home model in Virginia. They provided input into Virginia's state plan to meet the Healthy People 2010 goals for CSHCN. Parent focus groups have provided information on the Lead Program outreach methods. Parents also serve on various advisory boards, as task group members, and as presenters for in-service training. For example, a parent served on an expert panel for a legislative study on Group B Streptococcal Infection in Women. The parent assisted in developing statewide education materials that were distributed to over 8,000 medical professionals and families. Family representatives also serve on the Regional Perinatal Coordinating Councils, the Hemophilia Advisory Board, the Virginia Lead Task Force, and the OFHS Family and Community Health Advisory Committee. A parent representative of the Virginia SIDS Alliance served on a task group to evaluate and restructure the Virginia SIDS Notification and Referral Program. OFHS staff participates in a number of organizations supported by families, such as the Virginia Chapter of the Hemophilia Foundation, Spina Bifida Foundation, Cystic Fibrosis Foundation, Virginia SIDS Alliance, Community Center for the Deaf and Hard of Hearing, Virginia Parents Against Lead, and the Virginia Congress of Parents and Teachers.

/2003/ OFHS continues work to increase family input for its programs. The Virginia Newborn Hearing Screening Program (VNHSP) conducted a parent satisfaction survey among parents with infants who were screened for hearing loss. The new service delivery model for CSHCN builds in a greater emphasis on family-centered care and using families in the provision of services.

/2004/ Planning for the FY06 Needs Assessment will begin during this year. Special efforts will be placed on involving families in the needs assessment and public hearings process.

//2005/ The planning for the FY 06 Title V Needs Assessment has begun. Data sources are currently being identified as well as recent studies or assessments completed by other agencies and organizations. Plans include holding public hearings in each of the 5 health planning areas. Interviews will also be held with key stakeholders and the OFHS advisory groups will be given an opportunity for input into the needs assessment process. The OFHS Family and Community Health Advisory Committee will be involved in the development of the FY 06 state MCH priorities. //2005//

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. Juvenile Justice and the Department of 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 Maternal and Child Health Council, the Virginia Council on

Coordinating Prevention, the Governor's Advisory Board on Child Abuse and Neglect, and the Child Day Care Council. Neither the Maternal and Child Health Council or the Virginia Council on Coordinating Prevention has been convened during the past year. A number of the health and human services agency heads are represented on these advisory boards.

/2002/ - The 2001 General Assembly passed legislation abolishing the Virginia Council on Coordinating Prevention. The Maternal and Child Health Council has not met since 1998.

/2004/ The 2003 General Assembly passed legislation abolishing the Virginia Maternal and Child Health Council.

There are also ongoing opportunities to work with Virginia's health education programs and universities. For example, during FY 98, OFHS contracted with the Medical College of Virginia for training sessions to develop OFHS staff knowledge and skill in data analysis. In addition, OFHS also worked closely with the Center for Pediatric Research, Eastern Virginia Medical School (EVMS), in analyzing costs associated with low birth-weight infants, 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. Virginia Commonwealth University provided assistance with the Behavior Risk Factor Surveillance Survey (BRFSS), adolescent focus groups, and program evaluations including the Abstinence Initiative evaluation. The University of Virginia (UVA) recently provided assistance related to youth violence prevention activities.

/2004/ Currently OFHS contracts with Welligent (associated with EVMS) for the development and 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, has 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 Connection for Children centers to document their services and report them to the CSHCN Program. A major component of CCC-SUN that became operational during FY 03 is the documentation of the care coordination process of assessment, problem list, goals, interventions and evaluation. Using this data, the system assigns an acuity indication level of care coordination per client. The system assists the center manager in assigning new cases, monitoring the workload of the staff and validating the quality of care. The system also generates regional and statewide reports on the MCH Block Grant performance measures and the Healthy People 2010 Goals for CSHCN. In addition, OFHS contracts with two AHECs, Welligent and VPI&SU for activities related to the State Systems Development Initiative (SSDI) grant. The contract with VCU for the Abstinence Initiative evaluation and the BRFSS continues.

Contracts with the tertiary care centers for genetic consultation/services and for specialized services for children with special health care needs are also maintained. In the past, OFHS has contracted for primary care services through the community health centers.

DMAS developed and formalized a Medicaid Managed Care Advisory Committee with representatives from the five Medicaid MCOs, network providers, DSS and VDH. Representatives from Healthy Start and Children with Special Health Care Needs formally presented to the group. A second work group was formed to review prenatal, infant, children and CSHCN issues such as: the entry into prenatal care procedures, identification of CSHCN, and services for CSHCN. The perinatal nurse consultant, the Baby Care liaison, the CHSCN director, the Managed Care Policy Analyst, and the DMAS EPSDT Coordinator participate in this group that includes representatives from all the major state human services departments and the managed care groups. Discussions have centered on early enrollment in Medicaid or the CMSIP/FAMIS program. Title V staff also serve on the DMAS Prenatal, Infant, Children and Special Needs Committee, the Managed Care Advisory Committee and the FAMIS

Outreach Committee.

During the 2002 Session of the Virginia General Assembly, Senate Bill 264 was enacted that allows for the exchange of patient specific information between VDH, DMAS, Department of Social Services and the Department of Mental Health, Mental Retardation and Substance Abuse Services without concerns regarding HIPAA compliance. Currently established data sharing initiatives in the areas of lead poisoning prevention and children with special health care needs will continue. Other initiatives involve the matching of various program recipients (i.e. WIC, TANF, etc.) with Medicaid and FAMIS recipients in an effort to directly market to individuals whom may be eligible for other programs. The Managed Care Policy Analyst will work directly with the Secretary's Council on Audit and Control (the organization taking initiative for the implementation of SB 264) to establish more data sharing efforts that will improve the health and service offerings to women and children.

To facilitate the work of the Secretary of Health and Human Resources, the Title V program 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. They will continue to review and comment on legislation, regulations, and standards of other state agencies from a maternal and child health perspective.

During FY 04, the Multicultural Health Task Force (MCHTF) will continue to strengthen statewide research efforts directed at the elimination of racial and ethnic health disparities and their underlying causes. The MCHTF provides a forum among agencies, institutions and other organizations for resource sharing, problem identification and strategy implementation, linkage and network strengthening, and information dissemination. During the next year there will be a continued emphasis place on collaboration between health and human services agencies and local stakeholders serving multicultural populations. In May 2000, the MCHTF expanded into a statewide taskforce with representatives from the Virginia Department of Health, other state agencies, universities, Area Health Education Centers (AHEC), voluntary refugee resettlement organizations, and private health systems such as Bon Secours, University of Virginia Health Sciences Center and INOVA. This new collaboration at the state level brings Health and Human Services (DHHS) funded partners together to respond to the national level goal of 100 percent access and 0 percent disparities and addresses the # 2 OFHS strategic plan priority to reduce racial and ethnic health status disparities.

During FY 02, the MCHTF has identified research and information gaps as they relate to Virginia's racial and ethnic communities; existing statewide data resources; funding sources; and disseminated information to health and human services providers and communities. The State Systems Development Initiative (SSDI) proposal for FY 02-03 currently supports the work of the MCHTF and will provide funding to link key variables among data sets housed in the VDH data warehouse, such as vital records, hospitalization data and newborn screening data. Each of these data sources contains pertinent information regarding minority populations. To date, much of these data have remained independent. Linking key data will yield much higher quality information about the complex issues surrounding racial and ethnic disparities and support the Title V needs assessment process.

MCHTF has created the MCHTF State Research Agenda: Assessing Regional Racial and Ethnic Health Disparities which includes a standardized list of demographics, health outcome data, performance indicators and qualitative research questions that can be applied to all 5 VDH health services areas (HSA) in order to provide state level stakeholders with information describing disparities and contributing factors.

Additionally, Northern Virginia and Northwestern Virginia key stakeholders created two separate regional research agendas. The purpose of developing separate agendas is to provide regionally based key stakeholders with the opportunity to identify their specific informational needs and a mechanism for addressing the regional information gap. During FY 03, each of the agendas will be analyzed and results will be disseminated to all stakeholders and other interested parties through a second round of regional forums. The forums will meet an established need to link service providers with organizations and representatives from minority and multicultural groups. Insight into the

underlying causes or contributors to identified disparities will be discussed during forums, along with recommended program applications and other uses for the data. The regional reports will include both data and recommendations for strategies to eliminate racial and ethnic disparities at a regional level.

/2005/ The completion of the forums and regional reports has been delayed due to the inability of the contractor to finalize the report. A new contract with Dawn Bishop, the former SSDI Coordinator, is currently in place and it is anticipated that the key stakeholder forums will be held in late August and the regional reports will be finalized prior to September 30, 2004. //2005//

An interagency agreement exists between the Departments of Health and Medical Assistance Services 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 the Department of Health. The agreement has not recently been updated, however, a VDH/DMAS task team has been established to review and amend the agreement. New sections will most likely include such issues as data sharing, increasing the reimbursement rates for Baby Care and the new Title XXI - children's health insurance program (FAMIS). ***/2005/ Kim Barnes, the managed care analyst, is currently working on updating the VDH/DMAS Interagency Agreement. //2005//***

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, (f) making available current EPSDT program information brochures and other materials that are needed to communicate information to local health department patients, and (g) participating on the DMAS-reconvened Virginia Maternal and Child Health Workgroup to ensure communication and collaboration among its members.

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. The responsibility for the administration of Baby Care is a collaborative effort among three state agencies, i.e., the Department of Medical Assistance Services, the Department of Health, the Department of Social Services and managed care organizations. ***/2005/ The Baby Care program has not been reviewed for sometime. It is anticipated that a group representing the three agencies will review the program and make recommendations for improvements during this next year. //2005//***

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.

The Virginia Department of Health and the Department of Medical Assistance Services also have an agreement related to the Teenage Pregnancy Prevention Program. According to the agreement, the Department of Medical Assistance Services provides funding to the Department of Health for the costs of local teen pregnancy prevention programs. The Department of Health monitors the programs.

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 Fatherhood, Teen Pregnancy Prevention, Right Choices for Youth, Abstinence Initiative, the Resource Mothers Sibling 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. ***//2005/ TANF funding for VDH was reduced by the Virginia General Assembly for FY 05 and is only provided to support the Teen Pregnancy Prevention Initiative, the Partners in Prevention program and the Resource Mothers Sibling program. //2005//***

The MCH Help Line

During 1995 the OFHS evaluated the current MCH Help Line agreement with the Department of Medical Assistance Services and decided to seek information and referral services from a source more equipped to meet the needs of the maternal and child population. After evaluating a number of existing toll-free help lines, the Office of Family Health Services entered into an agreement with the Department of Social Services' Statewide Human Services Information and Referral System. The Memorandum of Agreement became effective July 1, 1996. The agreement with the Department of Social Services describes the plan for interagency administration, coordination, and financing and arrangements for collecting and updating provider data. In 2000 the agreement was amended to contract with the six individual regional sites. Data documenting maternal and child health related service calls is collected and reported to the OFHS quarterly as a condition of the agreements. This information provides data for future needs assessments and program planning. Copies of the most recent agreements are on file in the Office of Family Health Services.

The Statewide Human Services Information and Referral System is a state administered system with six regional sites across the state. 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.

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, and hearing services. During FY 03, 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.

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 the DCAH 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, the Virginia Health Care Foundation, and the Virginia Hospital Association. 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, as well as working groups such as the PASS Initiative work group.

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

F. HEALTH SYSTEMS CAPACITY INDICATORS

The health systems capacity indicators are reported annually as a measure of the ability of health systems to effectively address the needs of the MCH population. In addition, the health systems capacity indicators also include measures of the adequacy of State data systems to provide relevant policy and program relevant information and data that are essential in planning, implementing and evaluating MCH efforts. See Forms 17, 18, and 19 for specific multi-year data.

Health Systems Capacity Indicator #01: The rate of children hospitalized for asthma per 10,000 children less than 5 years of age.

Asthma is considered an ambulatory sensitive condition for which hospitalizations can be largely preventive 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. 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.

Health Systems Capacity Indicator #02: The percent of Medicaid enrollees whose age is less than one year who received at least one initial screen.

The percent of Medicaid enrollees whose age is less than one year that received at least one initial periodic screen has decreased slightly from 80.2 percent in 2001 to 78 percent in 2002.

Health Systems Capacity Indicator #03: The percent of State Children's Health Insurance Program enrollees whose age is less than one year who received at least one periodic screen.

The percent of State Children's Health Insurance Program (FAMIS) enrollees whose age is less than one year that received at least one initial periodic screen has increased from 54.1 percent in 2001 to 72.1 percent in 2002. Low utilization numbers may suggest few options for service or the presence of social issues that may influence patient/family care such as homelessness or inconsistent caregivers, lack of transportation, etc.

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.

In Virginia approximately 81 percent of pregnant women had adequate prenatal care according to the Kotelchuck Index. This percent has remained relatively stable since 1998.

Health Systems Capacity Indicator #05: Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State.

In 2002 the Medicaid population had a higher percent of low birth weight births and infant deaths than the non-Medicaid population. They also were less likely to begin prenatal care during the first trimester and to have adequate prenatal care according to the Kotelchuck Index.

Health Systems Capacity Indicator # 06: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants, children, and pregnant women.

The percent of poverty level for eligibility for Medicaid is up to 133% of the Federal Poverty Level. The eligibility for the SCHIP (FAMIS) program is up to 200%.

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

In 2002, 26.2 percent of EPSDT eligible children aged 6 through 9 years have received dental services during the year. In 1999, 32 percent received dental services. 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.

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 program.

In FY 03, 3.3 percent of Virginia's SSI beneficiaries less than 16 years old received rehabilitation services from the CSHCN Program. This is less than the 2002 level of 4.4 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 15.8% in the Care Connection for Children Program and 12.4% in the Bleeding Disorders Program. Due to type of diagnoses served in the Child Development Clinics the percentage is much lower at 2.9%. 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 # 09(A), #09(B) and #09(C): These indicators relate to the Title V

agencies ability to access data including linked data systems and childhood obesity and tobacco use data.

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 and again in 2003. 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. The Pediatric Nutrition Surveillance System (PedNSS) is not a resource for child obesity data in Virginia. The Virginia WIC program data, which are available to the MCH program, does not contain a sufficient sample of child obesity data. Individual school districts are required to routinely conduct hearing and vision screenings on students within specific grade levels. Although not mandated, some schools also collect data on heights and weights. The data are not maintained or analyzed at the state level. There is some consideration of potential legislation that would require school districts to include the collection of weight and height data.

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 does not participate in PRAMS, but is considering the use of a PRAMS-like survey of new mothers or applying for PRAMS funding in the future. In 2001, OFHS carefully considered the use of PRAMS but decided to seek other ways to collect this type of data based on the cost of administering PRAMS and the lack of available funding to support this effort.

The ability to link birth certificate data with other data such as WIC eligibility, newborn screening, infant death data, Medicaid eligibility or paid claims is mixed and requires additional work. Currently, infant birth and death certificates are linked and provided to the Newborn Screening program on an on-going basis. Linkages between the birth certificates and WIC, Medicaid data do not exist or are not routinely reported. Data from the birth defects surveillance system are available electronically.

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 healthcare. Recently diminished economic prosperity has significant implications for health care access and costs. 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, will be a major resource to continue decreasing the number of uninsured children in the state. 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. 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 strategic planning process, the OFHS Management Team reviewed Title V priorities, as well as needs assessment data and more recently completed assessments. The management team has refined the Title V priorities to reflect specific priority areas which are addressed through the program. Title V efforts will focus on Virginia's families including women of childbearing age, pregnant women, infants, children, adolescents, and CSHCN. FY 05 Title V priorities are:

1. Improve data systems, analysis and reporting capacity to ensure meaningful and quality surveillance of maternal and child health populations and health outcomes for use in the development of programs and policy.
2. Reduce racial and ethnic minority disparities in health status.
3. Reduce childhood obesity.
4. Increase quality health services through promotion of standards of care, such as Bright Futures, assessment of health outcomes and other infrastructure-based activities
5. Improve access to quality health services through promotion of early enrollment in to prenatal care, establishing medical homes and enrollment of eligible persons in Medicaid and FAMIS.
6. Improve identification of at-risk populations and assure linkage with prevention, early intervention and family support services.
7. Reduce mortality and morbidity from injury and violence.
8. Reduce dental disease among children and adolescents

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:

SPM # 2. Percent of children and adolescents who have a specific source of ongoing primary care.

SPM # 6. The rate of unintentional injury hospitalizations to children ages 1-14.

SPM # 7. The rate of assault injury hospitalizations among youth aged 10-19.

SPM # 8. The rate of neural tube defects among live births.

SPM # 9. The percent of children who are obese or overweight.

SPM # 10. The degree to which statewide data are available to monitor health-related behaviors among youth.

SPM # 11. The percent of newborns screened for hearing loss who received recommended follow-up services.

SPM # 12. The percent of low birth weight infants for African Americans in perinatal underserved areas.

SPM # 13. The percent of pregnant women in Virginia's perinatal underserved areas receiving adequate prenatal care.

SPM # 14. The percent of newborns screened for genetic diseases who receive recommended follow-up services. (Same as National Performance Measure # 1.)

B. STATE PRIORITIES

The priorities developed from the needs assessment completed in 2000 help guide Title V in addressing concerns that have arisen in this new environment. Improving access to health services and health insurance and improving the quality of health services are important priorities for Virginians. National Performance Measures (NPM)(# 2, 3, 4, 5, 6 provide measures of progress as we address these priorities in the children with special health care needs (CSHCN) population. NPMs # 7, 11, 13, 14, 15, 17 and 18 provide measures of progress as we address the needs of pregnant women, infants and children. NPMs # 1 and 8 and 12 provides a measure to show how well Virginia is addressing Priority # 6 -- improving identification of at-risk populations and assuring linkages with prevention, early intervention and family support services.

While public health and the Title V program have assumed the role of enhanced assessment, quality assurance, and redesigning the public health infrastructure, part of improving access to health services still requires direct service. Meeting the needs of vulnerable populations, such as CSHCN and uninsured pregnant women has not relieved health departments from providing direct services. While the number of patients served by clinics has fallen, particularly for Medicaid clients, health departments still operate as medical care providers and function as a safety net in many communities with limited resources. Maintaining reduced or basic services requires a base staffing level. As in the past, Title V remains a primary funding source for clinical preventive care services for pregnant women, infants and children for low-income populations, as well as providing care coordination services for CSHCN through the Care Connection for Children network.

Insurance status remains a prime indicator for health care utilization as evidenced by survey and birth certificate data. Improving access to quality health services remains a priority. Improvements have been observed in the proportion of uninsured children, but the underutilization of insurance available for children in low-income working families remains a focus for future efforts. Reducing delays in obtaining Medicaid and thereby increasing the likelihood that early prenatal care will be obtained also continues to be important. Medicaid patients, and those with no payment source, have exhibited poorer care utilization and outcomes. VDH will continue working with the interagency group, Prenatal, Infant, Children and Special Needs Committee (PICS), to designate priority areas, enhance a coordinated infrastructure, and provide a forum to make systems-based changes.

The current administration in Virginia has made increasing access to health insurance a top priority. The Governor, The Secretariat of Health and Human Resources, and state agencies such as VDH and DMAS have greatly strengthened efforts to increase enrollment in Virginia's revised Title XXI program for uninsured children, Family Access to Medical Insurance Security Plan (FAMIS). Consumer and health provider input is being solicited to develop policy and procedural changes to increase the proportion of eligible children who become enrolled in the program. Virginia's Title V program will address this priority need through participation in interagency promotional efforts, sharing of data among state agencies to identify potential enrollees, allowing local districts to utilize funds to augment their outreach and enrollment efforts, and provision of data and feedback which can help guide policy refinement.

Partnerships, such as PICS, exemplify VDH's evolving role from clinical provider to assurer of quality

services. Title V has made increasing quality health services through promotion of standards of care, such as Bright Futures, assessment of health outcomes and other infrastructure-based activities a priority. Promotion of Bright Futures signifies another VDH effort to assure and to improve quality health services among its own programs as well as with private providers serving MCH populations.

Accurate and successful assessment requires adequate data. To meet this need Title V will make improving data systems, analysis and reporting capacity to ensure meaningful and quality surveillance of maternal and child health populations and health outcomes for use in the development of programs and policy a FY 04 priority. The needs assessment identified gaps in data for measuring health behaviors among pregnant women and adolescents. Virginia will continue critical work to increase its data capacity. Significant data gaps, such as those for statewide youth health behavior, have been documented through projects such as Bright Futures Virginia: Healthy Young People 2001. To help measure progress made in statewide collection of youth health behavior, SPM #10 monitors the degree to which statewide data are available to monitor health-related behaviors among youth.

Under an expanding role for quality assurance and monitoring, a public health prime function will be providing appropriate and timely data. Title V programs have undertaken significant efforts to improve data collection systems and the ability to analyze, disseminate, and use data to assist those serving maternal and child health populations. The ability to share data to address public health needs has become a priority among top levels of state government facilitated by passage of legislation in 2002, which provides for data sharing among state agencies. With this new level of interagency cooperation, the Title V program will increase its capacity and function in assuring public health needs are identified and addressed.

The needs assessment has lead VDH to focus on promoting healthy behaviors to reduce significant causes of morbidity and mortality resulting from key concerns such as injury, violence, and obesity, and to reduce racial and ethnic disparities. To meet these needs, however, additional funds from Temporary Assistance for Needy Families (TANF), Virginia General Assembly, the Department of Medical Assistance, and the Department of Social Services have been required to supplement Title V dollars. Initiatives such as the Virginia Fatherhood Campaign and Partners in Prevention, address the critical importance of families.

Programs and resources geared to improving access to care, utilization of quality health services, and bettering health outcomes have been increasingly supported over the past years. Resource Mothers and the Baby Care Program provide case management and mentoring for pregnant teenagers and other high-risk mothers. Resource Mothers has had documented success in delaying repeat pregnancies and thus helping to ameliorate further negative economic and social consequences of teenage parenthood. Better Beginnings and Teen Pregnancy Prevention Initiative community coalitions also utilize community based activities to help identify, educate, and serve "at-risk" populations and assure linkage with prevention, early intervention, and family support services and increase their ability to access needed health services.

Continuing health status improvements in the past five years were evidenced by declining rates of infant and child mortality. These benefits have not been uniformly enjoyed by all segments of the maternal and child health population. Data showed minorities faring worse than whites in nearly all access and outcome indicators. Minority health takes on increased importance since Virginia continues to experience growing Asian and Hispanic populations. In 1998, Hispanics demonstrated the lowest proportion of first trimester prenatal care utilization. The worst outcomes, however, continue to be experienced by blacks in the Commonwealth. In fact, the gap in the infant mortality ratio between whites and blacks has increased in the past several years. Large disparities were observed in rates of low weight births, infant mortality, HIV infection, sexually transmitted diseases, teenage pregnancy, induced terminations, and homicides. Better overall health status for all Virginians remains incumbent on the ability to reduce these disparities.

In response to these trends, OFHS has sponsored the MultiCultural Health Task Force which conducted a many-faceted research initiative to identify health care needs among racial and ethnic

populations from both consumer and provider perspectives. Language emerged as a top barrier. Service providers identified needs to improve their capabilities to handle non-English speaking populations through additional translators, bilingual staff, and translated patient materials available from a centralized location. Cultural competency training and resources to conduct community outreach were among other issues named. Consumers and providers cited traditional barriers to service such as poverty, lack of insurance, and transportation as well as difficulty in navigating complex health care systems. Strengthening health providers' ability to competently serve persons from multicultural backgrounds will make better use of the resources and improve outcomes.

Data analysis also highlighted relationships between underserved areas and minority populations. Selected indicators and outcomes were utilized to identify perinatal underserved areas, a concept that encompasses both resource and underutilization patterns. Many of the 52 underserved communities have high proportions of minorities, particularly blacks, and are lacking in adequate preventive health services. In addition, many of these communities also experience higher than average proportions of teen and nonmarital births. These data have helped Regional Perinatal Councils (RPCs) better direct their efforts to specific community problems. To better target resources to reduce racial and ethnic disparities, the Virginia Healthy Start Initiative (VHSI) received funds to extend work in four communities with large disparities. To monitor progress, Virginia has two SPMs (#12, 13), which measure the percent of low weight births for African Americans in perinatal underserved areas and the percent of pregnant women in Virginia's perinatal underserved areas receiving adequate prenatal care. These measures fit with the Title V priority to reduce racial and ethnic disparities as well as improving access to health services and health insurance.

National data show an increase in childhood obesity. Over the past decade, overweight/obesity has significantly increased in children living within the Commonwealth of Virginia. A 2000 study of 4th grade students indicated that 37 percent were overweight or obese. The study found that boys have a higher prevalence of overweight than girls do (40 percent vs. 34 percent respectively) and African American children and children from "other" racial /ethnic groups are more likely to be overweight than their counterparts. Lack of regular physical activity, accessibility to calorie dense foods (candy, chips, soft drinks), larger portion sizes, family lifestyles and lack of interest in health and media messages contribute to the childhood overweight dilemma. Childhood obesity has been associated with elevated serum levels of total cholesterol. Obese children are reported to be 12.6 times more likely than non-obese to have high fasting blood insulin levels, a risk factor for Type 2 Diabetes (American Obesity Association, Sept 1999). The goal of reducing childhood obesity has become an important priority for Virginia (SPM # 9).

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. Although a dramatic decline in dental caries rates has occurred over the past several decades, many Virginia children still suffer needlessly from preventable oral diseases and conditions. Dental caries remains the most common chronic disease among U.S. children.

Dental disease and access to dental care is a chronic problem among low-income populations in Virginia. Dental surveys conducted in the Commonwealth have consistently shown that low-income children and adults have higher dental disease rates and less access to dental services. A statewide disease assessment in 1999 of more than 5,000 children showed that children on the free lunch program have higher disease rates, fewer dental sealants and lower filling needs met than their counterparts. This trend has also been confirmed for adults in the collection of data through the Behavioral Risk Factor Surveillance System Survey. In addition to improving access to quality health services and health insurance, Title V will make reducing dental disease among children and adolescents a priority.

The Center for Injury and Violence Prevention (CIVP) has been analyzing injury related deaths and hospitalizations since 1994. In 2001, injuries were the leading cause of deaths for persons aged 1 to

64. Injuries accounted for 78 percent of all deaths that occurred among persons aged 15 to 19. The Child Fatality Review Team recently reviewed 1998 unintentional injury deaths to children in Virginia who were four and under. The Team found that the majority of these deaths were preventable. Most of the fatal injuries occurred in the home setting and the findings underscored the importance of adult supervision. Reducing mortality and morbidity from injury and violence is an area of priority need. Success in this area can significantly lower child mortality (Outcome Measure #6). Two SPMs (#6, #7), the number of unintentional injury hospitalizations (children aged 1-14) and the number of assault injury hospitalizations (youth aged 10-19) help monitor progress in this area.

One of the most vulnerable populations, CSHCN, remains as a major priority, receiving a large proportion of Title V funds. Numerous special health care needs, e.g., emotional disturbance, asthma, and sickle cell anemia, affect thousands of Virginia children. The Title V program assures and coordinates health services on an individual basis for low-income families with CSHCN through its Care Connection for Children network, Child Development Clinics, Genetics Centers, and Metabolic Treatment Centers. The Newborn Screening Program, Sickle Cell Program, Virginia Newborn Hearing Screening Program (VNHSP), and the Virginia Congenital Anomalies Reporting and Education System (VaCARES) help determine CSHCN. Title V has made improving identification of "at-risk" populations and assuring linkage with prevention, early intervention, and family support services a priority. SPM # 11 and 14 will be used to monitor the progress on this priority.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

a. Last Year's Accomplishments

During FY 03, the Virginia Newborn Screening Services (VNSS) Program, which receives major funding from the Division of Consolidated Laboratories Services (DCLS) Enterprise funds (newborn screening kits revenue), continued to screen all newborns in Virginia for eight inborn errors of body chemistry (see Form 6 for specific screening data). VNSS planned for the implementation of a ninth disorder, medium chain acyl-coA dehydrogenase deficiency (MCADD), as mandated by the 2002 Virginia General Assembly.

In addition, the Virginia Genetics Program (VGP) continued to support two metabolic treatment centers for children identified through VNSS: Department of Medical Genetics at the University of Virginia and the Department of Medical Genetics at Virginia Commonwealth University. Under contractual agreements, these centers provide: (1) consultation for local health care providers to facilitate early diagnosis and treatment of infants identified as having abnormal results from newborn screening; (2) laboratory services to monitor blood levels and make recommendations for modification of diet and metabolic formula; (3) patient and family education related to specific disorders and their management; (4) coordination of necessary genetic testing for the family to assist them in making informed decisions; and (5) provision of data and long-term case management information to the VGP. The VGP manager oversees these contracts, which are funded through the Enterprise fund. The VGP also administered the provision of special food products, including formulas, for the treatment of individuals with inborn errors of metabolism.

During 2003, 76 newborns were identified with sickle cell disease and 99 percent of these newborns were tracked for referral into comprehensive care to begin penicillin treatment and prevent mortality as part of the Virginia Sickle Cell Awareness Program (VASCAP). To meet the goal of early identification and educational genetic counseling for the healthy trait carrier through screening in family planning and prenatal clinics, there were 9,729 hemoglobinopathy screens in 2003, up from 8,290 for CY 02, an eleven percent increase. VASCAP partners with

the public and private sector to provide community education and awareness on sickle cell disorders. This includes 48 professional and community health programs were provided during CY 03.

VASCAP also completed the following activities: (1) Updated guidelines for perinatal regions and family planning clinics to target the population for screening for those at highest risk; (2) developed partnerships with community based sickle cell programs to enhance visibility and reduce screening costs in the adult program; (3) identified a community-based partner for adult screening reimbursement for the Tidewater area; and (4) completed an aggregate report reflecting the demographics, genotype and clinic usage of newborns.

b. Current Activities

The Virginia Sickle Cell Awareness Program (VASCAP) provides the follow-up tracking for newborns identified with sickle cell disease (birth to five years of age). Tracking includes date of entry into comprehensive care, date penicillin is prescribed, and mortality. Biological parents of newborns identified with sickle cell disease are offered and provided hemoglobin electrophoresis through the state laboratory to differentiate between sickle cell disease, sickle beta thalassemia, and sickle with hereditary persistence of fetal hemoglobin in the newborn. One hundred percent of all clients receive appropriate educational genetic counseling when test results are obtained. Adult sickle cell screening, education, and follow-up genetic counseling continue to be provided through family planning and maternity clinics coordinated by local health departments. VASCAP offers, coordinates, and provides educational updates to all provider sites.

In spring 2004, VASCAP partnered with Virginia Commonwealth University Health System to present a statewide educational update on sickle cell disease. The conference took place in Richmond, Virginia and focused on medical case management, advocacy, research and education. The audience consisted of over 120 clients, physicians, and other health care providers who listened to and interacted with experts from the National Institutes of Health, the Maya Angelou Research Center on Minority Health, Sentara Health Care, Eastern Virginia Medical School, Children's Hospital of the King's Daughters, and the Statewide Sickle Cell Chapters, Incorporated.

During FY 04, Virginia Newborn Screening Services (VNSS), in cooperation with the Division of Consolidated Laboratories Services (DCLS), implemented screening for medium chain acyl-coA dehydrogenase deficiency (MCADD). New brochures and resource materials, geared for both parents and professionals, were developed for this effort. Statewide provider training was conducted at fourteen sites prior to implementation. All other materials, including policies and procedures, have been updated to include MCADD.

VNSS and DCLS staff have begun work to enhance the current newborn screening database. The goals are to ensure more efficient follow-up of newborns and the development of an automated mechanism to include diagnosed infants in the birth defects registry (VaCARES). VNSS continues to (1) screen all infants for nine 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. Eastern Virginia Medical School was added as a treatment center in March 2004.

c. Plan for the Coming Year

During FY 05, the VASCAP program manager will prepare a five-year aggregate report reflecting the demographics, genotype, and status of newborns identified with

sickle cell disease. The adult sickle cell screening program will also identify community partners in the Western Tidewater area. Finally, the program manager will investigate follow-up plans for education and counseling for parents whose newborns are identified with the sickle cell trait. A survey will be developed and administered to parents of children receiving services in our funded Pediatric Comprehensive Sickle Cell Centers.

In FY 05, VNSS will continue to (1) maintain screening of all infants born in Virginia for nine 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; (3) administer the provision of special food products for the treatment of individuals with inborn errors of metabolism; and (4) provide necessary education and technical assistance to providers. VGP will provide technical assistance and consultation to the Joint Commission on Health Care to conduct a study of the types of metabolic disorders for which infants are screened in other states and to compile a summary of the benefits and cost of such screening. House Joint Resolution 164 passed by the 2004 Virginia General Assembly mandated this study.

In addition, VGP will strengthen collaborative efforts with the VDH-managed CSHCN Program and the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) to link diagnosed children to needed resources, such as VDH-sponsored Care Connection for Children (CCC) -- a statewide network of regional programs that provide health care services, community support, and resources to children with special health care needs, including those with inborn errors of body chemistry -- and DMHMRSAS-managed Infant & Toddler Connection of Virginia (Virginia's Part-C Early Intervention system).

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)

a. Last Year's Accomplishments

The Child Development Clinic's (CDC) annual planning process was revised to incorporate the six goals from 2010 Express. Each of the eleven clinics was asked to include families as partners in all decisions made regarding their child's care. All CDCs surveyed parents to determine their level of satisfaction with care received. Results ranged from 85-100 percent of parents satisfied with the care received. Only one clinic received a rating below 90 percent.

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 CCC centers established family resource libraries. Two centers surveyed families to determine satisfaction with their services and made necessary changes to best meet identified needs. The 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. The CSHCN Program was awarded a parent scholarship from the Association of Maternal and Child Health Programs to allow attendance by a Virginia coordinator for Family Voices to its annual meeting. Virginia coordinators for Family Voices developed a plan to establish Family Voices of Virginia as a non-profit agency.

The CSHCN Program was also awarded the opportunity to participate in the National Institute for Children's Healthcare Quality (NICHQ) Medical Home Learning Collaborative. Parents of children being served by the practices were integral members of the three primary care practice

teams participating in the Collaborative and establishing the medical home model.

b. Current Activities

The CDCs prepared their annual plans based on the six goals from 2010 Express. They were requested to document the level of family participation in clinic operations for this fiscal year. Each clinic will continue to administer parent satisfaction surveys.

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 parent-to-parent support services.

c. Plan for the Coming Year

Central office staff will work with CDCs to encourage family involvement in all levels of care. The clinics will continue to develop and implement annual plans based on the 2010 Express goals for CSHCN.

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

Parent representatives have been invited to work with the Genetics Advisory Committee to assist that group in developing policies and programs that continue to support family-centered services.

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)

a. Last Year's Accomplishments

The Child Development Clinic (CDC) annual planning process was revised to incorporate the six goals from 2010 Express. Each of the eleven clinics was asked to assure that each child seen had a medical home and to refer the child to a medical home if one did not exist. All children seen for services were referred to a medical home. Clinics also were asked to improve communications with the medical home by sending the clinic's final report to the medical home within fourteen days. Previously, clinics had up to 60 days to send the report. This change was a challenge for CDCs with results ranging from zero to 95 percent reports mailed within fourteen days.

Three primary care practices along with a Title V team attended two learning sessions in the NICHQ Medical Home Learning Collaborative and completed between-session assignments. The Title V team included the program directors for the Hampton Roads and Central Virginia Care Connection for Children (CCC) centers that are working closely with the primary care practice teams in their catchment areas.

The CCC management team and the Division of Child and Adolescent Health Pediatric Screening and Genetics Services team finalized the plan for Virginia to meet Healthy People 2010 goals for CSHCN. The plan includes numerous activities to establish medical homes and to assist families in the use of the medical homes.

b. Current Activities

The CDCs prepared their annual plans based on the six 2010 Express goals and were requested to refer all children to medical homes. Clinics have been successful in referring children; however, they still face the challenge of sending reports to the medical home in a timely manner. Each clinic is required to measure the percentage of reports sent to the medical home within fourteen days of a completed evaluation.

Three primary care practices along with a Title V team attended the last learning session in the NICHQ Medical Home Learning Collaborative and completed between-session assignments. Utilizing the knowledge and skills obtained from the Collaborative, the three primary care practice teams, CCC centers and the Title V team are developing a plan to replicate the medical home model in additional practices. They have formed the Virginia Medical Home Coalition to implement the spread of the medical home concept in Virginia.

c. Plan for the Coming Year

Central office staff will work with CDCs to facilitate reports being sent to medical homes, schools, and other referring agencies within fourteen days of a completed evaluation. Clinics are exploring options of changing the format for the final report, developing the reports on-line, and revising processes to send reports in a more timely manner. CDCs will continue to provide annual plans based on the 2010 Express goals for CSHCN.

Through efforts of the Virginia Medical Home Coalition, the medical home concept will be adopted in at least four additional primary care practices. CCC centers and CDCs will continue to refer 100 percent of their clients to medical homes. This requirement is included as an outcome in their annual performance plans.

CCC centers continue to implement the plan for Virginia to meet Healthy People 2010 goals for CSHCN and their families. The plan includes numerous activities to standardize the core elements of the medical home; to promote the medical home approach; to achieve universal access to a medical home; and to use the medical home as a measure of quality care. Specific activities have been designated and included in the VDH contractual arrangements with CCC centers and CDCs.

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)

a. Last Year's Accomplishments

The Child Development Clinic (CDC) annual planning process was revised to incorporate the six goals from 2010 Express. Each of the eleven clinics was asked to assure that each child seen has medical insurance and to refer potentially eligible children without medical insurance to apply for Medicaid, FAMIS (SCHIP), and/or SSI. CDCs identified 53 uninsured children who appeared eligible for publicly financed health insurance. All of these clients were referred for Medicaid or FAMIS insurance. Approximately 44 children were seen with SSI and 79 children were referred for a SSI evaluation. In FY 03, 94.7 percent of CDC patients were insured. In addition, 92.7 percent of Care Connection for Children (CCC) and 92 percent of the Bleeding Disorder Program patients had health insurance coverage.

In FY 02, the CSHCN Program was funded for a Maternal and Child Health Improvement Project (MCHIP) CSHCN Health Insurance and Financing Grant to improve access to comprehensive insurance benefits and services for CSHCN. During the first grant year, the MCHIP grant activities focused on building the necessary infrastructure to support the grant project. A 40-member Advisory Task Force on Access to Health Care for CSHCN was

established and convened. The purpose of the task force is to strengthen and maintain a coalition of stakeholders in support of grant goals/objectives. This group also serves as the primary conduit for stakeholder input into grant activities.

The Central Virginia CCC is the first pilot site for the project. This center has formed a partnership with one health insurance plan to identify CSHCN among the health plan members and to demonstrate the value of community-based care coordination to CSHCN enrolled in a Medicaid HMO. Project activities also include contracting with Parent-to-Parent (PTP) of Virginia to provide parent outreach to enroll low income, uninsured CSHCN in public programs and parent training to develop parents' skills in providing active care coordination for their child. Three parents have been employed as trainers and have provided many outreach activities. On-site consultation by a national expert (Elizabeth Shenkman, PhD) was provided to three health insurers on the selection and implementation of a systematic mechanism (Chronic Disability Payment System) for identification of CSHCN among their health plan members.

CCC staff participated in community groups to promote enrollment of uninsured children in public programs. A major component of the CCC program is the provision of insurance case management to assist families to obtain, understand, and use health insurance. The MCHIP Project coordinator also served on the state Covering Kids and Families (CKF) Coalition Task Force on Values, Access, and Utilization. The Virginia CKF received a three-year grant from the Robert Wood Johnson Foundation to increase enrollment in SCHIP.

b. Current Activities

The CDCs prepared their annual plans based on the six goals from 2010 Express and are contractually requested to refer all eligible children without insurance to either Medicaid or FAMIS. Clinics routinely refer children without insurance to either Medicaid or FAMIS (SCHIP) programs.

The MCHIP CSHCN Health Insurance and Financing Grant continues to support project activities to improve access to comprehensive insurance benefits and services for CSHCN. The first pilot project was implemented April 2004. The Parent-to-Parent director, in collaboration with Central Virginia CCC, is developing a Care Coordination Notebook that focuses on providing information to parents about insurance programs, consumer rights, advocacy, and parent/professional relationships. The Notebook will serve as a training tool for the parent trainers and a "working" guidebook for parents to maintain records of their child's health care.

CCC centers continue to refer 100 percent of potentially eligible children to either Medicaid or FAMIS programs and follow-up with families to assure that the application is processed. Central Virginia CCC has established an agreement with Virginia Department of Medical Assistance Services for an expedited eligibility verification and enrollment process for FAMIS for "medically urgent" CCC clients. The center also established an agreement with a Medicaid HMO to fund .5 FTE care coordinator position to be housed at the center to coordinate care for the CSHCN enrolled in the health plan.

The CSHCN Program is collaborating with the Virginia Leadership Excellence in Neurodevelopmental Disabilities program to examine the issue of underinsurance through analysis of Virginia data from the National Children with Special Health Care Needs-State and Local Area Integrated Telephone Survey (CSHCN-SLAITS). Data from this analysis may provide additional feedback on areas of incomplete coverage for CSHCN. The MCHIP Project coordinator continued serving on the CKF Values, Access, and Utilization Task Force.

c. Plan for the Coming Year

CDCs will continue to refer all potentially eligible children to Medicaid, FAMIS, or SSI. Clinics will continue to provide annual plans based on the 2010 Express goals for CSHCN.

The MCHIP CSHCN Health Insurance and Financing Grant will continue to perform project activities to improve access to comprehensive insurance benefits and services for CSHCN. The two pilot projects will be implemented and evaluated. Project activities will include a new collaboration with the Virginia Chapter of the American Academy of Pediatrics and Medical Home Plus, a non-profit, private organization in Virginia that provides support to parents of CSHCN. These groups will use their contacts and leverage within the health care community to recruit additional health insurance plans for participation in the grant pilot projects. The collaboration includes promotion of the medical home concept among primary care providers. The Care Coordination Notebook will be published and distributed.

Each CCC center manages a Pool of Funds that assists uninsured and underinsured CSHCN to receive direct care services they otherwise could not afford. This Pool of Funds will be evaluated by each region to identify areas of underinsurance and services/fees not covered by these funds. Additional information from the CSHCN-SLAITS will be used as appropriate for this evaluation. The CSHCN Program will continue to work with the Department of Medical Assistance Services (DMAS) to identify issues and remove obstacles that cause underinsurance of CSHCN receiving Medicaid and FAMIS. Updated manuals and video-conference training by DMAS will be provided for CCC centers and CDCs to review Medicaid/FAMIS application procedures, discuss policy changes, and answer questions. CCC centers will continue to refer 100 percent of potentially eligible children to Medicaid, FAMIS, and SSI programs, and follow-up with families to assure that the application was processed.

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)

a. Last Year's Accomplishments

The Child Development Clinic (CDC) annual planning process was revised to incorporate the six goals from 2010 Express. Each of the eleven clinics was asked to develop two new referral sources within their communities; offer trainings or technical assistance to other providers in the community; serve as training sites for social work, nursing, or psychology students; provide services to foster care children; and offer field clinics or other specialty clinics to strengthen the community-based service system. All clinics participated in these activities.

In FY 03, the CCC network served 4,439 patients. The Bleeding Disorder Program served 248 patients (163 persons birth to age 21 years and 85 persons 21 years of age and older). The CDC network provided multidisciplinary diagnostic evaluations, interpretative reports, and care coordination to 1,510 new patients. An additional 1,152 patients (new and follow-up) received initial assessments, consultation, treatment, and other follow-up services.

The Bleeding Disorder Program developed a Website and a brochure for patients and families with inherited bleeding disorders and for health care providers seeking information and resources regarding inherited bleeding disorders in Virginia. The program added a toll-free phone number to increase access for their patients.

The CSHCN Program completed the transition in five of the six regional centers from the clinic model (Children's Specialty Services) to the care coordination model (Care Coordination for Children). The CSHCN Program has contracted with Virginia Commonwealth University for the Central Virginia region, Eastern Virginia Medical School for the Hampton Roads region, INOVA Health Care Services for the Northern Virginia region, and Roanoke Health District for the

Roanoke Area region. The CSHCN Program is managing the center in Southwest Virginia. A transition contract was implemented with the University of Virginia for the Blue Ridge region.

In FY 03 the CSHCN Program and CCC managers completed the case management standards of practice for the regional centers. Standards include required training and certification of the center's care coordinators. The Central Virginia CCC participated in the planning and implementation of a tele-broadcast for staff in Emergency Medical Services (EMS) that addressed the needs of CSHCN in emergency situations. This has been developed into a videotape to be utilized by state and national EMS providers. Southwest Virginia CCC collaborated with the University of Virginia (UVA) Office of Telemedicine to obtain grant funding for computer and video equipment to be housed in the health district in which the center is located. The equipment allows the clients to be served locally and avoid making the eight-hour round trip to UVA.

b. Current Activities

The CDCs prepared their annual plans based on the six goals from 2010 Express and were requested to continue strengthening their relationships with other community providers. Each clinic was asked to determine the greatest need for services within their community and continue to meet this need. Several clinics now reserve appointments for foster care children who may need to be seen relatively quickly and all clinics are evaluating their clients to assure that the children with the greatest needs are seen.

The regional Centers of Excellence for CSHCN facilitate access to comprehensive health and support services that are collaborative, family-centered, culturally sensitive, fiscally responsible, community-based, coordinated, and outcome-oriented to CSHCN and their families. The centers provide information and referral to resources, care coordination, 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 Blue Ridge CCC was implemented in January 2004, making the statewide network of six regional Centers of Excellence for CSHCN fully operational. In October 2003, care coordinators from all CCC centers received training on the provision of care coordination services. Two nationally-recognized expert speakers presented the basics of the care coordination model of care for CSHCN, the national standards of practice for case management, and the process for national certification for case management. During 2003, two social workers became Certified Advanced Social Work Case Managers by the National Association of Social Workers. A third social worker is currently completing the application.

The Bleeding Disorder Program is now serving approximately 73 percent of persons with hemophilia in Virginia--a 2 percent increase from the previous year. The program is contracting with an evaluator to survey hematologists and other health care providers to help identify and locate all adults with bleeding disorders. The program is increasing its outreach to those not currently enrolled in the comprehensive care program. This year, the outreach targets teenage girls and women with bleeding disorders. The program has been awarded a grant to develop an educational video on genetics counseling for persons with bleeding disorders.

The website, www.specialneedsresourcesva.org, was maintained by the CSHCN Program for families and health care professionals seeking information and resources for CSHCN in Virginia. This resource directory allows query by diagnosis, major CSHCN issues, and region of the state.

c. Plan for the Coming Year

CDCs will continue to strengthen relationships with other community providers to coordinate

services, reduce duplication of services, determine unmet needs, and assure that the children with the greatest need are served. Clinics will continue to provide annual plans based on the 2010 Express goals for CSHCN.

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

The Bleeding Disorders Program will complete its survey of hematologists and other health care providers to locate adults with bleeding disorders. The program will increase its outreach to those not currently enrolled in the comprehensive care program. The educational video on genetics counseling for persons with bleeding disorders will be completed. The program will conduct training on coagulation updates for health professionals and educational seminars for children attending hemophilia camp (Camp Youngblood).

Performance Measure 06: The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)

a. Last Year's Accomplishments

The CDC annual planning process was revised to incorporate the six goals from 2010 Express. Each of the eleven clinics was asked to provide services to help youth transition to the adult care system. Four clinics reported they provided transition services to their clients. CDCs often focus on serving younger children (under age 10) to identify developmental and behavioral 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 may not always be feasible.

CCC staff provided intensive care coordination for persons, age 18 and above, with cystic fibrosis to assist them in transitioning from the pediatric to the adult health care system and obtaining financing. A listing of financial assistance and health care programs and information on accessing them was provided to these families. The worksheet included a detailed listing of the child's prescribed medications and the available medication assistance programs. The care coordinators assisted the families as needed with the completion of application processes.

b. Current Activities

CDCs prepared their annual plans based on the six goals from 2010 Express and were requested to provide transition services to youth. The central office is encouraging clinics to work with their local school systems to identify the unmet needs of middle school students who may be encouraged to stop special education services when they leave elementary school. These students often have difficulties in middle school and often do not graduate from high school. Clinics are encouraged to provide evaluation, short-term treatment, and transition services for these children.

Virginia's plan to meet Healthy People 2010 goals 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 designated for the centers to accomplish and have been included in their contractual arrangements with VDH. These include identification of all open cases of children age 13 years and above to prioritize the group for transition of health care, education, social, and employment needs. The centers are identifying "adolescent friendly" specialists to assist with the transitions.

Training for the CCC care coordinators on their role in transitioning clients from the pediatric to the adult health care system is being planned for fall 2004. National experts on this subject have been invited to present at the training. The CSHCN Program and CCC managers are evaluating transition models that have been implemented in other states' CSHCN Programs and will develop transition standards of practice for CCC.

The Bleeding Disorder Program is providing outreach and consultation for teenage girls with hemophilia.

c. Plan for the Coming Year

CDCs will continue to provide transition services to youth seen in the clinics. This objective will be in the CDC annual plans for FY 05.

CCC centers will assist older children in the transition to adult care. This requirement is included as an outcome in the centers' annual performance plan. 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.

The Bleeding Disorders Program will enhance its transition services to older children using the CCC transition standards of care.

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.

a. Last Year's Accomplishments

In FY 03, Prince William, Rappahannock, Richmond, and Southside health districts used Title V funds to supplement immunization activities including increased education, outreach, and Clinic Assessment Software Application (CASA) immunization audits. Virginia Beach and Hampton health districts used Title V funds in the provision of child health consulting activities. This included conducting CASA audits at identified high risk child care centers and working with staff to increase rates and institute policies and procedures aimed at increasing immunization rates. Roanoke health district used Title V funds to support its Comprehensive Health Investment Project (CHIP). CHIP provides medical/social case management for low-income families with children up to age six. Alexandria, Hampton, and Norfolk health districts provide comprehensive primary care, including immunizations, to children with Title V support.

The child care health consultant continued to provide training and technical support to public health nurses and other professionals serving as child care health consultants. Key consulting activities are to provide CASA immunization audits and help centers institute system changes to support all attendees reaching and maintaining up to date immunizations. In FY 03, the role of the child care health consultant expanded to the Early Childhood Project director as VDH received an Early Childhood Comprehensive Systems Grant. A half-time coordinator was hired to continue child care consultation technical assistance to the field. The Early Childhood Project director continued to provide assistance as needed to Project Immunize Virginia, a coalition of public and private partners working towards improved levels of immunizations. The Early

Childhood Project director served as the Title V liaison to VDH's Division of Immunization to coordinate information sharing and collaborative efforts to increase immunizations. Consultation was also provided 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.

Title V staff helped develop the New Parent Kit, a Governor's initiative to provide all new parents in the Commonwealth with information about child health, development, safety, child care, and additional resources. The kit contains several items addressing immunization needs. Included in the kit are the following: the Bright Futures Health Record, which provides an immunization schedule; a custom designed calendar with appropriate monthly reminders and stickers to schedule immunizations; and a booklet on general child health care. The kit will be distributed through providers, hospitals, home visitors, and other community partners. The Resource Mothers Program is one of the lead organizations for distribution scheduled to begin in FY 04.

b. Current Activities

During FY 04, Title V funds were used to support efforts to increase immunization rates through infrastructure building activities in several health districts. Southside health district currently is conducting a CASA assessment of middle school students to identify students not adequately immunized against Hepatitis B and to immunize these students. This district is also reviewing FY 03 CASA results to determine how they can work with local health care providers to improve immunizations rates within the district. Rappahannock health district is using funds to train day care and Head Start staff to monitor immunization records to assure that 80 percent of two-year-old children are adequately immunized. Chesterfield and Prince William health districts used funds to support education, outreach, and/or audit activities. Virginia Beach and Hampton health districts continued using funds to support child care health consultant activities.

Title V continues to support case management programs that help increase immunization rates. Roanoke health district continued to use Title V funds for CHIP case management. Resource Mothers Programs evaluate whether teens and infants have had immunizations and assist those who need them in scheduling appointments to get up to date.

To address academic achievement in schools not passing Standards of Learning examinations, the Governor created the PASS initiative. As part of this initiative, the secretary of health and the secretary of education joined forces to address the unmet health needs in 34 Title 1 PASS schools. Volunteers from the departments of Health, Education, Medical Assistance Services, Social Services, Public Safety, and many others collaborated to create a web-based calendar for children and youth. The calendar highlights a different health topic each month and provides school-entry physical examination and immunization events in the three communities with the largest number of Title 1 schools (Richmond, Petersburg, and Portsmouth). Plans are underway to expand the web-based calendar for the 2004-05 school year.

The child care health consultant and the Early Childhood Project director conducted a training in March 2004, increasing the number of trained child care health consultants to 160 statewide. A calendar custom designed with health, safety, development, and Virginia resource information was printed and distributed to 17,000 child care providers across the state in collaboration with the Department of Social Services (DSS). In another joint project with the DSS Head Start Collaborative, the Healthy Child Care Tool Kit has been developed for child care providers of all levels. This kit contains information, resources, and a curriculum on numerous items including control of communicable disease, emergency preparedness, safe sleep environments, nutrition and physical activity, medication administration, and asthma.

c. Plan for the Coming Year

Chesterfield, Hampton, Portsmouth, Rappahannock, Roanoke, Southside, and Virginia Beach health districts will be directing Title V resources to support immunization outreach, education, and audit activities. Case management and mentoring programs, such as CHIP of Roanoke and Resource Mothers, will continue working with low income and/or teenage mothers to assure infants' immunizations are received.

The half-time child care health consultant will continue providing technical assistance to the field through the end of the Healthy Child Care Virginia funding in mid FY 05. To build sustainability, child care health consulting has been incorporated as a working committee under the VDH Nursing Council. One more child care health consultant training will be conducted. Consultation and partnering with Project Immunization Virginia, the VDH Division of Immunization, Head Start Collaborative, and the DSS Divisions of Child Care Programs and Licensing will continue. The Early Childhood Project director, in collaboration with Head Start, will conduct regional trainings across the state featuring use of the Healthy Child Care Tool Kit. Plans are to distribute 10,000 of the Kits through trainings in FY 05.

The New Parent Kit will be distributed statewide in FY 05. Plans are to distribute 100,000 English and 10,000 Spanish kits to new parents. Healthy Families, Resource Mothers, and CHIP of Virginia home visiting programs will continue coordination of local distribution. A Maternal and Child Health Bureau graduate student intern will assist in conducting evaluation of Kit use and impact on resource utilization.

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

a. Last Year's Accomplishments

In FY 03, the Resource Mothers Program reported continuing success in reducing repeat pregnancies; 3.68 percent of participants who completed the program had repeat pregnancies compared to an estimated 20 percent repeat rate for all teens. The program served 2,276 teens last year with the total number served since the programs' inception being 15,000.

The Teenage Pregnancy Prevention Initiative (TPPI) continued operations in seven health districts using funds from Department of Medical Assistance Services (DMAS) Medicaid and the Department of Social Services (DSS) Temporary Assistance for Needy Families (TANF) programs. Teenage pregnancy prevention programs were staffed and monitored. Each program successfully developed an evaluation plan that was approved by the VDH Institutional Review Board (IRB). All sites continued to monitor processes based upon the outcome funding model and began collecting outcome data. Quarterly meetings were held for information dissemination, training, and networking. Staff worked in conjunction with Virginia Commonwealth University - Survey and Evaluation Research Laboratory (VCU-SERL) on the TPPI evaluation. The TPPI Program coordinated funding for and monitored 19 Better Beginnings Coalitions (BBC). These coalitions continued efforts to increase awareness and to implement community approaches to the prevention of teenage pregnancy through youth development, media, and other methodologies. The first annual Adolescent Sexual Health Evaluation Conference was held in May 2003. Teenage pregnancy prevention program providers were convened to learn about current science-based approaches that address teenage pregnancies.

Title V funds supported teenage pregnancy prevention strategies in the Central Shenandoah, Central Virginia, Chesterfield, Cumberland Plateau, Hampton, Lord Fairfax, Piedmont, and Rappahannock health districts in FY 03. The teen birth rate in Virginia has continued to decrease and was 18.9 per 1,000 females ages 15-17 in 2002.

b. Current Activities

TPPI continues operations in the seven health districts specified by the Virginia General Assembly in 1993 and 1994. Funding for the program has shifted entirely to 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.

In FY 04, Title V funds are supporting teenage pregnancy prevention strategies in Central Shenandoah, Central Virginia, Cumberland Plateau, Hampton, Lenowisco, Lord Fairfax, Mount Rogers, Peninsula, Piedmont, Rappahannock, and Richmond health districts. Each of these programs has submitted a work plan and targets using the outcome funding model. Information and promotion of the National Day to Prevent Teen Pregnancy on May 5, 2004 is being provided to all field programs and health districts. The second annual Adolescent Sexual Health Evaluation Conference will be held in June 2004.

The Adolescent Sexual Health coordinator, the school age nurse consultant, and the director of Community Services for HIV/STD attended a meeting to build collaborative efforts among state stakeholders working with youth risk behaviors. The meeting was sponsored by the Society of State Directors of Health, Physical Education and Recreation, Association of Maternal and Child Health, National Alliance of State and Territorial AIDS Directors, and the National Coalition of STD Directors.

VDH Staff members are working inter- and intra- agency on a collaborative work plan to address youth sexual risk behaviors. The Divisions of Child & Adolescent Health, Women's and Infants' Health, and HIV/STD Prevention are collaborating to integrate teen pregnancy, STD, and HIV prevention efforts wherever possible. Programmatic areas currently involved are abstinence education, adolescent health, family life education, family planning, HIV/STD, resource mothers, and teenage pregnancy prevention.

To date, this group has developed a combined fact sheet, is offering a statewide "Can We Talk" train-the-trainer session (encourages parents to talk with their children) to local teams in April, and has scheduled a mini-stakeholders meeting for VDH and Department of Education staff to plan future integration efforts.

c. Plan for the Coming Year

The General Assembly appropriated level funding for the Teenage Pregnancy Prevention Initiative for FY05. 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. 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 05, Title V funds will be used to support teenage pregnancy prevention strategies in the Central Shenandoah, Central Virginia, Lenowisco, Piedmont, Rappahannock, and Richmond health districts. The third annual evaluation conference will be held to explore current trends in teenage pregnancy prevention programming, and staff from the above health districts will be included.

Resource Mothers staff will continue to collaborate with the Center for Sustainable Health Outreach (CSHO) at James Madison University to develop training curriculum on healthy behaviors for community health workers in CHIP, Resource Mothers, Project Link, and Community Health Centers to educate professional health care providers on working with community health workers. They will also collaborate on grant applications for training on mental health. The Virginia Center has established eight regional groups for training and disseminating educational materials on mental health.

The teen pregnancy, HIV, and STD integration group is considering the development of a statewide teen pregnancy prevention plan during FY 05.

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

a. Last Year's Accomplishments

The Division of Dental Health (DDH) supported local health department dental programs through the Title V funded quality assurance program. Last year, on-site quality assurance reviews were provided for the dental programs in the following local health districts: Fairfax, Mount Rogers, Virginia Beach, Western Tidewater, Rappahannock/Rapidan and Cumberland Plateau. Technical assistance was also provided for a new dental program in Rappahannock health district. VDH dental clinics served 27,773 individuals in FY 03. Out of 52,983 total visits, 37,480 visits were provided to children less than 13 years of age. More than 231,000 clinical services, including 26,000 dental sealants, were provided for these patients at a value in excess of 12 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, these staff were trained regarding anticipatory guidance and the fluoride varnish technique during a teleconference. Two health districts, Norfolk City and Thomas Jefferson, used Title V funds to support their dental programs.

Title V funds also provided materials for more than 50,000 children to participate in the school-based fluoride mouthrinse program. All program participants are using pre-mixed fluoride. The number of children in the program increased by approximately 1,500 within the last year. The VDH dental hygienist, funded by Title V, provided training to children, teachers, and nurses, and conducted on-site reviews of half of the 200 participating schools statewide.

Dental health education training was provided to customers including Head Start programs, school nurses, and VDH dental staff. Materials were developed to meet the statewide Standards of Learning for oral health. Educational assistance regarding oral health was given to the Department of Education for the PASS initiative, which includes those schools not currently meeting their SOL standards. All VDH dental health brochures regarding dental sealants, flossing, brushing, oral health and well being, and nutrition and dental health were translated into multiple languages this year.

DDH partnered with the statewide dental coalition, Virginians for Improved Access to Dental Care, to hold a dental health summit on September 29-30, 2003 and a state oral health plan was developed.

b. Current Activities

Title V provides funding for local health departments for dental services including dental sealants and education. In the current fiscal year, Title V provided funds for Norfolk City health district and provided 500 visits for preventive services, including dental sealants. Thomas Jefferson health district provided 126 preventive and comprehensive care visits and education

to 200 day care children. The Division of Dental Health (DDH) currently provides technical assistance to local public health dentists on preventive/comprehensive dental care including the placement of sealants. DDH also provides on-site quality assurance reviews of local health department dental programs and training for staff.

The school fluoride program is currently implemented in 50 counties. During the current year, it is expected that more than 50,000 children will participate in the school fluoride program. DDH is currently evaluating the effectiveness of the fluoride program. Analysis of this data has been delayed due to a vacancy in the division.

DDH continues to develop and distribute dental health education materials including brochures on an array of topics including dental health's link with overall well-being.

c. Plan for the Coming Year

Title V funding will continue to be provided to district dental programs during FY 05. The school fluoride rinse program will continue in FY 05 with efforts to expand the program into three additional counties. DDH staff will provide oversight of the program and training for children, teachers, and nurses in new school sites. A report on the effectiveness of the fluoride rinse program will be completed during this year.

On-site quality assurance reviews of local dental programs will continue during FY 05. A review is planned for the following health districts: Prince William, Chesterfield, Alleghany, Roanoke City, Alexandria, and Arlington.

DDH will continue partnering with the statewide dental coalition, Virginians for Improved Access to Dental Care, to further develop strategies from the statewide summit.

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

a. Last Year's Accomplishments

Title V funds support the Center for Injury and Violence Prevention (CIVP) in providing oversight to staff that manage a statewide transportation safety and child restraint installation and education program, which is funded through state revenue funds and a federal highway safety grant. CIVP continued to coordinate a statewide child safety seat distribution and education program for low-income families and annual statewide observance of child passenger safety week. CIVP coordinates a network of safety seat trainers and technicians who implement child safety seat check events around the state. CIVP disseminated pedestrian safety tool kits to elementary schools and coordinated a winter holiday child passenger safety radio campaign specifically targeted at fathers. CIVP coordinated a retailer-based education program to alert consumers to the dangers of using "second hand" safety seats. CIVP disseminated a large variety of child passenger safety, bike and pedestrian safety education materials to community providers through our injury prevention resource center and website.

b. Current Activities

CIVP is transitioning trainers and technicians to a new national certification process. CIVP is developing a statewide "first ride safe ride" campaign aimed at promoting hospital policies and practices that ensure safe transportation of newborns. CIVP is gearing up to provide a variety of summertime transportation safety messages.

The Governor's New Parent Kit, being piloted during FY 04 in the Tidewater and Southwest

areas of the state, contains specific directions on car seat safety for infants and children, as well as information on where parents can have their car seat checked for proper installation and receive information on the free car seat program. Plans are to distribute the kit to all new parents in the Commonwealth.

c. Plan for the Coming Year

CIVP will continue to disseminate child restraint devices and collaborate with state highway safety partners to implement a variety of strategies to involve Virginia's parents, youth, and the general public in motor vehicle injury prevention.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

a. Last Year's Accomplishments

In 2001, 67 percent of Virginia mothers were breastfeeding their infants at time of discharge. This data is collected by the Ross Laboratories Breastfeeding Survey. According to Ross, 2001 data is still the most recent data available. Current breastfeeding statistics for Virginia's WIC Program population reveal that 41 percent of women enrolled in the WIC Program are breastfeeding.

Another source of data that is Virginia-specific is the data collected by Healthy Start and Resource Mothers. These programs began collecting data on breastfeeding at all sites in January 2004. Data is being collected on the woman's choice to breastfeed, how long she breastfed if she decided to do so, and the reason for stopping.

b. Current Activities

The Virginia Breastfeeding Task Force developed workplace resources for Virginia employers to use so that breastfeeding mothers returning to work can be given a protective and supportive environment. These resource booklets are in the process of being distributed to each of the 50 largest businesses in Virginia. The workplace resources will also be added to the Task Force's web site.

The Task Force continually serves as a vehicle to ensure that state and local laws relating to child welfare and family law recognize and support the importance and practice of breastfeeding. Healthy Start and Resource Mothers also encourage breastfeeding among participants and keep data on the length of time women breastfeed and the reason for stopping. Focus groups were conducted through VHSI. Regional Perinatal Councils offer lactation education courses to area health care providers.

c. Plan for the Coming Year

During FY 05, the Division of WIC and Community Nutrition Services (DWCNS) will continue its plans for development of a statewide breastfeeding plan beginning with collaborative efforts within the Office of Family Health Services. The month of August will be promoted as Breastfeeding Awareness Month in Virginia. Plans include having the governor sign a proclamation and development of a press release for distribution among local health districts and local breastfeeding task forces.

DWCNS has also been awarded funding from USDA to enable state agencies to begin implementation of an effective and comprehensive peer counseling program and/or enhance an existing breastfeeding peer counseling program. As a part of this funding, DWCNS is in the

final stages of hiring a staff person who will function as the State Breastfeeding Peer Counselor coordinator. This position will be responsible for overseeing the implementation and management of health district breastfeeding peer counselor programs.

The Division of Women's and Infants' Health will continue to encourage breastfeeding among participants in Healthy Start and Resource Mothers. A report will be prepared on women who breastfeed and are participating in Healthy Start and Resource Mothers.

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

a. Last Year's Accomplishments

During FY 03, the Virginia Early Hearing Detection and Intervention (EHDI) Program participated in the following activities: (1) worked with hospitals to implement screening protocols and reporting requirements; (2) enhanced reporting structures for Virginia Infant Screening and Infant Tracking System (VISITS) Hearing Module; and (3) submitting quarterly reports to hospitals regarding their newborn hearing screening and reporting efforts.

In addition, with funds from the Health Resources and Services Administration, the Virginia EHDI Program continued to: (1) develop curricula for training and education of hospital staff, audiologists, and primary medical care providers; (2) produce public awareness materials that included a poster for parents printed in English and Spanish; and (3) receive a rating of "Excellent" from the National Campaign for Hearing Health for the second year in a row, for screening over 95 percent of newborns and having in place a statewide system for coordination, training, quality assurance, and follow up.

b. Current Activities

During FY 04, the Virginia EHDI Program carried out the following activities: (1) piloted the VISITS At Risk Module; (2) conducted five regional training sessions for hospital staff; (3) established an enhanced voice-mail system for the toll-free line, translated into four languages other than English; (4) conducted an evaluation of the VISITS At Risk Module and developed a plan for implementation statewide; (5) translated the parent brochure in five additional languages; and (6) provided newborn hearing flyers for the New Parent Kit to be distributed to all new parents in the state.

Virginia EHDI has participated in several teleconferences with program managers from Pennsylvania, West Virginia, Maryland, Delaware, and Washington DC to discuss getting data on resident newborns delivered in neighboring states. Virginia has received one commitment from one out-of-state hospital newborn hearing screening program director to report resident infants who fail the initial screen. Half of the births at this facility are to Virginia residents.

c. Plan for the Coming Year

In FY 05, the Virginia EHDI Program will continue to be administered as required by the Code of Virginia. Hospitals will continue 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 will be conducted. Hospitals will continue to receive quarterly reports on their screening rates. In addition, the EHDI Program will continue technical assistance and training efforts for hospital staff, primary medical care providers, and audiologists to improve screening and reporting of newborn hearing screens. Virginia EHDI will continue networking with other state programs and bordering providers to explore reporting arrangements for resident infants born in neighboring states.

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

a. Last Year's Accomplishments

During FY 03, Title V supported programs collaborated with multiple partners on both state and local levels to help decrease the percent of children without health insurance. Partnerships between Title V program staff, the Department of Medical Assistance Services (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 have resulted in increased outreach to children potentially eligible for Family Access to Medical Insurance Security (FAMIS, the state S-CHIP program) and Medicaid, now renamed FAMIS Plus.

At the state level, the director of the Division of Child and Adolescent Health (DCAH) serves as the VDH representative to the state Covering Kids and Families (CKF) coalition. The CKF coalition is supported through Robert Wood Johnson Foundation funding to support outreach, simplification, and coordination of efforts to enroll and retain children in health insurance programs. The MCHIP program manager participates in the CKF Values, Utilization, and Access Task Force and the DCAH policy analyst is a member of the Outreach, Enrollment, and Retention Task Force. The school age nurse consultant represents VDH on the Building Bridges grant awarded to the Department of Education to increase enrollment in FAMIS by contacting parents who were eligible for free and reduced lunches.

VDH continued efforts in FY 03 to build outreach, application dissemination, and assistance into appropriate programs and channels. The CSHCN Program continued to contractually require Care Connection for Children centers and Child Development Clinics (See NPM #4) to identify potential eligible children and assist families with obtaining health insurance and completing applications for FAMIS and FAMIS Plus (Medicaid). Resource Mothers assisted individual clients and their families in completing forms for FAMIS Plus and FAMIS. In addition, sites participated in community outreach activities and local enrollment efforts. Virginia Early Hearing Detection and Intervention Program provided referrals for FAMIS and FAMIS Plus for children without insurance needing follow up. Healthy Child Care Virginia and trained child care health consultants continued to provide information regarding children's health insurance programs and continued to promote the importance of having health insurance and a medical home.

In FY 03, Alexandria, Arlington, Chesterfield, Cumberland Plateau, Hampton, Norfolk, Roanoke, and Virginia Beach health districts used Title V funds to support provision of outreach, information, and referral for FAMIS and FAMIS Plus. All health districts were sent annual updates, information, and outreach materials for use in their communities.

b. Current Activities

State level partnerships continue to support collaborative efforts to enroll eligible children in available health insurance programs. The school age nurse consultant continued participation in the Building Bridges grant to increase FAMIS enrollment by contacting parents eligible for free and reduced lunches. Title V staff continued participation in the CKF state coalition and two task forces. One member chaired a subgroup to examine issues surrounding retention. VDH and DMAS has begun exploring linking the children's FAMIS/FAMIS Plus application to the current health department WEB VISION patient management system used in localities for patient eligibility and accounts management.

Outreach efforts through VDH programs continue to be strengthened. In March 2004, the

Women, Infants, and Children (WIC) Supplemental Nutrition Program conducted an outreach mailing to 134,000 enrollees to provide information about FAMIS and FAMIS Plus and to encourage application for participants or other contacts not currently enrolled. BabyCare, Resource Mothers, and Healthy Start conduct outreach to increase enrollment in FAMIS, and CCC centers and CDCs continue their identification and enrollment efforts. Virginia EHDI and child care health consultants also are continuing provision of information.

In FY 04, ten health districts -- Alexandria, Chesterfield, Cumberland Plateau, Hampton, Lord Fairfax, Norfolk, Prince William, Richmond, Roanoke, and Virginia Beach -- are using Title V funds to support outreach efforts. In the Tidewater area, several health districts are partnering with the local CKF-funded coalition to support more comprehensive on-site assistance. Annual updates outlining eligibility and other policy changes are provided for all local health districts and central office programs serving children.

The Title V program is supporting several public awareness and education initiatives. VDH is a partner with DMAS-led efforts for Cover the Uninsured Week in May 2004. Videos, buttons, and flyers promoting FAMIS and FAMIS Plus are being provided to local health departments, CCC centers, and CDCs. The Governor will be hosting a kickoff event. Other public awareness activities supported in part by Title V include information about FAMIS and FAMIS Plus in the New Parent Kit to be distributed to all new parents in the state and in the Commonwealth Section of iParent magazine.

Title V representatives are also participating in workgroups of the State Planning Grant activities led by the VDH Office of Health Policy through Health Resources and Services Administration (HRSA) funds.

VDH received a state Early Childhood Comprehensive Systems Grant (ECCS) from the Maternal and Child Health Bureau. One of the five ECCS critical areas is ensuring children have a medical home. The Virginia ECCS is currently conducting an environmental scan and engaging in planning processes.

c. Plan for the Coming Year

VDH will continue to collaborate with state and local partners. Title V staff will continue participation in the statewide CKF coalition and task forces. VDH will continue to explore the feasibility of implementing an application for FAMIS/FAMIS Plus through VDH's WebVISION, which may incorporate eligibility information already gathered during the normal VDH screening process. VDH will also participate in the redesigned and renamed Children's Health Insurance Program Advisory Committee as specified by the legislation from the 2004 Virginia General Assembly.

Programs such as the CCCs and CDCs will continue activities as outlined in NPM #4. Other programs will also continue outreach, information, and referral efforts. Information about health insurance and medical homes will be a component of the Healthy Child Care Tool Kit developed for child care providers, in collaboration with the Early Childhood Project coordinator, to be distributed through regional trainings in FY 05.

In FY 05, the health districts of Alexandria, Chesterfield, Cumberland Plateau, Norfolk, Richmond, Roanoke, and Virginia Beach will be using Title V funds to support outreach, education, and enrollment efforts.

Title V staff will support and participate in other grant activities such as the HRSA State Planning Grant and the Virginia ECCS, which may result in increased data, further identified needs, and policy development regarding health insurance status and options for children.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

a. Last Year's Accomplishments

The Division of Child & Adolescent Health (DCAH) collaborated with the Department of Medical Assistance Services (DMAS) to conduct regional Early Periodic Screening, Diagnosis and Treatment (EPSDT) training sessions for medical providers to increase the number of completed EPSDT examinations and to improve the quality of services provided. Evaluation of screening rates at the community level could not be provided by DMAS. This performance measure, however, improved from 78.5 percent in FY 02 to 86.0 percent in FY 03. During this time frame, roughly 34,000 additional children were enrolled in Medicaid, now known as FAMIS Plus.

VDH staff participated in several collaborative groups, which may contribute to increased EPSDT screenings. A representative served on the Covering Kids and Families Coalition Task Force on Values, Access, and Utilization. This group is directing some efforts towards enabling recipients to better understand and properly use the health insurance and health care systems. The Lead-Safe Virginia Program, supported by Centers for Disease Control and Prevention and Environmental Protection Agency funds, continued engaging in data match activities with DMAS to assure primary care follow up of Medicaid enrolled children with elevated blood lead levels. The data match also helps identify areas to target educational efforts to increase screening among Medicaid children. Title V representatives participated in the DMAS-led Prenatal, Infants', and Children's Services workgroup, which also addresses access issues.

In FY 03, Alexandria, Hampton, and Norfolk health districts used Title V funds to support the infrastructure to deliver comprehensive primary care encompassing EPSDT screening for Medicaid clients. Cumberland Plateau used Title V funds to support staff conducting EPSDT screenings in several schools.

b. Current Activities

DCAH collaborated with the DMAS to revise the EPSDT manual to incorporate the periodicity schedule included in Bright Futures (used as the standard of care for VDH). DCAH conducted regional trainings for health department staff (clinic and WIC) and school nurses to promote EPSDT screens using Bright Futures Guidelines. Emphasis was given on conducting developmental screenings.

In FY 04, Alexandria, Hampton, and Norfolk health districts continued use of Title V funds to support the infrastructure to deliver comprehensive primary care to children including EPSDT screening. Cumberland Plateau also continued conducting EPSDT through the school setting with Title V support.

The Title V DMAS liaison formed a new workgroup in FY 04 as part of the Office of the Secretary of Health and Human Resources (OSHHR) initiative to identify cost saving collaborations among HHR agencies. This group includes VDH, DMAS, and the Department of Social Services (DSS), and was formed to examine data related to health care received by foster care children. Efforts are underway to provide data to caseworkers on EPSDT screening needs of children in the foster care system who almost universally have Medicaid. With training on Bright Futures and the periodicity schedule as well as access to data of EPSDT screenings received by foster care children, caseworkers will be better positioned to promote and assure EPSDT services among this population with great needs.

c. Plan for the Coming Year

DCAH, DWIH, DMAS, the Virginia Chapter of the American Academy of Pediatrics (AAP), and other partners plan to develop a web-based training program offering continuing education credits for health care providers to use Bright Futures to improve the quality of well-child care and to promote EPSDT screens, particularly for school age children and adolescents.

The Bright Futures co-chair, consulting with Georgetown University, will be working with the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services to design training specific to mental health screening and referral based on Bright Futures Guidelines. In addition, in partnership with AAP, staff will design a web-based training module on breastfeeding and EPSDT for providers to increase their quality of care.

In FY 05, Alexandria and Norfolk will continue to provide comprehensive primary care with Title V support. The Hampton health district will no longer participate as a Medicaid HMO provider and will be redirecting Title V funding to serving other populations. Cumberland Plateau will continue using Title V to support staff conducting school-based EPSDT services.

The Title V DMAS liaison will continue facilitation of efforts to populate EPSDT screening frequencies into the DSS caseworker database (OASIS) to help improve EPSDT screenings among foster care children.

Resulting from work of the Joint Subcommittee Studying Lead Poisoning Prevention, the 2004 Virginia General Assembly passed SJR 64 which requests the OSHHR to establish a task force to conduct an examination of issues related to EPSDT. VDH will provide staff (school age nurse consultant) to work on this effort. The study will examine several issues specified in the legislation including: EPSDT protocols; delegation of tasks to nurses; and training, reimbursement, cost, and quality issues related to delegation. A report and recommendations will be made by November 2004.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

a. Last Year's Accomplishments

Providing early and adequate prenatal care and preventing unwanted pregnancies can play a role in preventing low weight births. Local health departments served approximately 14,000 maternity patients again in CY 03. At the same time the Family Planning Program served a total of 77,409 unduplicated patients (76,605 women and 804 men).

The Healthy Start Program provided case management services to 1,252 high-risk pregnant women, postpartum and interconceptional women and infants in four local communities (Norfolk, Portsmouth, Petersburg and Westmoreland County). In FY 03 1.6 percent of infants born to Healthy Start clients were very low birth weight (VLBW), which was lower than the baseline in 2001 (2.2 percent).

Regional Perinatal Councils (RPCs) continued to educate health care providers on factors associated with poor outcomes for infants and women including prevention of low weight births and infant resuscitation and transportation. For example, RPC 7 sponsored an educational workshop for health care providers at the annual Neonatal-Perinatal Perspectives, Perinatal Jeopardy Conference, which focused on low birth weight dramatic impact on morbidity and mortality.

In CY 03, all seven RPCs trained 14,124 professionals in obstetrical (289), neonatal (277) and other programs (144), totaling 1,721 program hours. Most were nurses (4,367) and respiratory therapists and consumers (6,527), while others were physicians (904), health educators (477), social workers (387), resource mothers (230), and nutritionists (116).

Region 1 (Southwest Virginia) continued to implement a smoking cessation program, "Breath Easy Baby!" Women are enrolled during their pregnancy and encouraged to remain smoke-free postpartum. The December 2003 report stated that 593 women were screened, 417 were enrolled and 169 quit smoking.

RPC 2 (Blue Ridge) continued to monitor the "Neonatal Transport Acuity Scores" and report findings and recommendations annually to the hospitals in their region. They noted this model has been successful in increasing the number of very low birth weight births at a level III hospital as evidenced by 96 percent of very low birth weight births occurring at a level III hospital in the Blue Ridge Region.

In addition, the RPC 2 fetal infant mortality review (FIMR) process revealed that women did not recall receiving information on preterm labor. Wallet-sized cards that depicts preterm labor warning signs/symptoms and response action steps were provided to obstetrical office/clinic settings throughout the region and are distributed to patients. The cards are accompanied by a comprehensive educational brochure from the March of Dimes.

The lay home visitors (Resource Mothers) received training in June 2003 on mental health needs of young parents when there is an external crisis (bioterrorism or natural disaster). The training also developed the Resource Mothers role as a trusted source in low-income communities during crisis.

b. Current Activities

Healthy Start case management and health education interventions are being provided to high risk minority women in four communities with high rates of infant mortality. Prenatal services are provided, including pregnancy evaluation, risk assessment and intervention, psychosocial assessment, and education through local health departments or arrangements with local hospitals, physicians, or clinics. Laboratory and pharmacy services, prenatal vitamins, and nutrition counseling are also offered.

Providers are trained in reducing low weight and preterm births. RPCs are working to reduce low weight births and VLBWs by using the 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.

Two RPCs are using March of Dimes grants to implement a "Low Birth Weight Review Program" that helps identify factors contributing to all low weight births. Information for this process will be shared with a consortium of community decision-makers that will provide recommendations for the health care providers in the community. 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.

RPC 3 (South Central) continues "Babies are Everybody's Business", which offers perinatal health education to consumers at their work sites.

RPC 4 (Northern Region) is in negotiations with more than 30 large corporations in the region. Services will be provided for pregnant employees and are more comprehensive than what could be provided by the RPC. This is an excellent example of how a RPCs FIMR recommendation is implemented in the community to improve health systems and access to care.

The Division of Women's and Infants' Health partners with the March of Dimes to develop, implement and publicize a campaign to prevent premature infants. In addition, family planning

clinics provide contraception and counseling to women to prevent unintended pregnancies that will prevent very low weight births among women at high risk of unintended pregnancy and those with previous very low weight births, prematurity, or major life stress.

c. Plan for the Coming Year

Very low weight births are the least likely low weight births to be prevented through the efforts of public health. However, the RPCs will continue to focus on development and maintenance of the community-level infrastructure necessary to support the delivery of perinatal services. The RPCs will also implement FIMRs and address issues related to low birth weight infants, access to care, and infant mortality. The RPCs will use FIMR data and analysis to determine which issues to address within the systems of health care for pregnant women and their infants. The RPCs will strive towards a goal for all regional perinatal care delivery systems to provide risk-appropriate care.

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

Resource Mothers and BabyCare staff will continue to receive information and training on substance abuse, depression, and domestic violence that may prevent low weight births. In a new partnership, a case management course has been designed for BabyCare nurses and social workers by VDH staff and Virginia Commonwealth University (VCU). Modules will be presented in five regional workshops with the goal of improving case management skills and the quality of service. Additional funds are being sought to develop more training on advanced case management.

DWIH staff will continue to participate in the March of Dimes campaign to prevent premature births and continue to provide data, technical assistance, and support to implement an effective public education campaign.

Healthy Start will continue to focus on reducing low weight births and infant mortality through the provision of case management services, health education, and interconceptional care to high risk women.

In 2004, health districts will use BabyCare, Resource Mothers, and the Healthy Beginnings Program to serve women in the health districts and improve perinatal outcomes.

The RPC 4 FIMR recommendation will continue to increase the awareness of preterm labor signs and symptoms among employees and their families in three large corporations in Northern Virginia. The RPC staff's collaboration with the work place health manager at INOVA hospital system resulted in a business plan to begin lunchtime education sessions on the warning signals of preterm labor.

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

a. Last Year's Accomplishments

The Center for Injury and Violence Prevention's suicide prevention efforts are funded by state General Assembly funding and a three-year CDC grant. The state funding has supported a radio public awareness campaign that was conducted in spring 2003; the campaign promoted help seeking among teens and encouraged use of the 1-800-SUICIDE hotline. State funding has also supported the development and dissemination of educational materials to educators,

parents, and teens across Virginia and the provision of grants to five suicide crisis centers to coordinate local prevention education activities. Accomplishments that have resulted from the CDC grant are as follows:

?In the first year of the project, 281 Question, Persuade, Refer (QPR) suicide warning sign awareness sessions were completed with middle and secondary school personnel providing gatekeeper training to 2,075 individuals.

?In the first year of the project, 42 Applied Suicide Intervention Skills Training (ASIST) suicide risk identification and counseling training sessions were completed providing comprehensive training to 1260 individuals.

?Of the 136 Virginia school divisions, 85 percent have had one or both gatekeeper trainings (QPR and ASIST) and/or ordered the available brochures.

?All five of the contracted crisis centers have certified QPR and ASIST trainers and all five spend at least a third of their time conducting gatekeeper training.

?Fifteen additional ASIST trainers completed certification requirements in June of 2003 in an effort to meet the demand for training.

?Three hundred corrections education personnel have received the QPR training.
?All school security personnel in the Richmond City School division have received QPR and QPR refresher sessions.

?One hundred sixty-three Emergency Medical Services personnel have been QPR trained to date with additional sessions already scheduled.

?QPR sessions have been given for a variety of audiences; presented at numerous conferences; and in some instances, provided for students themselves making the total number trained nearly 15,000.

b. Current Activities

CIVP will be providing a training update to our core group of ASIST trainers this spring. LivingWorks Education, Inc. has introduced Version X of the ASIST training model. Twenty-four current trainers will receive the update in a three-day session towards the end of April. CIVP is partnering with the Healthy Culpeper coalition in a countywide suicide prevention effort. Several planning meetings and gatekeeper trainings have been held and a "parent night", expected to reach over 500 parents and other community members, is being planned for the end of April. Suicide and violence prevention sessions will also be conducted at the Health for Success conference being held in mid-July at Longwood College. ASIST, QPR, and Second Step sessions will be presented.

Resource Mothers home visitors and Healthy Start staff will administer the Edinburgh screen to women who appear to be depressed and refer them to providers if indicated and depression is severe.

The Division of Child and Adolescent Health provided regional trainings to school nurses and health department staff on identifying depression and other mood disorders in children, using tools from Bright Futures in Practice: Mental Health.

VDH, the Department of Social Services (DSS), and the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) are collaborating with Georgetown University to develop a training program based on Bright Futures in Practice: Mental Health to

help case managers, school nurses, and others identify signs of mental health problems in children.

c. Plan for the Coming Year

Gatekeeper training will continue to be made available to middle and secondary school personnel. Special efforts to provide this training to college campuses and EMS providers will be made. Both groups have shown great interest in suicide prevention and they are already requesting the training.

A primary focus of the third and final year of the grant will be to build local capacity to continue the work beyond the grant cycle. This is being done in part by training people at the local level (community service board and local crisis center personnel, along with others who have a vested interest) to be gatekeeper trainers and/or advocates for awareness and prevention efforts. With advocacy and training capacity in place at the local level, a basic program can continue to function with state level coordination and support to enable continued provision of training materials.

VDH, DSS, and DMHMRSAS plan to pilot test the mental health training module during FY 05. The evaluation will be conducted by Georgetown University. The revised training program will be offered to health and human services agencies throughout Virginia. Target audiences include foster care case workers and foster care parents; Part C Early Intervention case workers; community services boards case workers; school nurses; home visiting program staff; and health department staff.

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

a. Last Year's Accomplishments

The Healthy Start Program 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.

RPCs 4, 5, 6, and 7 reviewed neonatal transports to hospitals and addressed areas needing improvement through educational classes and systems changes. One RPC reviews very low birth weight data from 10 hospitals to determine whether infants received the appropriate level of care and provided feedback to hospital administrators. Another developed guidelines for transport of high risk pregnant women.

RPCs 4, 6, and 7 conducted training on transport of very low birth weight infants for providers. In CY 03, all seven RPCs trained 14,124 professionals in obstetrical (289), neonatal (277) and other programs (144) totaling 1,721 program hours. Most were nurses (4,367) and respiratory therapists and consumers (6,527), while others were physicians (904), health educators (477), social workers (387), resource mothers (230), and nutritionists (116).

b. Current Activities

Resource Mothers and Healthy Start review data on clients so that interventions can be initiated to improve the care of pregnant women.

RPCs conduct FIMRs that identify barriers in the health care system and recommend ways to improve access to care and provision of services.

c. Plan for the Coming Year

Very low weight births are the least likely low weight births to be prevented through the efforts of public health. However, the RPCs will continue to focus on development and maintenance of the community level infrastructure necessary to support the delivery of perinatal services. The RPCs will also implement FIMRs and address issues related to low birth weight infants, access to care, and infant mortality. The RPC activities will use FIMR data and analysis to determine which issues to address within the systems of health care for pregnant women and their infants. RPCs will strive towards a goal for all regional perinatal care delivery systems to provide risk-appropriate care.

RPC 2 will maintain the proportion of very low birth weight infants born at level III hospitals in the Blue Ridge region by completing annual maternal/newborn transport reviews, review findings, and recommendations with the hospitals participating in the reviews. RPC 2 will continue to provide the most current literature/research and professional recommendations at each transport review meeting.

Likewise, RPC 3 will continue maternal/newborn transport reviews and provide FIMR findings and recommendations from the reviews at each meeting with the participating hospitals. They will continue the FIMR process and implement recommendations that are provided by the case review team through the consortium and implement community based initiatives.

RPC 4 will continue maternal/newborn transport reviews in all of the community hospitals and provide feedback and discussion on risk appropriated care during each meeting. They will also continue to provide perinatal educational topics to the community hospitals.

RPC 5 plans to increase the number of maternal transports and decrease the number of very low birth weight infants from level II hospitals. They will implement the FIMR recommendation to increase the awareness of preterm labor signs and symptoms among Spanish-speaking women in the Northern Virginia region with the development of an educational program with March of Dimes funding.

RPC 6 will educate health care providers and consumers on perinatal conditions contributing to low birth weight and very low birth weight births. They will also improve the health outcomes of very low birth weight infants by assuring resuscitation and stabilization of infants according to AAP/AHA and Perinatal Continuing Education Program (PCEP) guidelines by physicians and nurses in rural communities prior to transport.

RPC 7 will increase perinatal care providers' knowledge related to regionalization of care and national ACOG standards by distributing ACOG information and through the use of maternal/neonatal transport review meetings. They will increase perinatal providers knowledge of issues and available resources for patients as they relate to low birth weight and very low birth weight by annually assessing their education needs and providing educational programs.

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

a. Last Year's Accomplishments

Last year, 77 percent of Healthy Start clients entered prenatal care in the first trimester. While this is significantly lower than the state rate of 88 percent, these low-income African American women have significant barriers to obtaining early prenatal care.

RPCs supported Healthy Start and collaborated with local agencies in the community, such as

the Browning Health Ambassador Project in Norfolk and Portsmouth, to promote access to care. The staff of the council provides education sessions for staff that visit the women of childbearing age in their homes.

RPC 3 (Lynchburg) worked with Community Voices, a program that trains community residents to be lay health advisors, who in turn teach those in the community about the components of perinatal health. Lay health advisors increase community awareness of perinatal health care by conducting educational seminars in churches, community centers, civic/social organizations and agencies, day care centers, and health care provider sites. They also operated Beds & Britches, an incentive program that aims to increase the number of women who access prenatal care during the first trimester. This is funded by small grants, community donations, and fundraising.

RPC 5 offered Spanish and English curricula for prenatal care, as well as perinatal care educational resources in Korean, Vietnamese, and Chinese languages to all the clinics and health departments.

OFHS program management staff participated in the Prenatal, Infant, Children and Special Needs (PICS) committee convened by DMAS. PICS has been instrumental in identifying best practices, developing clinical guidelines, providing education, and addressing service delivery problems for the MCH population. The PICS committee conducted a survey of providers that made it clear that providers need training on the tools used to identify depression.

b. Current Activities

Outreach is conducted by staff in local health departments, Resource Mothers, and Healthy Start to get pregnant women into prenatal care in the first trimester. A new data collection web-based tool for Resource Mothers and Healthy Start collects data on entry and adequacy of care. The lay home visitors educate childbearing-age women about the importance of prenatal care and where they can obtain it. RPCs are also working with providers to increase access to prenatal care.

Healthy Start provides case management services to pregnant women and interconceptional women to improve access to prenatal care services in its four local communities. In addition, the Resource Mothers and Healthy Start programs participate in collaborative planning to increase the assessment of pregnant women for substance abuse and depression. Staff develop private provider skills through training to serve low-income pregnant women and facilitate their access to medical insurance and community resources. Healthy Start monitors the effects of improved nutrition services on pregnant women and their infants.

DWIH assisted in the distribution of a pamphlet that explains state laws requiring screening for substance abuse and HIV and providing protocols for physicians to use for assessment. DWIH distributed it to RPCs to give to providers. The pamphlet was developed in partnership with VDH, DSS, and DMHMRSAS.

The preparation of the report of the Virginia Action Learning Lab (ALL) task force survey is underway. The purpose of the survey was to determine if health care providers who serve women of childbearing age are 1) providing HIV counseling and testing and 2) providing screening and assessment of pregnant women around substance use and abuse. Data support the need for increasing provider education and support of rapid testing options during labor and delivery.

RPCs are collaborating with local agencies in the community and conducting FIMRs with local hospitals in their regions to identify factors associated with infant and maternal mortality.

RPC 2 is following a minimum of ten pregnancies at a local health department from the time the women test positive until delivery to evaluate them and then ensure that the women receive adequate and early prenatal care. This process will allow the RPC to identify systems issues that impede early entry into care.

Health departments that are no longer providing prenatal care are referring clients to providers in the community. Staff are following up with women who have a positive pregnancy test to make sure they are counseled and obtain the appropriate referral for health care services. Several staff have made arrangements with physicians in their districts for prenatal care to ensure early access to prenatal care. Collaboration continues with other agencies in the community (schools, social services, community services boards).

c. Plan for the Coming Year

RPC 1 will be offering the American Red Cross and Healthy Pregnancy Healthy Baby Instructors course to certify 18 additional childbirth educators in the Southwest region by 2008.

RPC 2 will collaborate with the Henry County-Martinsville Health Department to determine if there are systems issues impeding early entry into prenatal care. They will also collaborate with For the Children, a local organization dedicated to improving the lives of children, 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 also increase the proportion of lay health advisors' (in Lynchburg and Danville) understanding of the importance of early and adequate prenatal care so that they in turn can educate their patients. They will maintain the Beds & Bitches prenatal care incentive program in planning district 11, which encourages women to enter in to prenatal care in the first trimester.

RPC 4 will increase the proportion of the region's health care providers' awareness of entry into care statistics and barriers and provide education on the topics related to the statistics and barriers. They will increase communication and networking between maternal child health directors and health departments, thereby increasing awareness of barriers and trends of entry into prenatal care.

RPC 7 will increase awareness of participation in regional home visiting programs, perinatal services providers, and agencies offering services to the perinatal patients and their families by maintaining the enrollment of women in the Norfolk and Portsmouth Virginia Healthy Start Programs.

The HIV statewide task force will meet during the summer of 2004 to discuss the final report and to evaluate next steps. The committee responsible for writing the report will have it ready for dissemination soon thereafter. This project remains a collaborative effort between the Division of Women's and Infants' Health, the Division of HIV/STD and the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS).

The PICS committee will consider whether substance abuse and domestic violence could be part of the training offered to providers. Healthy Start and Resource Mothers will continue initiatives to improve access to care.

DWIH is assisting the secretary of health and human resources with a study on access to rural obstetrical care.

DWIH will finalize the update of the maternity guidelines for use in health department prenatal clinics and distribute the guidelines during FY 04.

PICS will review ways to assure that prenatal patients enrolled in managed care organizations and those in localities without MCOs receive similar education and assessment.

FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

General Instructions/Notes:

List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|---|-------------------------------------|--------------------------|-------------------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State. | | | | |
| 1. Maintain screening of nine inborn errors of body chemistry-metabolic, endocrine, and hematologic. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. Monitor all newborn screening results and conduct aggressive follow-up on all abnormal results. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 3. Provide PKU formulas and other food products. | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Maintain the Virginia Infant Screening and Infant Tracking System (VISITS) birth defects database. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Mantain contracts with medical specialists statewide to provide metabolic treatment and consultation. | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Provide information and consultation as requested to explore the expansion of newborn screening services via Mass Spectrometry technology (mandated study) | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 7. VASCAP will continue to provide follow-up tracking for newborns identified with sickle cell disease. | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|--|--------------------------|-------------------------------------|--------------------------|--------------------------|
| | DHC | ES | PBS | IB |
| 2) 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) | | | | |
| 1. Family members routinely serve on committees and advisory boards of the CSHCN Program. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Provide family-to-family support as a basic service of Care Connection for Children (CCC) centers. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | | | | |
|---|--------------------------|--------------------------|--------------------------|-------------------------------------|
| 3. Collaborate with Family Voices and Parent-to-Parent to enhance family decision-making ability. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Administer parent satisfaction surveys at CCC and Child Development Centers. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Monitor activities and outcomes. Adjust CSHCN state plan as needed. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|--|--------------------------|-------------------------------------|--------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 3) 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) | | | | |
| 1. Collaborate with other community agencies to expand the availability of medical homes for CSHCN. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. CCCs and CDCs work with families to ensure that children served are referred to a medical home. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Participate in the NICHQ Medical Home Learning Collaborative. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Monitor activities and outcomes. Adjust state plan as needed. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|--|--------------------------|-------------------------------------|--------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 4) 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) | | | | |
| 1. CCCs and CDCs will refer 100% of eligible children to Medicaid, FAMIS and SSI. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Provide health insurance case management as a basic service of the CCC centers. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Continue the MCHIP/CSHCN Health Insurance and Financing Grant to improve access. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Monitor activities and outcomes. Adjust the state plan as needed. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | | | | |

| | | | | |
|-----|--------------------------|--------------------------|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|---|-------------------------------------|-------------------------------------|--------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 5) 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) | | | | |
| 1. Provide leadership in planning, developing, and implementing efforts to improve services for CSHCN. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Provide care coordination for CSHCN from birth through twenty years. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. CCC centers administer a CSHCN Pool of Funds. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Bleeding Disorders Program provides a system of services for people with bleeding disorders. | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. CDCs provide diagnostic and evaluation services for children from birth through twenty years. | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. CDCs partner with others to coordinate care for children with behavioral problems. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Monitor activities and outcomes. Adjust the state plan as needed. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8. Participate in statewide committees and interagency councils for CSHCN issues. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 9. Provide training and technical assistance. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|---|--------------------------|-------------------------------------|--------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey) | | | | |
| 1. CCCs provide transition of services from pediatric to adult health care services. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Monitor activities and outcomes. Adjust the state plan as needed. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|------------------------------|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |

| | DHC | ES | PBS | IB |
|--|--------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| 7) 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. | | | | |
| 1. Provide funding to local health districts to supplement outreach efforts for immunizations. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. Promote Bright Futures Guidelines to increase utilization of preventive health care. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Support home visiting programs such as CHIP of Virginia and Resource Mothers. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Participate in Project Immunize Virginia Coalition. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Collaborate with stakeholders to publish information regarding immunization requirements. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|---|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years. | | | | |
| 1. Provide oversight of teenage pregnancy prevention programming in 7 health districts. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Fund Better Beginnings Coalitions (BBC) in 19 communities. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Evaluate teenage pregnancy prevention programs. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Fund and support teenage pregnancy prevention strategies in local health districts. | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Support statewide train-the-trainer workshops to help parents talk with their children about sensitive topics including sexuality (e.g. "Can We Talk" curriculum). | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 6. Continue efforts to integrate HIV, STD, and teen pregnancy prevention messages. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. Develop statewide teen pregnancy prevention plan. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth. | | | | |
| 1. Provide funding to local health departments for dental services including | | | | |

| | | | | |
|---|-------------------------------------|--------------------------|-------------------------------------|-------------------------------------|
| dental sealants. | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Evaluate the school fluoride rinse program through survey of 1,000 children with regard to tooth decay status and sealants. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. The school rinse program provides fluoride to 50,000 children in 200 schools without access to community water fluoridation. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Quality assurance is provided to one-third of dental programs statewide each year and includes on-site clinical and community review. | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Educational materials in multiple languages are provided to health department dental programs, Head Start programs, and school nurses. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|--|-------------------------------------|-------------------------------------|-------------------------------------|--------------------------|
| | DHC | ES | PBS | IB |
| 10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children. | | | | |
| 1. Continue the dissemination of child restraint devices. | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. Coordinate public and provider education campaigns. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 3. Continue promoting child safety seat check events. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Continue buckle up campaigns for high schools. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|--|--------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 11) Percentage of mothers who breastfeed their infants at hospital discharge. | | | | |
| 1. Offer workplace lactation resources for Virginia employers. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. Promote August as Breastfeeding Awareness Month in Virginia. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 3. Develop and staff a Breastfeeding Station at the Virginia State Fair. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Continue to provide breastfeeding education and support of health care providers. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 5. Continue research in racial/ethnic disparities and influence of fathers in breastfeeding rates. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | | | | |
|-----|--------------------------|--------------------------|--------------------------|--------------------------|
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|--|-------------------------------------|--------------------------|--------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 12) Percentage of newborns who have been screened for hearing before hospital discharge. | | | | |
| 1. Enhance, implement, and evaluate the Virginia Early Hearing Detection and Intervention Program. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Maintain the Virginia Infant Screening and Infant Tracking System database. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Develop curricula and implement training and education opportunities. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Provide hospitals with quarterly updates on program strengths and areas of need. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Manage the HRSA Universal Newborn Hearing Screening grant. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. Monitor all newborn hearing screenings and ensure retesting as needed. | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|---|-------------------------------------|-------------------------------------|--------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 13) Percent of children without health insurance. | | | | |
| 1. Collaborate with partners to increase enrollment in state sponsored health insurance programs. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Participate in initiatives and coalitions aimed to reduce uninsured rates. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Fund local health districts for outreach and enrollment activities. | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Support surveillance, monitoring, and dissemination of data related to children's health and insurance status. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program. | | | | |
| 1. Collaborate with partners to increase enrollment in state sponsored | | | | |

| | | | | |
|---|-------------------------------------|--------------------------|-------------------------------------|-------------------------------------|
| health insurance programs. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Participate in initiatives and coalitions aimed at increasing utilization of care. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Fund local health districts for outreach and enrollment activities. | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Promote Bright Futures to increase access to preventive health care for children and adolescents. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Encourage school nurses to use Bright Futures materials to promote EPSDT screenings to parents. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 6. Develop and maintain web-based continuing education training modeules, based on Bright Futures, to promote EPSDT screens in partnership with Va Chapter AAP and Department of Medical Assistance Services (state Medicaid agency). | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. Collaborate with Departments with of Social Services and Medical Assistance Services to develop standard training modules, based on Bright Futures Mental Health, to identify and refer children with mental health concerns. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|--|-------------------------------------|-------------------------------------|--------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 15) The percent of very low birth weight infants among all live births. | | | | |
| 1. Partner with March of Dimes to develop and implement campaign to prevent premature births. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Provide Healthy Start intervention in four communities with high infant mortality. | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Provide prenatal services through local health departments, hospitals, physicians or clinics. | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Train providers in reducing low weight and preterm births. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|---|--------------------------|-------------------------------------|-------------------------------------|--------------------------|
| | DHC | ES | PBS | IB |
| 16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19. | | | | |
| 1. Provide gatekeeper training for middle and high school youth. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. Promote radio-based teen public awareness campaign. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 3. Develop and disseminate school guidelines. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

| | | | | |
|--|--------------------------|--------------------------|--------------------------|-------------------------------------|
| 4. Continue public and provider information dissemination. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|--|--------------------------|--------------------------|--------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates. | | | | |
| 1. Review Resource Mothers and Healthy Start client data to develop plan for improving care. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. All regional perinatal councils(RPC)will conduct fetal infant mortality reviews (FIMRs). | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. RPCs will continue to review neonatal transports to hospitals and work with health care facility to develop a plan for improvement. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. RPC 7 will review very low birth weight data to determine appropriate level of hospital care. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|---|--------------------------|-------------------------------------|--------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester. | | | | |
| 1. LHD staff will conduct outreach activities to get women to into early prenatal care. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Continue to develop a plan to increase prenatal care based on the provider survey. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. RPC 3 will use lay home visitors to educate women about the importance of prenatal care. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. All RPCs will educate providers on the ways to increase access to prenatal care. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | | | | |
|-----|--------------------------|--------------------------|--------------------------|--------------------------|
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *The percent of children and adolescents who have a specific source of ongoing primary care.*

a. Last Year's Accomplishments

In FY 03, Title V funds supported the Comprehensive Health Investment Project (CHIP) case management program in the Roanoke health district. The CHIP program provided medical/social case management for families with children aged 0 to 6 years in low-income families. Both CHIP and Resource Mothers are Title V enabling services to ensure that children have a primary care provider. In FY 03, Title V supported outreach efforts to identify medical homes in Arlington, Chesterfield, Cumberland Plateau, New River, Richmond, Prince William, and Virginia Beach. Title V supported comprehensive primary care services in Norfolk, Hampton, and Alexandria.

The Division of Child & Adolescent Health (DCAH) collaborated with the Department of Medical Assistance Services (DMAS) to conduct regional Early Periodic Screening, Diagnosis and Treatment (EPSDT) training sessions for medical providers to increase the number of EPSDT examinations conducted and to improve the quality of services provided. Through these efforts, the concept and importance of the medical home was reinforced.

b. Current Activities

Funds are currently being used in ten health districts to support promotion of medical homes. These districts include Alexandria, Chesterfield, Cumberland Plateau, Hampton, Lord Fairfax, Norfolk, Prince William, Richmond City, Roanoke City, and Virginia Beach. Health districts are employing a variety of strategies to ensure that children and adolescents receive care within a medical home. In Alexandria, Hampton, and Norfolk, health districts continue to provide primary and preventative care for children in accordance with community needs. Other health districts are conducting various activities using Title V funds, which include case management, education efforts incorporating the medical home concept, and assistance with obtaining children's health insurance.

Resource Mothers and DCAH staff continue collaborating on the New Parent Kit described in NPM #7. Home visiting groups such as CHIP of Virginia, Healthy Families, and Resource Mothers are coordinating local distribution efforts to provide all new parents in the state with a kit. Pilots in Southwest and Tidewater regions started in March 2004. The Kit contains information about choosing and using a pediatrician as well as information about obtaining health insurance and accessing additional health resources. Title V representatives serve on several groups whose mission includes increasing access to care and medical homes. These have been referenced in discussions of NPMs #13 and #14.

As referenced in NPM #13, VDH received an Early Childhood Comprehensive Systems (ECCS) Grant. One of the primary areas of focus required in this initiative is promotion of medical homes for the early childhood population. The Virginia ECCS grant is currently conducting the required environmental scan. A survey is being conducted among early childhood serving agencies and organizations. Questions address current activities and gaps regarding children's access to a medical home. Data will be used to help drive future activities, including those supported by Title V, to promote access to and use of medical homes. As the Virginia ECCS strategic planning process progresses, the Title V program will partner where possible to improve systems of care and medical homes for the early childhood populations.

As discussed in NPM #3, representatives from the CSHCN Program, Care Connection for Children network, and private pediatric practices participated in the Medical Home Learning Collaborative sponsored by the National Institute for Children's Healthcare Quality.

c. Plan for the Coming Year

In FY 05, VDH will fund health district activities that promote access to medical homes. These districts include Alexandria, Chesterfield, Cumberland Plateau, Norfolk, Richmond City, Roanoke City, and Virginia Beach. Districts will be conducting primary care clinics, case management, public education, and/or outreach to enroll children in health insurance.

VDH will continue working on multidisciplinary groups such as the Covering Kids and Families (CKF) Task Force on Values, Access, and Utilization of Services and the Prenatal, Infant, and Children's Services (PICS) committee. These groups will continue their work in forming partnerships and promoting messages regarding the importance of preventive care, increased ability to navigate systems of care, and monitoring use of services.

The Title V program will examine findings from the VECCS needs assessment regarding access to and provision of medical homes for the early childhood population. Title V will support and partner with VECCS strategic planning efforts to improve the early childhood system of care including assuring medical homes for children.

Title V will work to refer children to their medical home for routine immunizations instead of providing stand alone immunization clinics. The program will work with DMAS to identify physicians willing to serve as Medicaid providers and medical homes for children and adolescents in communities throughout Virginia. Title V representatives will continue collaborating with the Virginia Chapter of Academy of Pediatrics to promote the concept of Medical Home and work with the Virginia Academy of Family Practice to promote this concept in practice.

As referenced in NPM # 13, VDH OFHS submitted an application to MCHB for a planning grant. Pending award of the grant, VDH will be conducting an environmental scan to assess barriers related to obtaining medical homes, utilization of care systems, and other systems issues. Under the ECCS framework, partnerships will be explored which could improve capacity and process to ensure medical homes for young children.

State Performance Measure 2: *The rate of unintentional injury hospitalizations to children ages 1-14.*

a. Last Year's Accomplishments

VDH's Injury Prevention Resource Center supported hundreds of community groups with educational materials for their injury prevention projects. CIVP implemented the full integration of bike training and helmet promotion programs into the Health and Physical Education Curriculum in four schools and supported thirty-five community helmet promotion projects with mini-grants. CIVP coordinated a statewide holiday bicycle helmet distribution and education project in conjunction with Virginia's Salvation Army and Sergeant Santa toy drive programs.

b. Current Activities

CIVP is coordinating annual statewide educational observance of bike safety month to

encourage school and community-based safety activities. CIVP is providing three regional playground safety trainings for school and parks and recreation staff based on the SAFE model, which addresses Supervision, Age Appropriate Developmental Design, Falls to the Surface, and Equipment and Surface Maintenance. CIVP staff are also managing fire and gun injury prevention programs and educating a variety of stakeholders with presentations on injury prevention.

The New Parent Kit referenced in NPMs #7, 10, and 13 provides a section on safety materials. Home-safety (childproofing), poisoning prevention, and hot water safety are among the topics covered.

c. Plan for the Coming Year

CIVP plans to continue to provide training and consultation on injury prevention strategies, share prevention education resources, disseminate safety devices (e.g. bike helmets, smoke alarms, gun locks), and support community injury prevention projects.

The New Parent Kit contains safety information on prevention of unintentional injuries and will be distributed statewide to all new parents in the Commonwealth.

State Performance Measure 3: *The rate of assault injury hospitalizations among youth aged 10 -19.*

a. Last Year's Accomplishments

In conjunction with the Safe and Drug Free Schools program at the Department of Education and the School Safety Center at the Department of Criminal Justice Services, VDH coordinated an annual resource dissemination of parent education materials for back to school events and trainings on school-based youth violence prevention programs (PATHS, Aggressors, Bystanders, Victims, Get Real About Violence, Second Step) for audiences around the state. VDH also promoted a website, Best Practices for Youth Violence Prevention, that was developed in conjunction with the Department of Education and Virginia Commonwealth University, Center for the Study and Prevention of Youth Violence. The website enables educators to research all the programs that meet national standards and to identify the program that best meets the needs and goals of their community audience.

b. Current Activities

In an effort to encourage health care providers to screen youth patients for violence risk factors and provide resources and referral based on the level of risk, CIVP is disseminating a health care provider's manual and screening reference cards to pediatricians and family physicians across Virginia. The materials were adapted from similar resources developed by the Massachusetts Medical Society.

c. Plan for the Coming Year

VDH plans to continue to share youth violence prevention resources through the website and targeted mailings and to continue to collaborate with other state level partners to coordinate trainings and workshops on youth violence prevention for community stakeholders. VDH also plans to develop and implement a statewide bullying prevention campaign pursuant to the following recommendations from the MCHB National Campaign: 1) promoting routine monitoring for related risk factors and quick intervention for children/adolescent bullies and victims; 2) convening multidisciplinary community-based coalitions to improve coordination of the assessment, intake, and referral of children/adolescents for community services;3)

supporting the development of safe school policies, plans, and prevention programs to address bullying behaviors; 4) promoting training and continued education on bullying prevention strategies in health, safety, and medical fields; 5) coordinating public education for parents, teachers, and others who are in contact with children/adolescents to help them recognize and intervene in episodes of bullying; and 6) contributing epidemiological expertise and the public health perspective to refine the evidence available on the causes, consequences, and prevention of bullying.

State Performance Measure 4: *The rate of neural tube defects among live births.*

a. Last Year's Accomplishments

In FY 03, the director of Pediatric Screening and Genetic Services (PSGS), a unit within the DCAH, continued to manage a three-year, CDC-funded birth defects surveillance and prevention grant. The purpose of the grant project, Virginia Congenital Anomaly Tracking and Prevention Improvement Project (VaCATPIP), is to advance the Virginia population-based birth defects surveillance, prevention, and service program--Virginia Congenital Anomalies Reporting and Education System (VaCARES). Funds continued to be used to maintain VaCATPIP to achieve the following objectives: (1) identify and implement methods to improve, sustain, and expand the capacity of VaCARES to ascertain cases and generate timely population-based surveillance data; (2) enhance the analysis and reporting mechanisms of VaCARES; (3) evaluate VaCARES surveillance methodology; (4) involve additional partners in Virginia to expand VDH neural tube defects (NTD) prevention; (5) evaluate VDH NTD prevention activities; (6) strengthen the involvement of appropriate partners within Virginia to improve children with birth defects access to comprehensive, community-based, family-centered care; and (7) evaluate progress on improving access to services.

During FY 03, PSGS--working with the Divisions of Women's and Infants' Health (DWIH) and WIC/Community Nutrition Services (DWCNS)--managed several Virginia CATPIP NTD-prevention strategies. A part-time contractor, in collaboration with the Virginia Council on Folic Acid (VCFA), facilitated two regional physician continuing medical education (CME) folic acid dinner presentations in October 2002. A third event planned for Southwest Virginia was cancelled due to low participation. Although 1,500 invitations were mailed, 32 participants attended the two workshops held in Northern and Eastern Virginia. The contracted Genetic Counselor Senior (GCSr) completed work with the VDH Behavioral Risk Factor Surveillance Survey (BRFSS) coordinator on developing and incorporating folic acid awareness questions into the 2003 Virginia BRFSS cycle. The GCSr completed the development of ten VaCARES public fact sheets, including one on spina bifida and one on anencephaly, for distribution to parents. In addition, DWIH purchased and distributed multivitamins containing folic acid for women of child-bearing age through Virginia RPCs.

DWIH continues to supply the following brochures to courts in the state: "Get the B Attitude on Folic Acid", "What Every Family Should Know About Preventing Birth Defects", and "Why Every Woman Needs Folic Acid".

b. Current Activities

During FY 04, the soon-to-be-hired Virginia Folic Acid Campaign Manager (VFACM) position was changed from contractual to a wage position. Most NTD-prevention strategies were put on hold due to recruitment delays. In December 2003, the PSGS staff, in partnership with VCFA and the Division of Dental Health, reprinted and distributed to all WIC clinics, local health departments, community health centers, and free clinics, a small educational tabletop display about the importance of folic acid and the prevention of NTD in infants. The small size makes it easy to display in waiting areas or clinics.

In January 2004, DWCNS staff implemented the following VaCATPIP NTD-prevention activities in coordination with the VCFA: (1) provided leadership and support for enhancing the present function of VCFA; (2) coordinated and disseminated the folic acid message to women of childbearing age; (3) developed and initiated a statewide folic acid informational campaign plan to include primary and secondary prevention in coordination with key stakeholders; and (4) developed and implemented a plan to provide folic acid to women who have a child with a neural tube defect, as identified by VaCARES.

Staff have initiated development of the campaign plan, which will be implemented over the next grant period. This plan will include a televised public service announcement, radio interview, and press release to increase awareness about the use of folic acid. It will also provide English and Spanish folic acid materials and folic acid supplements to health care and educational organizations; support the submission of articles about folic acid to professional journals and health care/educational organizations; ensure participation in public and professional conferences to distribute folic acid information; and evaluate the use of a folic acid display designed in 2003. Furthermore, the contracted GCSr began implementation of the following VaCATPIP Year-3 NTD-prevention strategies that had been placed on hold due to prior vacancy: (1) continued development of a pilot program for the counseling and education of families who have a child who has a neural tube defect, and (2) continued planning to assess the number of children with spina bifida who are enrolled in Part C Early Intervention services.

c. Plan for the Coming Year

During FY 05, PSGS and DWCNS will manage the completion of the following VaCATPIP NTD-prevention strategies: (1) VFACM will continue as an active participant on the Virginia CFA to provide leadership and support for enhancing the present function of the VCFA; (2) GCSr will continue a pilot program for the counseling and education of families who have a child who has a neural tube defect; (3) GCSr--in collaboration and consultation with DWCNS, DWIH, Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services, Virginia Genetics Advisory Committee, and VCFA will continue to assess the number of children with spina bifida who are enrolled in Part C Early Intervention services; (4) VFACM and key stakeholders will continue to develop and initiate a statewide folic acid informational campaign plan to include primary and secondary prevention; (5) VFACM will assure the continued provision of folic acid to women who have a child with a neural tube defect, as identified by VaCARES; and (6) GCSr will work with contractors to develop a regional genetics education program for professionals based on assessed educational needs.

State Performance Measure 5: *The percent of children who are obese or overweight.*

a. Last Year's Accomplishments

The contract for a formal evaluation of the After School Curriculum Kit was awarded to Virginia Tech. The VA FITWIC project was completed and posted on the National WIC Association web site in July 2003, allowing other states access to our materials.

VDH helped form Virginia Action for Healthy Kids (VAFHK), a statewide task force to address childhood obesity. The five steering committee members include representatives from VDH, the Department of Education, Virginia Tech, and the Southeast Dairy Council.

b. Current Activities

DWCNS generated a report containing survey findings of physicians regarding their attitudes, knowledge, beliefs, and practices regarding childhood overweight. This report was co-written by our office director, Dr. David Suttle, and was published in the American Journal of Public Health.

DWCNS has spearheaded an employee wellness program for VDH employees called Step Up for a Healthier Virginia, which is a stair climbing challenge of the world's tallest buildings using the thirteen floors of our office building. To date, 15,250 floors have been climbed!

In an effort to bring heightened awareness of the growing epidemic of obesity, DWCNS has developed Eat Smart Virginia, a family obesity prevention tool kit. The goal of the kit is to educate families on the risks associated with obesity, provide sound nutrition practices and principles that can be used to combat obesity, and supply techniques to increase physical activity across the life cycle. The tool kit contains guidelines for healthy eating and physical activity for all stages of the life span with the ultimate goal of obesity prevention. Eat Smart Virginia is designed to serve as a vehicle to strengthen collaborations with health organizations, community groups and organizations, and the faith community as we collectively combat obesity.

The VAFHK has developed the Curriculum Resource Guide for Nutrition and Physical Activity Classes Aligned with 2001 Virginia SOLs. The Guide was distributed to health and physical education teachers, school nurses, and others who teach nutrition or physical activity within the schools. VAFHK also developed nutrition integrity guidelines that were distributed to all school divisions. The First Lady of Virginia is the Honorary Chairperson.

VDH collaborated with the Department of Education to conduct the Health and Physical Activity Institute in July 2003. Approximately 180 health and physical education teachers attended the institute to learn about new health curricula emphasizing nutrition education from kindergarten through 10th grade and techniques to teach physical education to encourage lifelong physical activity. The Curriculum Resource Guide for Nutrition & Physical Activity Classes (Aligned with 2001 Virginia SOLs), written for this event to address the problem of childhood obesity, was unveiled. The Health and Physical Activity Institute will be presented jointly by VDH and the Department of Education in July 2004. Over 200 health and physical education teachers are expected to attend.

The Board of Health and the Board of Education are meeting to determine what can be done to address childhood obesity within Virginia public schools. The final recommendations will be made in September 2004.

c. Plan for the Coming Year

The formal evaluation of the After School Curriculum Kit will begin in September 2004. Secondly, in an effort to collect obesity data for Virginia, DWCNS has sent out 610 letters to hospitals, universities and colleges, county offices, large corporations, research institutions, and many other organizations in Virginia. DWCNS will analyze and enter data into a database that will be continuously updated. DWCNS is also developing a database where districts and organizations can log on and see what VDH and other communities are doing to fight obesity in all age groups.

In July and August 2004, DWCNS nutrition staff will be providing training to health districts around the Commonwealth on Addressing Childhood Overweight in Our Communities, Training for a Public Health Initiative. This training is geared toward public health professionals and members of their communities for developing collaborative strategies in addressing childhood overweight in their communities.

In a recent Virginia specific data search, DWCNS received data from Commonwealth medical screenings (18,000 state employees), outpatient clinics, an obesity treatment center, college student centers, and several community coalitions. We are expecting a database of over 5.5 million Virginians coming from the Division of Motor Vehicles. DWCNS is also expecting data from two other universities, a fitness center, and an organization that works with public schools. In the search for data, DWCNS identified future collaborative partners.

VDH will work with the Department of Education to implement the Board of Health and Board of Education recommendations to address childhood obesity.

VDH is collaborating with the Department of Education to develop a web-based curriculum resource guide for health and physical activity classes aligned with the 2001 Virginia SOLs. This effort will expand the effort started in FY 04 to include all health topics. It also will provide the same level of curricula resource support for staff teaching health and physical education topics that is provided to teachers in 'core' subjects.

State Performance Measure 6: The degree to which statewide data are available to monitor health-related behaviors among youth.

a. Last Year's Accomplishments

The report Healthy Young People 2001: A Picture of Virginia's School-Age Population, compiled by the VDH School-Age Population Task Team, was published and disseminated in FY 02. This report presents data on the health conditions, health risk behaviors, and health care resources in youth in Virginia. Unmet health needs, as well as gaps in available data to identify needs, are portrayed in the publication.

In FY 02, the Title V program explored the possibility of conducting a statewide Youth Risk Behavior Survey (YRBS) to meet some of the data needs identified in the Healthy Young People 2001 report. Title V staff collaborated in a workgroup that planned for a coordinated administration of the Communities That Care survey, the Youth Tobacco Survey, and the YRBS. Communities That Care is sponsored by the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) to meet federal funding reporting requirements. The Youth Tobacco Survey is supported and funded by the Virginia Tobacco Settlement Foundation. These surveys have been conducted once statewide and provided data related to youth substance use. The YRBS was identified as a potential tool to provide needed data on physical activity, nutrition, unintentional injury risk behaviors, violence, and sexual behaviors. Plans were made to proceed with joint administration of the two surveys previously conducted and the YRBS will not be added at this time. VDH continues to communicate the need for this data.

b. Current Activities

VDH is collaborating with the Department of Education to collect and report body mass index (BMI) data for students according to measurement. A BMI data field is being added to the physical activity report card that is completed on each student.

c. Plan for the Coming Year

In FY 05, available data related to youth behaviors impacting health will continue to be monitored. DMHMRSAS and VTSF plan a statewide administration of Communities That Care and the Youth Tobacco Survey. These data will provide further information about youth substance use. In FY 04, the Title V program is exploring plans to develop a surveillance

system to monitor height and weight in children in public schools. Proposal of legislation requiring collection and reporting of height and weight data in public schools at kindergarten, third, seventh, and tenth grades is under consideration. During FY 05, the Department of Education (DOE) should be able to report BMI data for all students in Virginia based on the Physical Activity Report Card results that are reported to DOE.

State Performance Measure 7: The percent of newborns screened for hearing loss who received recommended follow-up services.

a. Last Year's Accomplishments

During FY 03, the Virginia Early Hearing Detection and Intervention (EHDI) Program completed the following: (1) enhanced reporting structures for Virginia Infant Screening and Infant Tracking (VISITS) Hearing Module; (2) developed the VISITS At Risk Module designed to identify infants and young children who are eligible for Part C Early Intervention services and to generate an electronic referral; and (3) continued participation in the CDC Evaluation Project studying the problem of lost to follow up.

With funds from the HRSA Universal Newborn Hearing Screening Grant, the Virginia EHDI Program completed the following activities: (1) continued development of curricula for training and education of hospital staff, audiologists and primary medical care providers; (2) provided entry-level and intermediate-level training for early intervention providers and early educators through a collaborative contract with Virginia Department of Education; (3) produced public awareness materials that included a display addressing the roles and responsibilities of the primary medical care provider in the newborn hearing screening follow-up process; and (4) produced a video version of the publication, Information for Parents of Children With Hearing Loss Virginia's Resource Guide for Parents, presented in American Sign Language, open captions, and spoken English; and (5) received a rating of "Excellent" from the National Campaign for Hearing Health for the second year in a row for screening over 95 percent of newborns and having in place a statewide system for coordination, training, quality assurance, and follow up.

b. Current Activities

During FY 04, the Virginia EHDI Program carried out the following activities: (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 Sensory Kids Impaired-Home Intervention 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; (3) established an enhanced voice-mail system for the toll-free line, translated into four languages other than English; (4) enhanced the VISITS Hearing Module to allow documentation of tracking and follow-up activities as well as patient outcomes; and (5) hired a follow up coordinator fluent in English and Spanish to increase capacity to follow up on the growing Hispanic population.

c. Plan for the Coming Year

In FY 05, the Virginia EHDI Program will engage in the following activities: (1) continue training efforts for audiologists and primary medical care providers with a focus on hands-on, skills-building for audiologists and replication of the American Academy of Pediatrics teleconferences held last year; (2) establish and maintain a hearing aid loaner bank for infants and young children (to age 3 years) that would be available when the child is first diagnosed; (3) disseminate the parent Resource Guide video that was created in FY 04 to audiologists and other programs statewide; and (4) collaborate 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.

State Performance Measure 8: *The percent of low birth weight infants for African Americans in perinatal underserved areas.*

a. Last Year's Accomplishments

The Division of Women's and Infants' Health (DWIH) continued to provide Healthy Start case management services and health education to African American women in four local communities (Norfolk, Portsmouth, Petersburg, and Westmoreland County). Healthy Start staff served 1,252 pregnant women, postpartum/interconceptional women and infants last year, of whom 75 percent were African American.

Also, DWIH completed the Perinatal Underserved Report 2003, which describes the problem of racial disparities in detail and describes the adequacy of health care services and providers by region. It will be available to the public on the division web site.

b. Current Activities

The Healthy Start Program is conducting outreach to facilitate pregnant women's entry into early prenatal care. The program continues to provide case management, medical nutrition therapy, and health education services, and to assess for substance abuse and depression. Staff continue activities aimed at encouraging pregnant women to stop smoking or taking drugs. Data is being reviewed to examine outcomes and to modify the program to increase effectiveness. Preconception education, including nutrition counseling, is provided.

Some local health districts funded by Title V are focusing on reducing low birth weights. In addition, some regional perinatal councils are working to educate providers on what they can do to reduce low birth weights.

RPCs 6 and 7 serve as Healthy Start consortiums and provide support to the Healthy Start sites in their region. Each RPC has a FIMR process and the consortium has members that make up a case review team to identify concerns in the community. The consortium is the community action team that assists with implementing initiatives in the Healthy Start communities. In these regions, over half of the infant deaths are African American infants.

Sessions to educate providers on perinatal depression were provided last year to raise awareness of the affect of perinatal depression on parenting and care of children and infant deaths associated with women experiencing depression. Last year, both RPCs 6 and 7 completed a training session to educate health care providers about perinatal depression. Healthy Start staff attended these sessions and administered the Edinburgh screening tool in their communities. The nurse coordinators for the Healthy Start sites assessed the community for available mental health services and developed a resources list to use with their clients.

RPC 3 has a Community Voices program funded by the March of Dimes that addresses African American infant mortality through a lay health advisor system of "Each One, Teach One." Community residents are trained in basic perinatal health, which they then pass on to their family, friends, churches, workplaces, and social/civic organizations. This curriculum places great emphasis on the risks of preterm labor and low birth weight for African Americans. The South Central Perinatal Council's Community Voices program has already trained over 100 lay health advisors in the community.

RPCs provide SIDS education in support of the "Back to Sleep" campaign, as well as the folic acid and prematurity prevention campaign sponsored by the March of Dimes. They work closely with the community service board in their region to address substance use and the provision of mental health services.

c. Plan for the Coming Year

Healthy Start will continue to focus on African Americans in the four communities to reduce low birth weight and infant mortality. The Division will continue efforts to reduce racial and ethnic disparities in health status among pregnant women and infants. The Perinatal Periods of Risk Approach will be considered for implementation in the Healthy Start Program.

RPC 6 has identified that co-sleeping occurs more often in Richmond City and is associated with many infant deaths. This year, RPC 6 is developing a community campaign to educate the community on infant mortality and the importance of providing a safe sleeping environment. RPC 6 is working with VDH to improve immunization rates among infants born to HbsAG positive mothers.

RPC 7 will continue FIMRs and the Sudden Infant Death Surveillance Program to identify potential variables and factors, provide regional Back to Sleep and Safe Sleeping Environment to hospitals, health departments, day care centers, faith-based groups and other community programs. RPC 7 is also conducting a review of low birth weight births at a local hospital. The information will be used to identify factors related to the infants and women in this region. Data will be reviewed with the consortium to determine the percent of low birth weight cases that received late or inadequate care and other contributing factors.

State Performance Measure 9: *The percent of pregnant women in Virginia's perinatal underserved areas receiving adequate prenatal care.*

a. Last Year's Accomplishments

DWIH worked with representatives of provider organizations serving pregnant women and infants to increase access to care and the quality of care to poor, pregnant women, particularly those in perinatal underserved areas. Requests for proposals were developed by the division for local health departments and regional perinatal councils that emphasize improving outcomes.

The Healthy Start/Resource Mothers data system was converted into a web-based system that improved accuracy of data collected and improved reporting on performance measures and outcomes.

RPC 1 staff was active with local Partners in Prevention programs and served on other agencies' committees such as Project Link, Resource Mothers, Baby Care and CHIP. A past project that continued is public education on the importance of folic acid. Staff administered the smoking cessation case management program to help pregnant women receiving health department services.

RPC 2 (Roanoke Valley Community Based Group/Blue Ridge) collaborated with Project Link, a community-based substance abuse program, to provide information on available resources for distribution through physician's offices in the Roanoke Valley. Sixty-one physician offices received the information packets and a brief in-service on what the packets contains and how to utilize the packet. It also conducted an initiative to educate women on the benefits of folic acid by utilizing stylists in salons.

RPC 3 continued the lay health advisory training program, Community Voices, and worked to decrease African American infant deaths by using the program, Taking it to the People, created in response to recommendations for the FIMR process. The program centers on the curriculum entitled Taking it to the People, a perinatal health course developed by RPC 3 for the layperson, which covers basic perinatal health topics as well as psychosocial issues such as domestic violence and substance abuse.

RPC 5 co-sponsored a media campaign for SIDS prevention and promoting folic acid. They also provided and coordinated educational programs in the Metropolitan Washington/Baltimore area.

RPCs 6 and 7 conducted seminars for providers and Healthy Start staff on perinatal depression last year to increase awareness of perinatal depression and its affect on parenting and care of children and infant deaths associated with severe depression. Healthy Start staff began using the Edinburgh screening tool in their communities. The nurse coordinators for Healthy Start sites assessed the community for available mental health services and developed a resource list to use with their clients.

The report titled "Improving Access to Perinatal Care in Rural and Under Served Areas: Update Data Report" was completed using the 1996-2000 vital statistics and the 2002 manpower information that was collected by the RPCs. The report will be available on the VDH web site.

b. Current Activities

RPC 3 (South Central Virginia) is using the March of Dimes grant for a Community Voices program in Danville, Virginia. They are using this grant to train community workers to encourage women to seek early prenatal care. RPC 3 has a Community Voices program funded by the MOD that addresses the African American infant mortality through a lay health advisor system called "Each One, Teach One." Community residents are trained in basic perinatal health, which they then share with their family, friends, churches, workplaces, and social/civic organizations. This curriculum places great emphasis on the risks of preterm labor, and low birth weight for African Americans. The South Central Perinatal Council Community Voices program has already trained over 100 lay health advisors in the community. Likewise, the council continues "Babies are Everybody's Business" which offers perinatal health education to consumers at their work sites.

All RPCs continue to provide SIDS education in support of the "Back to Sleep" campaign and support the folic acid and prematurity prevention campaign sponsored by the March of Dimes. They work closely with the Community Services Board in their region to address substance use and the provision of mental health services.

c. Plan for the Coming Year

DWIH will continue to distribute and use information in the updated perinatal underserved report to target health department and regional coordinating council efforts on improving care to pregnant women in these areas. The division will also work collaboratively with DMAS, managed care organizations, VDSS and DMHMRSAS to increase access to quality care for women and infants.

RPC 7 (Eastern Virginia) is conducting a review of low weight births at a local hospital. The information will be used to identify factors related to the infants and women in this region. Data will be reviewed with the consortium to determine the percent of low birth weight cases that received late or inadequate care and other contributing factors.

RPC 6 (Central Virginia) has identified co-sleeping occurring more often in Richmond City and being associated with many of the infant deaths. This year RPC 6 is developing a campaign to educate the community on infant mortality and the importance of a safe sleeping environment. RPC 6 is working with VDH on improving immunization rates to infants born to HbsAG positive mothers. The "Back to Sleep" campaign continues in the region.

All RPCs will continue to provide SIDS education in support of the "Back to Sleep" campaign and support the folic acid and prematurity prevention campaign sponsored by the March of Dimes. They will work closely with the community service board in their region to address substance use and mental health services.

The Virginia Healthy Start Initiative will continue to track adequacy of prenatal care and facilitate access to care for clients.

State Performance Measure 10: *The percent of newborns screened for genetic diseases who receive recommended follow up services.*

a. Last Year's Accomplishments

This is now NPM #1. The new NPM #1 incorporates the Virginia Title V Program's SPM #14, which reported on the percentage of newborns screened for genetic disorders receiving appropriate follow up.

During FY 03, the Virginia Newborn Screening Services (VNSS) Program, which receives major funding from the Division of Consolidated Laboratories Services (DCLS) Enterprise funds (newborn screening kits revenue), continued to screen all newborns in Virginia for the following eight 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, and (8) hemoglobinopathies.

The goal in FY 03 was to ensure that all confirmed positive newborn screening results were referred for treatment (see Form 6 for specific screening data). VNSS tracked and followed up on all abnormal results and assured that confirmed cases were referred into treatment. The full-time nurse position, hired in 2002, became vacant in October 2003 due to resignation. Until that position is rehired, an additional contract nurse has been employed to ensure VNSS day-to-day operations and management are maintained. This staffing level enabled VNSS to continue to provide timely follow up for all new cases, conduct a scheduled regulatory review, and plan for the implementation of a ninth disorder -- medium chain acyl-coA dehydrogenase deficiency (MCADD) -- as mandated by the 2002 Virginia General Assembly.

In addition, the Virginia Genetics Program (VGP) continued to support two metabolic treatment centers for children identified through VNSS: Department of Medical Genetics at the University of Virginia and the Department of Medical Genetics at Virginia Commonwealth University. Under contractual agreements, these centers provide the following services: (1) consultation for local health care providers to facilitate early diagnosis and treatment of infants identified as having abnormal results from newborn screening; (2) laboratory services to monitor blood levels and make recommendations for modification of diet and metabolic formula; (3) patient and family education related to specific disorders and their management; (4) coordination of necessary genetic testing for the family to assist them in making informed decisions; and (5) provision of data and long-term case management information to the VGP. The VGP manager oversees these contracts, which are funded through the Enterprise fund. VGP also administered the provision of special food products, including formulas, for the treatment of individuals with inborn errors of metabolism.

b. Current Activities

This State Performance Measure is the same as the current NPM # 1.

During FY 04, Virginia Newborn Screening Services (VNSS), in cooperation with Division of Consolidated Laboratories Services (DCLS), implemented screening for medium chain acyl-coA dehydrogenase deficiency (MCADD). New brochures and resource materials, geared for both parents and professionals, were developed for this effort. Statewide provider training was conducted at fourteen sites prior to implementation. All other materials, including policies and procedures have been updated to include MCADD.

VNSS and DCLS staff have begun work to enhance the current newborn screening database. The goal is to ensure greater efficiencies in follow up of newborns and the development of an automated mechanism to include diagnosed infants into the birth defects registry (VaCARES). VNSS continues to (1) screen all infants for nine 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. Eastern Virginia Medical School was added as a treatment center in March 2004.

c. Plan for the Coming Year

This State Performance Measure is the same as the current NPM # 1.

In FY 05, VNSS will continue to (1) maintain screening of all infants born in Virginia for nine 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; (3) administer the provision of special food products for the treatment of individuals with inborn errors of metabolism; and (4) provide necessary education and technical assistance to providers. VGP will provide technical assistance and consultation to the Joint Commission on Health Care to conduct a study of the types of metabolic disorders for which infants are screened in other states and to compile a summary of the benefits and cost of such screening. House Joint Resolution 164 passed by the 2004 Virginia General Assembly mandated this study.

In addition, VGP will strengthen collaborative efforts with the VDH-managed Children with Special Health Care Needs Program and the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) to link diagnosed children to needed resources, such as VDH-sponsored Care Connection for Children (statewide network of regional programs that provide health care services, community support, and resources to children with special health care needs, including those with inborn errors of body chemistry) and DMHMRSAS-managed Infant & Toddler Connection of Virginia (Virginia's Part C Early Intervention System).

FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

| STATE PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1) The percent of children and adolescents who have a specific source of ongoing primary care. | | | | |
| 1. Fund and local health districts to assist families in finding and utilizing a | | | | |

| | | | | |
|--|--------------------------|-------------------------------------|--------------------------|-------------------------------------|
| medical home. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Participate in initiatives and coalitions that aim to increase utilization of medical homes. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Continue surveillance, monitoring, and dissemination of data related to utilization of care. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Work with the AAP to promote the Medical Home concept for all children and adolescents. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Work with school nurses to promote the Medical Home concept to school children and their parents. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| STATE PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|--|--------------------------|-------------------------------------|-------------------------------------|--------------------------|
| | DHC | ES | PBS | IB |
| 2) The rate of unintentional injury hospitalizations to children ages 1-14. | | | | |
| 1. Provide radio-based public awareness campaigns. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. Provide community injury prevention project support. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Disseminate public education materials. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 4. Continue dissemination of safety devices (e.g. child restraints, gun locks, smoke alarms) | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| STATE PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|--|--------------------------|-------------------------------------|--------------------------|--------------------------|
| | DHC | ES | PBS | IB |
| 3) The rate of assault injury hospitalizations among youth aged 10 -19. | | | | |
| 1. Continue screening and counseling resource development and dissemination to health providers. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Provide prevention program training and referral for schools. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Disseminate public education materials. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | | | | |
|-----|--------------------------|--------------------------|--------------------------|--------------------------|
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| STATE PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|---|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 4) The rate of neural tube defects among live births. | | | | |
| 1. Continue active participation on the Virginia Council on Folic Acid to provide leadership and support. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Continue a pilot program for the counseling and education of families who have a child with a neural tube defect. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 3. Continue to assess the enrollment of children with spina bifida in Part C services. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Continue to develop and initiate a statewide folic acid informational campaign plan to include primary and secondary prevention. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 5. Assure the continued provision of folic acid to women who have a child with a neural tube defect, as identified by Virginia's birth defect registry. | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 6. Work with contractors to develop a regional genetics education program for professionals based on assessed educational needs. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| STATE PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|---|--------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 5) The percent of children who are obese or overweight. | | | | |
| 1. Evaluate after-school Curriculum Kit. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Provide training to school staff on obesity prevention initiatives. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 3. Fund and support local health district programs that address childhood obesity. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Participate in coalitions and collaboratives aimed at policy and program development to promote healthy nutrition and adequate physical activity. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Collaborate with Department of Education to develop and maintain web-based health and physical activity curriculum resource consistent with Standards of Learning for health, physical education, and elementary classroom teachers. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 6. Support activities of Virginia Action for Healthy Kids to improve access to healthy foods and increased physical activity opportunities within schools. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Pyramid Level of Service

| STATE PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|--|--------------------------|--------------------------|--------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 6) The degree to which statewide data are available to monitor health-related behaviors among youth. | | | | |
| 1. Monitor current statewide data collection activities that measure youth health-related behaviors. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Compile and disseminate available data related to youth health behaviors. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Identify gaps and needs for data related to youth health behaviors. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Collaborate with Department of Education to obtain statewide Body Mass Index data for students. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| STATE PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|---|-------------------------------------|--------------------------|-------------------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 7) The percent of newborns screened for hearing loss who received recommended follow-up services. | | | | |
| 1. Administer statewide early hearing detection and intervention program.2. Mail letters to parents a | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. Mail letters to parents and primary care providers regarding screening results and follow up. | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Implement aggressive tracking activities for children lost to follow up. | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Collaborate with Part C Early Intervention System to streamline referrals and document outcomes. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| STATE PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|--|--------------------------|-------------------------------------|--------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 8) The percent of low birth weight infants for African Americans in perinatal underserved areas. | | | | |
| 1. Conducts outreach through Healthy Start to get pregnant women into prenatal care early. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Provide information to pregnant women on risks from smoking and drugs. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Offer preconception education including nutrition counseling. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

| | | | | |
|--|--------------------------|-------------------------------------|--------------------------|-------------------------------------|
| 4. RPC 2 will work with the local health department to identify systems issues impeding early entry into prenatal care. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. RPC 2 will collaborate with For the Children to increase community awareness about racial disparities and the importance of early and adequate prenatal care. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. RPC 7 will increase awareness of Resource Mothers and Health Start programs in Norfolk and Portsmouth to increase participation. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| STATE PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|--|--------------------------|-------------------------------------|--------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 9) The percent of pregnant women in Virginia's perinatal underserved areas receiving adequate prenatal care. | | | | |
| 1. Resource Mothers and Healthy Start identify strategies for women to obtain adequate prenatal care. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. RPC 3 will conduct outreach to encourage pregnant women to get adequate prenatal care through increasing the number of lay home visitors who understand the importance of this. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Resource mothers in some areas will provide transportation for prenatal care to women in underserved areas. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. VHSI will provide case management services to high risk women to ensure receipt of adequate prenatal care. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. RPC 4 will increase awareness of the entry into care statistics and barriers, and will provide seminars addressing these areas. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. RPC 6 will educate providers and consumers on the factors contributing to low weight births. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| STATE PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|---|-------------------------------------|--------------------------|-------------------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 10) The percent of newborns screened for genetic diseases who receive recommended follow up services. | | | | |
| 1. Maintain screening of nine inborn errors of body chemistry-metabolic, endocrine, and hematologic. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. Monitor all newborn screening results and conduct aggressive follow-up on all abnormal results. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 3. Provide PKU formulas and other food products. | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Maintain the Virginia Infant Screening and Infant Tracking System (VISITS) birth defects database. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Mantain contracts with medical specialists statewide to provide | | | | |

| | | | | |
|---|-------------------------------------|--------------------------|-------------------------------------|--------------------------|
| metabolic treatment and consultation. | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. VASCAP will continue to provide follow-up tracking for newborns identified with sickle cell disease. | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Provide information and consultation as requested to explore the expansion of newborn screening services via Mass Spectrometry technology (mandated study) | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

E. OTHER PROGRAM ACTIVITIES

Continue support for family planning provided through clinics in local health departments. Family planning services will include the following: a complete medical history and physical assessment; routine laboratory testing; offering a variety of FDA-approved contraceptives including voluntary sterilization for patients in low income levels; treatment of gynecologic problems including STDs; level one infertility, referral and follow-up as indicated; education and counseling on many topics related to reproductive health; and pregnancy testing. Funding to purchase the newer cytology screening technologies remains insufficient; however, plans are in place to explore options. The demand for voluntary sterilization continues to exceed the funding level.

The VDH Family Planning Program, in collaboration with the Division of STD/AIDS and the Division of Consolidated Laboratory Services, cooperates in a CDC-funded infertility project to screen women served in STD and Family Planning Clinics for chlamydia. All three are members of the Region III Chlamydia Project Advisory Committee that provides guidance and recommendations regarding Chlamydia prevention activities in the states that comprise Region III. The VDH Chlamydia Project is determining if screening criteria need to be changed on the basis of prevalence and incidence. They are also considering chlamydia urine testing for teens when it is not necessary to obtain a Pap test in a family planning clinic. In addition, they intend to provide state and local health department data to each health district on a yearly basis.

As an abstinence plus contraception education program that promotes healthy families through marriage, Partners in Prevention (PIP) has had the opportunity to collaborate with the Virginia Family Planning Program and the Virginians Against Domestic Violence coalition. A research-driven social marketing campaign was implemented in FY 02 and FY 03 to promote the public health benefits of waiting until marriage to have children. The educational efforts of 17 community coalitions continued in FY 02 and FY 03, with an emphasis on contraception education, domestic violence prevention, and the formation of healthy relationships.

The School Nurse Consultant met with CDC staff in May 2004 to share best practices, begin discussing local plans for the 2010 Goals, and discuss various operational issues.

The School Nurse Consultant developed a draft Asthma Management Manual for school personnel. The final Asthma Management Manual will be distributed statewide in September 2004.

An interagency Coordinated School Health workgroup has been recently established to develop a plan for coordinating school health services. The workgroup is co-chaired by staff from the OFHS and the Department of Education.

The Emergency Response/First Aid Guide for use in schools and childcare facilities was distributed to schools in Virginia in 2003-2004.

The School Admission Form was revised in October 2003 to provide more emphasis on medical home and reference the Bright Futures sources.

The School Nurse Consultant has partnered with DOE to provide training and technical assistance to school nurse coordinators and school nurses on numerous topics throughout the year.

With the assistance from CDC staff, the School Nurse Consultant coordinated training for school nurses on using Bright Futures Mental Health in the early identification of depression in children.

The Early Childhood Nurse Consultant has continued management of a CDC funded grant focused on clinical interventions for asthma and obesity in Head Start facilities in the Richmond metro area; this is a pilot under consideration for replication elsewhere.

The Early Childhood Nurse Consultant has continued to work with the Governor's initiative on school readiness.

A legislative study prescribing patterns for treatment of ADHD was completed.

Staff participated on two interagency projects related to mental health- one on an integrated plan for access to services by children and adolescents, and the other on evidence-based treatments for children and adolescents.

The Child Fatality Review Team located in the Office of the Chief Medical Examiner (OCME) is established in the Code of Virginia. The team reviews categories of child death and develops recommendations to prevent similar deaths and to improve the reporting and investigation of these fatalities. During this past year, the team completed a review of caretaker homicide and undetermined deaths to children during the years 1998 and 1999. Currently the team is reviewing all motor vehicle deaths to children who were injured or died in 2002. Pursuant to House Bill 452 relating to children left unattended in vehicles, the team elected to add a motor vehicle related mini-review to this effort. The team will review all hyperthermia/hypothermia deaths to children left in cars.

The Maternal Mortality Review Team located in the Office of the Chief Medical Examiner (OCME) will continue regular meetings throughout the year. The committee structure was modeled after the recommendations in Strategies to Reduce Pregnancy-Related Deaths and includes physicians, nurses, social workers, epidemiologists, representatives from the Virginia Hospital and Healthcare Association, the Virginia Perinatal Association, the Chief Medical Examiner, the director of the Office of Family Health Services and other VDH staff. The team reviews all deaths to women within one year of the end of their pregnancy, whether that pregnancy ended with a termination, a fetal death, or a live birth.

The Center for Injury and Violence Prevention (CIVP), Domestic and Sexual Violence Prevention Program, is developing an outreach program for health care providers using materials from the Family Violence Prevention Fund. A staff member is available to provide training and education regarding issues about domestic and sexual violence, including the need for universal screening of patients and clients by health care providers. Materials to assist in the screening process are available to local health departments, as well as private providers of health care services. CIVP is also working to promote the prevention of domestic and sexual violence by or towards children and youth by both primary and secondary prevention methods.

F. TECHNICAL ASSISTANCE

General Systems Capacity

1. Financial/Grant Monitoring Systems. Identify states with best 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 changes to the Title V financial/grant monitoring system.

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. (Also supports Virginia's SSDI efforts)

2. PRAMS-Like Survey. Identify a state that has implemented a state PRAMS-Like survey to provide consultation on how they developed and implemented their survey. The consultation would also include lessons learned and assistance in identifying costs estimates.

V. BUDGET NARRATIVE

A. EXPENDITURES

Form 4 lists expenses for FY 03 by the types of individuals served. There is a variance of approximately \$2 million for the pregnant women served from the budgeted amount of \$3,623,412 to \$1,673,221 expended. The expended amount is based on the actual visits while the budgeted amount is an estimate based on the prior years visits. The amount expended for infants was less than the budgeted amount for FY 03 due to the increased funding to support screening activities and visits. 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 district health departments. The FY 03 budget was adjusted to project services for Enabling Services. However, in FY 04 added emphasis is being placed on health education and translation services. The infrastructure expenditures in FY 03 increased from the prior year due to the Director vacancy being filled.

B. BUDGET

Federal funds are designated for preventive and primary care services for pregnant women and mothers. Specifically, these services include the following:

- Policy and procedural oversight concerning women's services
- Nutrition services for women
- Contracts to local health departments for maternal health services
- Pharmacy and laboratory testing for pregnant women
- Regional Perinatal Coordinating Council to include professional outreach education
- Fetal Infant Mortality Review (FIMR)

Prevention and primary care services for infants are budgeted. Specifically, these services include:

- Policy and procedural oversight concerning infant services
- Contracts to local health departments for infant health services
- Regional Perinatal Coordinating Council to include professional outreach education
- Newborn screening and follow up

Funds for prevention and primary care services for children and adolescents include activities aimed at reducing the incidence of health problems and the prevalence of community and risk factors for these problems. Services also include the promotion of health and the provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, and the overall management responsibility of secondary and tertiary care. Specific services include:

- Policy and procedural oversight concerning child and adolescent program development
- Nutrition services
- Child and adolescent health programs including injury prevention, lead poisoning prevention, Child Care Nurse Consultant Services, Medical Home/Access to Care initiatives
- Resource Mothers Program, primary care initiatives, and school health
- Family planning services for patients under age 22 and teen pregnancy prevention
- Maternal health services for patients under age 22
- Laboratory testing and pharmacy services, sickle cell services
- Dental health education and assessment

Funds dedicated to serve population include the following services:

Policy and procedural oversight concerning women's services
Contracts to local health departments for family planning services
Laboratory testing and pharmacy services

Services for children with special health care needs 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. Services also include the development of community-based systems of care for such children and their families. Examples are:

Specialized medical-surgical care programs
Care coordination
Interdisciplinary diagnostic evaluations
Follow-up services
Inpatient hospitalization
Outpatient surgery
Pharmacy services
X-ray and laboratory services
Supplies and equipment
Genetic testing, counseling and education
Nutrition services

Agency administrative costs are incurred by the Virginia Department of Health in the administration of federal and other grants by individuals other than those employed for the sole purpose of support for the grant. As in previous applications, the FY05 budget does not include funds for administrative costs. The definition of administrative costs adopted by the Virginia Department of Health relative to the Title V Block Grant includes the following cost components:

- a. Overall agency management and policy direction for the Title V Block Grant.
- b. Agency provision of accounting, budgeting, payroll, financial control, and financial reporting services as required for the grant by individuals other than those employed for the sole purpose of support for the grant.
- c. Personnel services, including classification and compensation management, grievance handling, recruitment and referral of applicants, program monitoring for equal employment opportunity, standards of conduct and employee performance evaluation.
- d. Support services for the provision of essential supplies, equipment, mail materials and technical assistance.

As required by Section 505 of Title V, the state will budget at least 30% of the total federal allocation for preventive and primary care services for children. Also, at least 30% of the total federal allocation for family-centered, community-based, coordinated care for children with special health care needs, and the development of community-based systems of care for such children and their families. As shown in Budget Form 2, \$4,030,002 or approximately 31.00% of the total budgeted federal funds of \$13,001,114 will be used for preventive and primary care services for children (including infants) and adolescents; \$5,451,878 or approximately 41.93% of the total will be used for children with special health care needs. The remaining 27.07% of the total budgeted federal funds or \$3,519,234 will be used for preventive and primary care services for pregnant women, mothers, and non-pregnant women over 21 years.

The funds provided by the state for FY02 for maternal and child health services are at a level that exceeds the fiscal year 1989 level. During the period of October 1988 through September 30, 1989, \$8,718,003 in state funds for Title V maternal child health services was expended; this compares to the fiscal year 2002 allocation of \$11,598,037 in state funds for these services. During federal fiscal year 1989, a total of \$9,033,260 in federal fund was expended and the Commonwealth of Virginia overmatched the 4:3 requirement by \$1,943,058.

The amount of state funds expended in fiscal year 1989 was determined by including all state funds used for the Title V match and overmatch for all Title V-funded units, and for the childhood immunization program. The state has an established fiscal management system to ensure a clear audit trail. A specific program coding numbers is assigned to each program, which is not duplicated. The program director or designee reviews all requests for payments. All new financial new financial systems used by the Department of Health are reviewed by internal and state auditors prior to implementation and receive the approval of State Auditor's Office. The State Auditor's Office audits all federal programs yearly and its report is forwarded to federal program officials.

Title V funds are used to carry out the purposes of this title and the following activities previously conducted under the Consolidated Health Programs:

- a. Lead poisoning prevention: The program currently receives funds through a CDC State and Community-Based Childhood Lead Poisoning Prevention Programs grant and an EPA grant. Title V funds are used to provide programmatic direction to this program.
- b. Genetics: The three original programs located at the University of Virginia, Virginia Commonwealth University, and the Eastern Virginia Medical School and a fourth genetics center, the Fairfax Genetics and IVF Institute, currently receive funds. Projected funding for Fy2005 is \$859,030.
- c. Virginia did not receive Sudden Infant Death Syndrome (SIDS) funds; however, the Division of Women's and Infants' Health does provide information to families of SIDS infants.

Based on the State's previous use of funds under this title, a reasonable proportion of the allotted funds will be used to carry out the purposes of the Act described in Section 501(a)(1)(A) through (D).

Title V funds (\$4,030,002) 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 the following services: family planning services, local health department prenatal and child health services, genetic testing/counseling/pharmacy and education, Regional Perinatal Coordinating Councils including professional outreach education, primary care initiatives, injury prevention, lead poisoning prevention, and local programs to reduce infant mortality including the Resource Mothers Program and the Nutrition Intervention Project for Underweight Pregnant Women. These services serve the purposes outlines in Section 501(a)(1)(A) and (B).

Title V funds (\$5,451,878) will be used to provide and promote family-centered community-based, coordinated care for children with special health care needs and the development of community-based systems of care for such children and their families. These services include specialized diagnostic, treatment; care coordination and follow-up services provided by children's specialty clinics and child development clinics. These services meet the purposes described in Section (a)(1)(C) and (D).

The general funds targeted to support the match requirement are estimated at \$11,598,037. These dollars dedicated as match for Title V exceed the 4:3 requirement by \$1,847,202. Program income is estimated at \$1,415,463. The total budget, including projected match Title V funds, and program income is estimated to be \$26,014,614.

Along with \$26,014,614 in Title V federal and state funds designated Form 2, additional Federal funds are provided for maternal and child health services in Virginia. In FY 2005, CDC funds include Title X, \$4.4 million; Behavioral Risk Factor Surveillance Systems, \$217,034 and other CDC programs totaling \$1,028,176. Other anticipated sources of MCH targeted funding include dollars for the Women, Infants, and Children (WIC) nutrition program. The actual amount of FY05 is unknown at this time; however, funding is estimated to be \$72 million. Additionally, estimated funds dedicated for Healthy Start are \$1 million; AIDS programs including surveillance and HIV testing, \$5.5 million; injury prevention, \$399,329; SSDI, \$100,000; Abstinence Education, \$859,320; and Lead Poisoning Prevention, \$460,083.

In FY 2005, the \$3.2m additional funding is due to other federal funding received from Department of Medical Assistance Services (DMAS) for the Resource Mothers Program(\$447,500). The Department of Social Services provides Temporary Assistance to Needy Families (TANF) funding totaling \$1.8 million, which includes funding for Teen Pregnancy Prevention Initiative (\$910,000), Partners in Prevention (\$765,000), the GEMS Program (\$176,800). Maternal and Child Health Bureau (MCHB) additional grant funds include Universal Hearing Screening, \$239,245 and the Increasing Insurance for CSHCN grant, \$234,700. Also, \$43.9 million in state and local funds and revenues are budgeted for statewide maternal and child health services, including family planning and dental health services.

There are no known un-obligated balances for the state fiscal year ending June 30, 2004 that are budgeted for the next state fiscal year 2005. Once the final balances are known, Virginia will provide a budget revision and identify the additional initiatives that will be funded with the balances. The revision will identify initiatives and ensure the 30-30 requirement is met.

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.