

STATE TITLE V BLOCK GRANT NARRATIVE

STATE: VT

APPLICATION YEAR: 2005

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I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

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

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 assurances and certifications are maintained on file in the Vermont Department of Health's central administrative offices. The information can be accessed by contacting Sally Kerschner, Vermont Department of Health, Division of Health Improvement, PO BOX 70, Burlington, VT. 05402, 802-865-7707.

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

Ongoing public input for Title V programs takes a variety of forms that allows direct Title V input and also input into general MCH programs. The public budget process is one opportunity, as the governor's budget is published in the newspaper and open to comment by various advocacy groups and members of the public. An annual legislative committee session is purposely advertised for public attendance to allow for input into Title V and other federal grant applications. The Division of Community Public Health has conducted focus groups on behalf of the WIC, EPSDT, and Healthy Babies, Kids and Families programs to assess satisfaction with programs and services, and to solicit input for suggested improvements as well as additional services. The Office of Dental Health has conducted focus groups with low income consumers about access to/satisfaction with Dental Care. CSHN partners with parents (including parents of CSHCN who are not served or are not eligible for CSHN programs) through Parent to Parent and its facilitated focus groups, surveys and interviews. Through P2P, CSHCN hires parents as Children's SSI coordinators, providing outreach to Vt's families whose children are eligible for SSI. In addition, seven of the CSHCN clinical staff are parents of children with special health needs. The Advisory Council for Vermont's Medical Home grant also includes three parent representatives, one parent staff member, and two other "professional representatives" are also parents of CSHN. The re-established Family Advisory Council for CSHCN is entirely composed of parents, with regular attendees numbering six to seven parents.

II. NEEDS ASSESSMENT

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

III. STATE OVERVIEW

A. OVERVIEW

Vermont is located in the northeast region of the United States, a New England state sharing its northern border with Quebec, Canada. It is a rural state with the 2000 census showing a population of 608,827, ranked as 49th in population nationally. Almost all Vermonters are identified as white, although this number decreased slightly over the past ten years - 96.8% in 2000 (vs. 98.6% in 1990). About 2% (14,273) of Vermonters identified themselves as biracial or multiracial and another one half of one percent (3,063) people said they were black. Although, nationally, Hispanics are rapidly growing in numbers as a group, in Vermont they make up only 0.9 % of the population. In addition, close to 1,000 Vermonters identified themselves as Vietnamese in 2000 (compared to 236 in 1990) and the Chinese population doubled to 1,330 during the decade of the 1990's.

The 2000 census revealed several expected trends in Vermont's age distribution. The median age of Vermont residents in 2000 was 37.7, up from 33 in 1990. The population group experiencing the largest increase was the 45-54 age group, with an increase from 10.2% (1990) to 15.4% (2000). The number of people aged 85 and older also increased, from 7,523 (1990) to 9,996 (2000). The number of children aged birth to 19 increased slightly to 166,257. However, those children under five years of age decreased, from 41,261 (1990) to 33,989 (2000).

Household composition is changing, also. The number of Vermonters living alone increased by 28% in the past decade, to 63,112. Also, there is an increase in the number of unmarried partners living together -- 18,079 (47%). The number of households with married couples living together fell to 52.5% of all Vermont households. Married couples with children younger than 18 (the traditional nuclear family) make up 23.2% of the households in Vermont, a statistic that mirrors national trends.

In 2000, there were 6,271 marriages (32% out of state residents) and 2,526 divorces. On July 1, 2000, a new Vermont law went into effect granting same-sex couples in Vermont all the benefits, protections, and responsibilities under law as are granted to spouses in a marriage. From July - December, 1,704 civil unions were established in Vermont (78% being out-of-state).

Vermont was the second fastest growing New England state during the 1990's, as population increased by 8% according to the 2000 census. Of the 251 towns and cities in Vermont, only seven have total populations that exceed 10,000. Vermont's largest city is Burlington, with an estimated population for 2000 of 38,889. Vermont has 14 counties, and one metropolitan statistical area (MSA), the greater Burlington area. The estimated population of this MSA is 166,126, representing approximately 27% of the state's population.

Vermont's governmental structure consists of state government and town/city government, with essentially no county governmental structures, except for certain key services such as the court system. The bicameral legislature is considered a citizen legislature that is in session during January through May each year. During the Fall, 2002 election, a Republican governor was elected to his first term in office, replacing a long term Democrat who did not run for re-election. The fall elections allowed for legislators of more politically conservative leanings to be elected to the House. Vermont citizens participate directly in town/city government through annual town meetings. Vermont is divided into twelve Agency of Human Services districts, each with a district office of the Vermont Department of Health headed by a District Director (Vermont's equivalent to a local health official).

Vermont is a scenic and mountainous state. However, its rural nature presents the issue of sparse populations having ready access to resources and services. Residents living in isolated areas of the state may have special difficulties accessing services and medical care (particularly in the harsh winter months) due to their remote locations and the less than optimal road conditions. Another challenge for the delivery of Title V services is the fact that a sizeable proportion of Vermonters are living either in poverty or are living very near the poverty level. Vermont's poverty rate was 10.1% for 1998-2000, which was 21st lowest among the states. The rate has not changed substantially over the last fifteen years. Of these families who live below the FPL, 24 percent are families with a female head of household. Approximately 1 in 7 Vermont children lives in poverty. Unemployment rates range from 1.8% for Chittenden County (Vermont's most populous county) to 5.9 percent in Orleans County (Vermont's second most rural county), resulting in a state average of 3.6 % (2000 census.) Five percent of Vermont's population has less than a 9th grade education; eight percent haven no high school diploma; thirty two percent have a high school diploma or equivalent and eighty-six percent have a high school diploma or higher (2000 census data.)

Using other measures of health status, the 2001 Family Health Insurance Survey conducted by the Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA), shows Vermont's uninsured rate as being 8.4%, while the rate for children is 4.2%. This makes Vermont as being among the top ten states with the lowest rates of uninsured in the nation (national rate of 14.3%.)

In other indicators, Vermont ranks first in the nation in the ratio of teachers to students in the public schools: 12.1 pupils to one teacher vs. a national ratio of 16:1. Vermont is sixth lowest in the rate of reports of child abuse and neglect: with a rate of 240 reports per 10,000 population aged birth-18 years vs national rate of 419 in 2001. Vermont has the second lowest rate nationally of violent crime. In 2002, Vermont's rate (the number of crimes known to police per 100,000 population) was less than one-fourth of the national average: 106 compared to 495 for the nation.

Since 1980, the Refugee Resettlement Program has relocated over 4,000 refugees to Vermont, increasing the cultural and linguistic diversity of the population being served by the health care and social service system of the state. Recently resettled refugees have arrived primarily from Vietnam and the Balkans, along with a rise in refugees from Africa. This population of new residents may have more difficulties in accessing the health care system and other services because of language barriers, cultural differences, and unfamiliarity with the American health care system and available health resources. In addition, there is a shortage of trained interpreters and translators. Addressing the needs of this group is another challenge in the delivery of Title V services.

In examining coverage by providers of health care services, analyses show a generally acceptable ratio of physicians to population. However disparities by geography affect access to health care. Thus, even the loss of one provider can be significant for the special populations (such as MCH) living in the rural areas. Statewide, there are 32 primary care pediatric practices with 113 practicing pediatricians. This is approximately 80.9 full time equivalents, indicating a higher coverage for Vermont statewide as compared to the recommended 63.2 for Vermont's population size (GMENAC recommends 10.7/100,000 population.) However, marked disparities are revealed by analysis of FTE coverage within the state, revealing 8 out of 14 Health Care areas have inadequate or severe shortage of pediatric coverage. In addition, there are 51.8 FTE's of OB/GYN providers statewide, yet two counties have no OB/GYN providers, six have only two, and the remaining OB/GYN's practice in six counties. The same issue is evident with dental providers: Vermont's overall provider to population ratio of 1/2,564 for primary care dentists is similar to the national average, however several counties have either a short supply of dentists and specialists or have a large number of dentists approaching retirement age. The Office of Rural and Primary Care is tracking these trends and supporting activities to recruit new providers to the state.

Vermont is experiencing a professional nursing shortage, as is the rest of the nation. A survey of 6,008 nurses in 2001, indicated the median age for nurses is 46 years, with 75% being over 40 years old. The average number of years working as an RN is fourteen. Forty percent of those surveyed, who report working in Vermont, work in a hospital setting. Twenty-one percent indicated that they are "somewhat" or "very" likely to leave their primary position in the next twelve months. Of these nurses, 27% said they would leave because of job dissatisfaction and 28% because of salary dissatisfaction. The VDH, in conjunction with a broad based statewide coalition and the University of Vermont (UVM), is working on a variety of recruitment and retention strategies for the increasing the capacity of the nursing workforce in Vermont. Early successes are indicated by UVM's 17% increased enrollment of nursing students in August, 2001 and a 74% increase in first-time, first-year applications as of February, 2002.

Vermont Health Care Reform

In July of 1995, Vermont's Medicaid 1115 Research and Demonstration Waiver application to implement the Vermont Health Access Plan (VHAP) was approved. The waiver has allowed for a basic package of insurance coverage for previously uninsured adults with incomes up to 150 percent of the federal poverty level (FPL). In February, 1999, eligibility for previously uninsured adults was expanded to include parents and caretaker relatives of Medicaid-eligible children up to 185% FPL. The waiver also allowed for mandatory enrollment into a managed care plan for nearly all Vermonters who have Medicaid/Dr. Dynasaur (the name for children's Medicaid) insurance as their sole source of health insurance. Individuals with another source of insurance, or who are recipients of Medicaid Home and Community-Based Waiver Services, or who are in the Medicaid Hi-Tech program, remain

covered by the Medicaid FFS model.

The 1115 Waiver was implemented as of January 1, 1996. Enrollment into managed care plans began on October 1, 1996 for Medicaid families, children, and newly insured VHAP enrollees. One managed care plan, Kaiser Permanente/Community Health Plan/Access Plus, participated at the outset, and a second, Blue Cross/Blue Shield BlueFirst, joined as of January 1, 1997. Vermont is fortunate in that virtually all medical doctors in the state accept Medicaid insurance. A November 1997 survey that took place since the inception of VHAP indicated that an estimated 93.2% of Vermont children had health insurance coverage. By 2003, the latest health insurance survey indicated that an estimated 95.8% of Vermont's children have health insurance. In October 1998, the children's Medicaid program, Dr. Dynasaur, expanded eligibility for children birth to 18 years to include those with incomes up to 300% FPL, further reducing the percentage of Vermont children who are uninsured. (Vermont had been covering children with incomes up to 225% FPL since the early 1990's.)

The MCH Director and other key MCH staff continue to be involved in the administration of the Medicaid program. For example, through EPSDT, the MCH Director and program managers continue to assure that children and youth have access to quality health care through the dissemination and updating of Vermont's periodicity schedule and the provider toolkit that accompanies it. These staff work very effectively and collaboratively with Vermont AAP and AAFP to continuously review, develop, and distribute best practices for pediatric care.

In Vermont, individuals with disability-based SSI are also eligible for Medicaid. A study group examined strategies for enrolling SSI recipients in the managed care plans. After a brief pilot in two counties, it was determined that the best form of managed care for these individuals would not be a pre-paid HMO model, but rather a primary care/case management model (PCCM). This PCCM program, called Primary Care (PC) Plus, began in October, 1999.

//2003/ The latest Health Insurance survey indicates that an estimated 95.8% of Vermont children have health insurance. As of April, 2000, Kaiser Permanente had left the Northeastern market and Blue Cross Blue Shield, in mutual agreement with the Office of Vermont Health Access, had terminated the BlueFirst program. PC Plus was therefore expanded to accommodate the additional beneficiaries. As of June, 2003, approximately 85,000 people were enrolled in PC Plus. **//2005// No updates//2005//**

The Child Health Insurance Program (Title XXI)

Vermont's application for the Child Health Insurance Program (CHIP) has been approved, but with modifications to its original application. Children who have no other insurance coverage are enrolled in PC Plus and are eligible for the Title XXI enhanced federal match rate. This group of approximately 3,100 children comprises the Vermont CHIP enrollment. Children who have another form of insurance are not eligible for CHIP, but continue to be eligible for the expanded Medicaid/Dr. Dynasaur program described above. These under-insured children are enrolled with Medicaid as a secondary payer of last resort, after insurance (or commercial HMO), on a fee-for-service basis. Vermont is exploring strategies to promote enrollment in these expanded insurance opportunities for children. With these advances in coverage, we believe that universal access to health care has been achieved for Vermont children.

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The FFY 2004 Vermont state budget includes a provision to implement a premium assistance program for SCHIP beneficiaries whose families have access to employer sponsored insurance. Prior to implementation, the commissioner must report to legislative committees regarding the cost-effectiveness of the initiative, including the cost of administering the program compared to potential savings.

//2005// No updates//2005//

Current Priorities

(See also Section IV for discussion of the MCH 10 Priority Needs and the national/state performance measures.)

The "Vermont Blueprint for Health" is a venture initiated by the governor, which is dedicated to achieving a new health system for Vermont. The Blueprint is several things: it is the vision that health care can be made better for Vermonters; it is a plan that provides the structure and outcomes to achieve that vision; and it is a partnership of organizations, public and private, that are committed to its implementation. The goals are 1) To implement a statewide system of care that enables Vermonters with, and at risk of, chronic disease to lead healthier lives. 2) To develop a system of care that is financially sustainable, and 3) To forge a public-private partnership to develop and sustain the new system of care. The framework for change is based on the Chronic Care Model. As its ultimate goal, the Model envisions an informed activated patient interacting with a prepared, proactive practice team, resulting in high quality encounters and improved health outcomes. It has six components: community, health system, decision support, delivery system design, self management education and clinical information systems. Intense planning for implementing the Blueprint is taking place at the writing of this report - updates on progress and timeline will be included in future Title V applications.

Vermont continues to prioritize the strengthening of community based and statewide systems to support families' access to quality and affordable health care, including those with children with special health care needs. Vermont is considered exemplary in its successes in providing health insurance for its citizens. Presently, over 92% of Vermont residents have some form of health insurance, with 96% of infants, children and adolescents being covered. However, efforts continue to address families who may have some form of insurance but who are under-insured. Vermont has received a Robert Wood Johnson grant (Covering Kids) to develop and provide enrollment outreach to such families. Another area in need of attention is the utilization of health care among school-age children and adolescents; the School EPSDT Health Access Program is engaged in efforts to address this issue, along with coordination efforts with the Department of Education. Dental health care access is a longstanding problem for Vermonters and one that the Department of Health is addressing through the activities of the Dental Health Unit and the present work (FFY 2004) to develop a statewide oral health plan. Existing strategies include outreach to families via schools and other services, increasing dental care reimbursement rates, increasing the number of towns with fluoridated water systems, and increasing data tracking abilities via linkages with Medicaid.

Although Vermont has made significant progress in lead poisoning screening, there continues to be room for improvement. In 2000, the Commissioner of Health issued revised screening guidelines that recommended universal testing of 1 and 2 year old children. VDH is undertaking efforts to increase lead testing of children and promote the Vermont Lead Law that requires maintenance practices in rental properties and childcare facilities (see description of the activities of the Childhood Lead Poisoning Prevention Program in Section IV B.)

The mental health needs of children and families are also of special concern and receive attention across a number of agencies within the Agency of Human Services. One focal point for activities related to children's mental health is the Children's UPstream Services (CUPS) grant, a 5-year project to support and preserve families of young children who are at risk for experiencing severe emotional disturbance (SED). Also, Community Public Health is working with the Vermont Child Health Improvement Program (VCHIP) to implement tools for screening for depression in youth in well child checks.

Opportunities to increase the effectiveness of this collaboration will be found in the reorganization of AHS (July, 2004) when the Department of Mental Health combines with the Department of Health (see discussion IIC Organizational Structure.)

Healthy Babies, Kids and Families (HBKF) uses a system of care approach to coordinate services for pregnant women, infants, and children up to age 6 years.

The program is managed in each of the 12 health districts through the cooperative efforts of local Maternal and Child Health Coalitions. Within each health district, the Department of Health provides

the primary administrative functions, including: formal enrollment of women and infants into the program; determination of the level of service for which the individual is eligible, based on medical and psychosocial needs; referral to appropriate community resources; data collection; reports of aggregate information; program evaluation; and oversight of standards for service providers. The program was initiated in four health districts in 1994 and has been operating statewide since February 1997. Pregnant and postpartum women are referred to this program through local medical providers, service agencies, WIC clinics, EPSDT outreach, school nurses, the statewide toll-free Help Your Baby, Help Yourself hot line, and self referrals.

The prenatal component of this program focuses on all pregnant women, with particular emphasis on women identified at high risk for a low birth weight delivery (e.g., history of premature labor, multi-gestation, late entry into prenatal care). The program provides periodic home visits or group encounters that include assessment, education, assurance of access to care, and case management services. Medicaid reimburses for home visits by MCH nurses and family support workers and perinatal group education for pregnant and postpartum women. Home visits, group encounters, and telephone contacts are continued through the postpartum period. Hospital discharge planning is guided by the Maternal Postpartum and/or Newborn Follow-up Algorithm. Examples of specific activities include offering home visits during the weekend and evening hours and the development of services for fathers, such as the national "Boot Camp" program. Special priority is given to pregnant and parenting teens. Priority for HBKF services is also given to infants birth to 12 months of age and high risk children ages 1-5. Activities include ensuring regular primary care, screenings and immunizations; assessment and referral for identified concerns of the parent or provider; and connections to community resources.

/2003-2004/ During this period, the Healthy Babies program has been expanded to a more comprehensive system of care offering services to pregnant and postpartum women, infants and children up to their sixth birthday, with a name change to Healthy Babies, Kids, and Families (HBKF). Funding from National Academy of State Health Policy (NASHP) enabled participation in the national Assuring Better Child Development (ABCD) Consortium and supported this expansion. A new emphasis is also the offering of comprehensive preventive services related to early child development (See sections on Performance Measures)/2005/ ***The AHS reorganization will result in HBKF to be moved from the VDH into the newly formed Department of Children and Families. See Section III. C. for more information.***

The new Vermont EPSDT periodicity schedule has been important in the effort to promote new approaches to child and adolescent health supervision, consistent with the current emphasis on health promotion and the prevention of psychosocial morbidity. A clinical providers' tool kit has been developed and distributed which contains screening tools and incorporating information related to the EPSDT periodicity schedule. The tool kit continues to be distributed to pediatricians, nurse practitioners, family practice physicians, and school nurses. Ongoing efforts are being directed toward systems development with regard to the implementation of these standards of practice. A committee of VDH staff and health care providers and QI experts are presently working on updates for the clinical guidelines and the providers' toolkit. Planning is underway for an obstetric clinical guidelines/periodicity schedule.

VDH continues to be active in several other areas of maternal and child health. The Health Department continues with an award winning media campaign to promote communication between parents and their children (ages 11-15 years) about the relationship between the use of alcohol and drugs and vulnerability to sexual advances. In light of welfare reform, day care quality, affordability, and availability has become an even greater priority. VDH is continues to expand the statewide system called Healthy Child Care Vermont, now folded in to the ECCS grants, which provides technical assistance to child care providers about key health and safety issues. In addition, the Division of Community Public Health participates in a state advisory committee on welfare reform. The welfare reform advisory committee continues to focus on child care and transitional child care for parents receiving ANFC, the draft policy that exempts women who are trying to escape family violence from the work requirements under welfare reform, and ANFC parents' transportation needs relating to employment or training.

The Department of Health has become increasingly concerned about the high rates of marijuana and alcohol use among adolescents in Vermont, and the state has a federal grant from the Center for Substance Abuse Prevention that provides funding for research-based community programs to prevent alcohol and drug use among Vermont youth. In addition, a growing concern about the use of illegal drugs such as heroin and cocaine has focused new planning and community based efforts. In 2003, a methadone clinic (associated with Fletcher Allen Health Care) was established in Vermont -- planning for one more clinic is beginning. Beginning research and assessment has begun on the issue of prenatal alcohol consumption and the resultant effects on the fetus - funding for development is being researched at present.

The Office of Minority Health and the ARCHES program is increasing its activities to evaluate the substance abuse practices of Vermont's minority youth, including those of racial, ethnic, refugee, immigrant and GLBTQ minorities. As the needs of these minorities are further identified, OMH is working with VDH divisions to develop specific programs to support these subpopulations.

The Vermont Department of Health divisions of Community Public Health (CPH) and the Alcohol and Drug Abuse Programs (ADAP) are responding to a growing maternal child health concern regarding high risk opiate addicted pregnant and parenting mothers. As the client is identified, she may be referred to the Comprehensive Obstetrical Service (COS) for prenatal care including screening, nutrition, and referrals to substance abuse treatment. Consultation with a neonatologist occurs at 28 weeks EGA. COS (supported by Title V funds) has become a model and resource for this population around the state. By joining efforts, these divisions and many community partners such as mental health, child welfare, hospitals, home health agencies, pediatric and obstetrical practices, corrections and substance abuse providers are developing a state wide system of care for these mothers, children, and families. ADAP and CPH are working to support communities in the development of community based response teams. These teams are being modeled after the Healthy Babies Kids and Families community steering committees and use a child protection empanelment process to protect family confidentiality. Several public health district offices have taken the lead in their communities with this effort. Goals for this year include the development of community response teams in all districts, secure funding to hire a case coordinator for this intake and direct service coordination, conduct monthly conference calls with districts to identify service barriers, foster communication and support, and make recommendations for service delivery and system change.

New initiatives are being planned to not only combat obesity and promote physical fitness in all ages, but also to increase food security for children and their families. In the fall of 2003, Vermont's governor requested that the Dept of Education and the Dept of Health collaborate to develop strategies to counteract the problem of increasing incidence of overweight among children and youth. The result was a proposal for the Fit and Healthy Kids initiative. Key strategies were selected for implementation and funding for staff was allocated in the state budget for SFY 2005. Funding will also increase the number of Run Girl Run sites to 23, serving over 450 girls (Run Girl Run is a year round program designed to give middle school girls the information, training, confidence and support to make healthy lifestyle choices) Also included in the initiative is an expansion of the Fit WIC program. In addition, in July, 2004, Vermont will receive CDC funding for the grant program, Nutrition and Physical Activity Programs for Prevention and Control of Obesity and Related Chronic Diseases. A steering committee will assist in creating a comprehensive state plan for the prevention of obesity and other chronic diseases. The plan will include strategies for integration with WIC, Comprehensive School Health, and the Department of Education as well as other programs working with children and adolescents. Strategies identified will be used to create effective interventions to increase healthy behaviors among all Vermonters, including children, youth and their caregivers. Local coordination between District Offices (WIC) and food shelves and other services aims to reduce prevalence of food insecurity. See also Priority Need 10 and

SPM 10.

The Vermont Injury Prevention Plan, produced by the Injury Prevention Coalition, contains action steps designed to reduce the incidence in the MCH population of the following: suicide and suicide attempts, child abuse, drinking and driving, the prevalence of driving/riding without use of safety belt, fire injuries and deaths, and work related injuries. The Injury Prevention Program is also working on an implementation grant focusing on the issues of domestic violence and the development of clinical guidelines for health care providers. In addition, the VDH is developing strategies to strengthen the capacities of the Office of Women's Health. The Title V planner works closely with OWH to coordinate on women's health issues. New planning is focusing on the health needs and reproductive health needs of incarcerated women. In the Tobacco Control Work Plan (issued June, 2001), the VDH put forth a ambitious plan with detailed strategies aimed at reducing smoking rates by half in all segments of Vermont's population. Particular attention is given to the high rate of smoking among pregnant women. The Diabetes Control Program is updating the publication, Diabetes Prevention and Control, with recommendations and guidelines for management within the school setting in order to inform elementary and secondary school personnel. Also, the Pediatric Periodicity Schedule has been updated to include screening guidelines for type-2 diabetes and pre-diabetes in overweight children.

Environmental health issues that are of special concern for children's health continue to be a focus of attention for assessment and planning. Collaboration continues between the Divisions of Community Public Health and Health Protection's Environmental Risk Assessment Unit in the ongoing specialized training of local environmental designee public health nurses. Over this past year, much of these nurses' time and energy has been focused on the local implementation of activities to protect the public against acts of terrorism (biological, chemical, etc.) Vermont receives funding for continuation of the cooperative agreement with CDC to upgrade state and local jurisdictions' preparedness for and response to bioterrorism, other outbreaks of infectious disease, and other public health threats and emergencies. Grant year 2002-2003 focused on assessing the capacity of the health department in the context of the greater community, planning and beginning to build the critical infrastructure for preparedness using an all hazards approach. Particular progress has been made in communication and information systems, laboratory capacity, and epidemiology and surveillance. Relationships have been built throughout the state between the VDH Local Health Offices and schools to broaden surveillance capacity in the school arena. We are using forms/systems designed for chickenpox reporting as a way of assuring that the dialogues are ongoing. We now are receiving reports from 80% of all schools in the state. As a small state, we have a close relationship between VDH Central, the local offices, and other state and local agencies, professional and voluntary organizations, hospitals, and the National Guard. We are also developing cross border collaborations. Local action planning which includes plans for the needs of the MCH population, is happening via the Local Emergency Planning Committees (LEPC). The VDH District Offices are a major participants in these groups. /2004/ A major activity of this grant year was not expected, that is, the launching of a major preparedness campaign related to smallpox. Vermont vaccinated 130 civilian health care workers, all adults and all of whom had been previously vaccinated. In Vermont, that equates to 2% of the total population. There were no significant adverse events. In the coming year, assessment and planning and implementation will continue. This year chemical identification capacity will be added to the Department of Health State Laboratory capacity in biological agents. /2005/ As of 12/03, all PHN's have been trained in smallpox vaccination techniques. Planning continues for the three day emergency response training to be held in August, 2004. This training will be designed according to the Incident Command System for Public Health. The exercise will be held in two out of the twelve VDH districts and efforts are being organized to address the special issues of emergency response for women and children. All District Offices have have a disaster plan in place. In the coming year, the final year of the Cooperative Agreement Cycle, Vermont will be increasing preparedness for health related effects for an expanded number of agents and events. Vermont will continue to refine its preparedness systems and develop

criteria to indicate level of readiness. These preparations will be increasingly tested through a variety of types of exercises with evaluation and refinement coming out of each exercise. Vermont will also be investing more energy into the full continuum of readiness - from the entire state to small systems. These efforts will be channeled through a greater collaboration with partners. Although there has been great progress in planning, Vermont knows there are many years ahead to fully complete, refine, and update all the aspects involved in emergency preparedness.

Infant mortality reduction continues to be a high priority for the Health Department. The infant mortality rate in Vermont has dropped to 4.2/1,000 live births, the lowest rate ever reported in Vermont. However, our MCH surveillance reports indicate that the preliminary 2003 rate is drifting back up, and two leading indicators related to infant mortality, low birthweight and preterm delivery, are increasing sharply. These data will be monitored by the VDH and the Infant Mortality committee and used to guide strategic interventions. Two campaigns have been outlined toward the reduction of SIDS (Back to Sleep) and reducing the exposure of infants and children to second hand smoke. VDH continues to focus on the prevention of preterm deliveries and identification of psychosocial risk factors that put women at risk for preterm delivery. Also, the Infant Mortality Committee has been conducting a comprehensive analysis of the Vermont-specific causes and associated factors for infant mortality - this process was slowed in the winter of 2002-2003 because of the priorities of bioterrorism and HIPAA planning, but was rejuvenated in the fall, 2003 with increased attention to biological factors in addition to behavioral and SES factors related to poor pregnancy outcome. Public awareness activities are also focused on sleep positioning and safe sleep environments. Parent education materials that are sponsored by the VDH Healthy Babies, Kids and Families program and are given out during pregnancy and at birth to all Vt parents emphasize risk factors for SIDS/SUDI such as back to sleep, cigarette smoking, and co-sleeping or bedsharing. In 2002, the legislatively mandated Birth Information Council was formed under the direction of the Commissioner of Health. The broad based membership of the committee recommended the creation of a Birth Information System to enhance Vermont's ability to identify and refer to services appropriate newborns with special medical conditions. This strategy was approved by the state legislature and CDC funding is being used to hire a Birth Information System Coordinator who will begin work in July, 2004. Efforts at increasing surveillance of infant and child death and injury are getting a boost from the new system of enhanced hospital emergency department data in addition to the hospital discharge data. The MCH Planner, the Injury Prevention Coordinator, and the Office of the Chief Medical Examiner are beginning to collaborate on improved data collection methods from infant/child death certificates. The MCH Planner, surveillance staff, and the Injury Prevention Coordinator (along with representatives from the the Child Fatality Review Committee) are working on the national pilot to develop a web-based Child Death Review data gathering system.

Other planning initiatives include the application for an Early Childhood Comprehensive Systems Initiative Grant (ECCS). The goal is to develop cross-service systems integration partnerships in support of children in early childhood to enhance their ability to enter school healthy and ready to learn. This grant will assist the state and local communities in efforts to build early childhood service systems that address critical components of access and medical homes, social emotional development of young children, early care and education, parenting education and family support. In 2004, Vermont is beginning the second year of planning for development of a unified system of early care, health and education. This work corresponds well with other initiatives that have been underway in the state over the last two years, including a TA grant from North Carolina's Smart Start and also the AHS reorganization.

Additionally, in the Fall of 2002, the VDH was awarded and infrastructure and expanded health education grant from CDC. Planning is accomplished via newly hired coordinators and the statewide School Health Coalition works toward coordinated school health services in schools. In addition, an interagency team between the DOE and the VDH will coordinate statewide health-related activities for school aged children. The recently formed Linking and Learning

newsletter, from a partnership with the VDH, Department of Education, and the American Cancer Society, highlights local and statewide programs on obesity prevention, physical activity promotion, HIV prevention, and tobacco use prevention.

The Office of Minority Health is supporting the operationalizing of the Department of Health's resolution to eliminate racial and ethnic disparities. In addition, the OMH is facilitating the development of strategies and recommendations from the Minority Advisory Committees and the Physicians Healthcare Survey. Also, OMH is supporting community-based trainings for health care professionals in the delivery of culturally competent health care. In this past year of 2003-2004, the OMH has started a comprehensive and vigorous statewide strategic planning effort. The resultant health plan for minorities in Vermont will rely heavily on input from community based minority coalitions. The MCH/Title V planner and other MCH staff in VDH are participating in this planning and will collaborate on implementing the resulting strategies.

The CSHN director continues as a member of the AHS Respite Care Policy Cluster. Some of the identified concerns include issues of delegation of nursing activities to lesser-credentialed attendant staff; the need for greater case management; the nature of the need for attendant care, covering a spectrum from "medically necessary for the child to "economically necessary to support parent employment," and concern whether a medical model (the child's disability cause him to need attendant care) is comprehensive and flexible enough.

CSHN is emphasizing planning for systems of infrastructure building in order to meet the goals set forth by the six newly added performance measures (FFY2003) For example, CSHN is working on the PCS reimbursement program (See Priority Need # 9) and development of a medical home (Priority Need #1.) Other priorities include the continued expansion of the system of universal hearing screening, strengthening of the metabolic screening program and expansion of the screening profile, evaluating supports for youth as they transition to adulthood, and strengthening community support services for families. Active participation in the Monitoring and Measuring Project (Utah State University) is strengthening the CSHN capacity for evaluation and program planning. This activity was slowed in CY 2003 year because of demands on staff time for smallpox and HIPAA planning. However, the several years of planning and collaborating with M&M consultants have enabled internal communications to begin on Vermont's approaches to address the new National Performance Measures # 2- #6 and evaluation of the data from the National Survey (SLAITS). See descriptions of NPM's and III. B, Agency Capacity. In other major advances, CSHN implemented a new statewide expanded newborn screening panel in November, 2003 - see attachment to this section for the listing of the new panel and see discussion for NPM #1 for activities.

Vermont Department of Health Planning Initiatives (See also III E - State Agency Coordination)

Vermont Health Plan: A Call to Action was released at a press conference on June 15, 1999. In keeping with the enabling legislation, this plan is intended to "set[s] forth the goals and values of the state." The document examines health issues in five broad categories: human biology, habits and behaviors, the environment, economics and social factors, and health care. Issues and needed actions that are critical to the health of mothers, children and families are incorporated throughout the document. The first edition of the Annual Action Plan was released in the Spring of 2000. This comprehensive document draws on the Title V plan and other documents to identify strategies for addressing these issues.

The Health Department completed work on Healthy Vermonters 2010 through the selection and prioritization of objectives found in the draft document, Healthy People 2010 Objectives. This process will allow Vermont to focus attention on those national objectives that are of greatest concern for its citizens. The national objectives for Maternal, Infant and Child Health and Family Planning have been adapted for Vermont's specific public health needs. This process was completed in the year 2000, released in 2001, and the selected objectives and related

strategies will be coordinated with the planning efforts described in Title V and the Annual Action Plan. Planning activities have also been coordinated with the Health Status Report, released in June, 2002. Other status reports deal with Men's Health and Women's Health. A woman's reproductive health needs assessment is being finalized in the spring of 2004.

For FFY 2006, a major assessment and planning process will take place to prepare the 2005 MCH Needs Assessment. Work has begun to amass data and planning information to incorporate into this assessment which is compiled every five years for the Title V MCH Block Grant. New data is also being gathered via MCH-specific projects and also via collaboration with other VDH offices (such as Minority Health, Women's Health, Dental Health, and Nutrition.) An approach of assessing both the strengths and needs of Vermont's MCH population will be used. Region 1 has begun communication via conference calls on how to incorporate this approach in the New England Regional Assessemnts. Beginning plans are evaluating performance measures that are strengths-based and to develop new measures that describe positive aspects of MCH in each NE state.

B. AGENCY CAPACITY

Preventive and Primary Care Services for Pregnant Women, Mothers, and Infants:
Prenatal and Postnatal Program: The Healthy Babies, Kids and Families System of Care is an enhanced, comprehensive, family-centered public health program for pregnant and postpartum women and infants up to five years who receive Medicaid. (For clients not on Medicaid and in need of these services, Title V provides payment.) HBKF is designed as a coalition among obstetrical and pediatric health care providers, public health and home health nurses, Parent Child Centers, and participating families. Case management, counseling and health education, risk reduction intervention, home-based care, group education and other supportive services are bundled together into one package tailored to meet the individual's health needs. See Overview.

Addison County Parent Child Center - Prevention of Teen Pregnancy Program - supported by Title V funds - provides outreach and prevention services to Addison County pregnant teens, young parents, and their families. Support groups are provided to both male and female teens and preteens who are considered at high risk of pregnancy, and pregnancy prevention education is provided at the local junior high and high schools. The "Dads" program, which is supported by Title X funding, works with young and expectant fathers to develop effective parenting skills. Close ongoing collaboration with HBKF.

/2003/ No updates /2004/ No updates **//2005// No updates //2005//**

Sudden Infant Death Syndrome (SIDS) and Sudden Unexplained Death in Infancy (SUDI) is undergoing a review of program protocols and goals. Goals are: 1) To reduce the impact of unexpected infant death on Vermonters via public education about infant care practices, 2) Assure system of care for families that provides compassionate investigation and appropriate grief serices. See P. Need #5.

Comprehensive Obstetrical Services Program is administered by the Department of Obstetrics and Gynecology at Fletcher Allen Health Care in Burlington, provides comprehensive, team based, maternity care to women who are socially/economically at-risk. who are statewide, but primarily in northwestern Vermont. A VDH public health nurse is on-site and enrolls clients in WIC/KBKF. /2003/ No updates. //2004/ No updates **//2005//Participates in the newly formed statewide Community Response Teams and receives referrals for specialized services for opiate-addicted pregnant woman.//2005//**

Family Planning Program includes medical services, including physical exams, screening for cancer and sexually transmitted diseases, contraceptive methods and pregnancy testing; education and counseling about reproductive health, breast self-exam, STD/HIV risk reduction, pregnancy and

infertility; and community education programs such as mother-daughter seminars, school-based education and professional seminars. Services are provided via funds contracted to Planned Parenthood of Northern New England (PPNNE), and are offered at 12 PPNNE sites statewide. Funded by: Federal Title X, Social Service Block grant, State general funds, Medicaid reimbursement. All services are available on a sliding fee schedule for those with incomes up to 250% FPL; no one is turned away because of inability to pay. Services are targeted to women of child bearing age, particularly those of low income and under age 25. Services to men are available, and young men are encouraged to participate in counseling and education with their partners. A recent grant from the Office of Population Affairs will test methods for increasing participation by men (ages 18-24) in family planning. /2003/ No updates. /2004/ The contract bid for family planning services was put out for competitive bid and awarded to PPNNE. The new outreach/education program for men is available on the web at www.themanphone.org. **//2005// Collaboration between VDH and PPNNE has been expanded and strengthened to take action on certain findings in the 2003 Vermont Family Planning Needs Assessment, such as reproductive health needs of refugees and women in correctional facilities. Male Outreach Program, The ManPhone, is expanded to statewide coverage. //2005//**

Genetic Services are provided through a VDH contract with Children's Health Care Service at Fletcher Allen Health Care, which operates the Vermont Regional Genetics Center. Services include genetic counseling to families, evaluation, diagnosis, and treatment of genetic conditions; public information programs about teratogens, a pregnancy risk information toll-free hotline; and extensive technical assistance and consultation to VDH. Services are available statewide. Special "travel clinic" are provided to insure statewide coverage. Services are funded by Title V, including federal, state match, and state overmatch dollars, as well as patient fees (however, individuals are served regardless of ability to pay. /2003/ No updates. /2004/ Geneticist provided extensive TA to the Birth Information Council. **//2005// Geneticist offers consultation to metabolic, NBS programs and other CSHN programs//2005//**

Newborn Screening Program provides for the genetic screening of occurrent births via legislation adopted in 1996 requiring screening for the following: phenylketonuria, galactosemia, homocystinuria, maple syrup urine disease, hypothyroidism, hemoglobinopathies, and biotinidase deficiency. **//2005// NBS panel now upgraded via legislation to include 14 additional conditions. The fee has increased from \$27.50 to \$33.30. Vermont uses the New England Newborn Screening Laboratory at U Mass for processing specimens. See NPM 1 and attachment III.A.**

Perinatal Program at the University of Vermont is partially funded by Title V and provides professional education, transport conferences, and statistical analysis for individual hospitals and providers who treat medically high-risk pregnant women and neonates. /2003/ No updates. /2004/ Close collaboration with many statewide initiatives, such as Infant Mortality and Birth Information Council. //2005//Continue with ongoing services and close coordination with Infant Mortality committee on issues such as maternal/fetal transport, individual hospital data analysis, and professional education.//2005//

Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is a nutrition and education program benefiting infants, children under age five, and pregnant, postpartum and breastfeeding women with low-to-moderate income levels. This program provides supplemental foods and nutrition counseling as an adjunct to health care. Enrolled participants receive weekly home delivery of foods, tailored to their particular needs and eligibility factors, through contracts with local vendors. Nutrition education is offered at least twice during the client's certification period. Individuals with specific nutrition-related concerns receive additional nutrition education contacts from nutritionists. Programs such as the EPSDT Program, Immunizations, Healthy Babies, Kids and Families, and the Childhood Lead Poisoning Prevention Program are integrated with WIC. VDH uses a joint WIC/Medicaid application form that automatically assesses and identifies Medicaid eligible clients.

Office of Women's Health: formed in 2001 and staffed by a part-time prevention specialist.

OWH goals include improving the health status of women, assuring access to high quality, comprehensive and coordinated health services, promoting healthier lifestyles and improving public policies that affect women's health. OWH works closely with Women's Health Vermont and other statewide women's advocacy groups. /2003/ At this time, funding is limited to state general funds that support the position with few funds available for programmatic activity. If approved, an application submitted to MCHB this spring (2002) will allow expanded programmatic activity./2004/ The MCHB grant to establish an Integrated Comprehensive Health Services Program was approved but not funded. OWH continues to be staffed by a part-time PH specialist. Women's Health Vermont has ceased activity due to the end of its funding in June, 2003. //2005// The MCHB grant was resubmitted with a planned implementation date of Fall, 2004 - grant to support development of women's health infrastructure in VDH and communities. New projects are: working with PPNNE on needs assessment, development of services for women in correctional facilities and outreach to refugee women.//2005//

Office of Minority Health (OMH) supports VDH programs to become culturally competent in programming and staff training. Past support activities: development of the Alcohol and Drug Abuse Program's Rite of Passage Initiative, the implementation of a DHHS-OMH grant to address disparities in cancer, diabetes, and heart disease within the Lao and American Indian communities through the strengthening of intergenerational relationships, and the increase of tobacco cessation and prevention program activities within the minority and GLBTQ populations. The VOMH is a member of the Interpreter Task Force that coordinates training opportunities for Vermont non-English language interpreters and translators. Activities within this reporting period include the initiation of the AIDS Resources, Community Health Education Service (ARCHES) project (supporting minority community based organizations in regard to HIV/AIDS programs). /2003/ OMH advises AHS when planning the mandatory staff trainings on diversity and cultural sensitivity and provides consultation and support for community based trainings on Culturally Competent health care. /2004/ In 9/02, OMH received CLEAS (Community Linkages for Education and HIV/AIDS Services) grant to enhance capacity of community based minority serving organizations to respond to HIV/AIDS needs locally. //2005//OMH launched a major strategic planning and coordination process to bring cohesion to minority communities and to plan a statewide minority health conference on disparities - purpose being to determine priority areas for minority health action and related strategies. In April, 2004, a major workshop was held to launch strategic planning process. Four components were selected and workgroups are meeting to determine goals, objectives, and action steps. OMH working with AHS to revise approach to staff training about cultural competency. //2005//

Preventive and Primary Care Services for Children:

Immunization Program - See NPM 7. Vaccine Purchase and Distribution Program's goal is to strive for the elimination of all vaccine preventable diseases. The program purchases vaccines, conducts assessment of immunization coverage, conducts surveillance of vaccine preventable disease, assists in outbreak control, provides education and TA for clinical providers and the public, and develops policies and plans that support immunization strategies and evaluate effectiveness and QA activities. The vaccines purchased by this program are provided without charge to physicians who participate in the Vaccines for Children program. In addition to the actual provision of the vaccine, the Immunization Program assures that the vaccines are appropriately allocated and available to providers, shipped, stored, and handled according to guidelines and made available to individuals for whom they are indicated. /2003/ No Updates. /2004/ Coverage rates in 2003 were adversely impacted by numerous vaccine supply shortages nationally which necessitated restrictions on the number of doses and the ages at which they could be administered. //2005// No updates.//2005//

Childhood Immunization Registry work began post enabling legislation in 1998. The statewide, web based registry is populated via electronic birth certificate data. Efforts are currently underway to develop an immunization registry pilot project in one area of the state to set up a database of all children, birth through 18 years, and their immunization records. The registry is expected to result in higher immunization levels, generate all legal immunization records and

corresponding documents for child care operators and school personnel, and provide easier assessment of current immunization status by health care providers. These efforts will decrease missed opportunities to bring children up to date with their immunizations. Also, the fully functional statewide immunization registry will include a reminder/recall system to keep children up to date with the recommended immunization schedule. All of the core data elements recommended by the National Immunization Program and approved by the National Vaccine Advisory Committee will be recorded electronically. (See NPM 7) /2003/ By December, 2002, the registry will be populated with 10% of the birth cohort, and three private provider sites and six public provider sites will have been established to pilot the program. /2004/ By December, 2003, the registry will be populated with a minimum of 75% of the birth cohort for that year using EBC and 10% of the VFC providers. //2005// See NPM 7. Plans are to develop pilot project in one area of the state to set up a database of all children, B-18 years and their Iz records.//2005//

Childhood Lead Poisoning Prevention Program (CLPPP) provides free blood lead screening (via capillary technique) for children at health clinics located in the 12 VDH district offices and PHN's offer TA and training for providers to incorporate this screening within their practices. The VDH coordinates with Vermont Chapter of the American Academy of Pediatrics to promote office based blood lead screening as being done in the private sector. CLPPP provides an environmental assessment of a child's home and day care if the child is severely poisoned (> 20 micrograms/deciliter) or has persistent levels of 15-19 micrograms/deciliter. In owner-occupied housing, VDH works with parents to develop a plan to make their home safe. In rental properties, VDH (via HUD grant) works with the property owner to implement a lead hazard reduction plan. The Vermont Housing and Conservation Board can assist owners with finances and project management. The State of Vermont in 1994 enacted legislation requiring that the VDH implement regulations to certify and train lead abatement contractors in the state. The VDH has funding from the Environmental Protection Agency for its lead abatement licensing and compliance activities. CLPPP conducts education campaigns and training programs for rental property associations, state agencies, Headstart, childcare providers and other community organizations. Updates see P Need 7.

Early Periodic Screening, Diagnosis and Treatment (EPSDT) operates under an interagency agreement with the Department of Prevention, Access, Transition, and Health Care Access (PATH, formerly the Department of Social Welfare), the state Medicaid agency. Services for children (families making up to 300% FPL): include: education on preventive health care and age-appropriate health screening; assistance with scheduling medical, dental, and other health-related appointments; assistance in locating medical and dental providers; information/referral on health and community services, and targeted follow up. Vulnerable children are prioritized, such as those in foster care and children of migrant workers. , are the highest priority for EPSDT outreach. The Fostering Healthy Families program (in collaboration with Social and Rehabilitative Services) provides special assistance to children in state custody to ensure they are up-to-date with preventive health care. The Vermont Agency of Human Services is undergoing major reorganization that will result in many of the previous departments being assigned to other, newly formed or newly consolidated departments. This effort is an attempt to make services more efficient, client-centered and accessible. Previous EPSDT efforts will continue wiht reorganized governmental units such as the now autonomous Office of Vermont Health Access (Medicaid). The Kids in Safety Seats (KISS) Program (in partnership with Governor's Highway Safety Program) continues to provide education to the parents of young children Also, EPSDT developed/distributed health screening recommendations and literature for Medicaid families to be aware of appropriate preventive health care. Vermont (working with AAP and AAFP) updated standards for preventive care titled "Health Screening Recommendations for Children and Adolescents." And associated Provider Toolkit of best practices. The EPSDT School Health Access Program continues to improve health access for school aged children via a variety of collaborative/community based activities -- funded by contracts from VDH to the school districts. See related PM's and Priority Needs. /2003/ In FFY03, the school health access program will generate over \$2.5 million with

95% of the school supervisory unions participating. //2004// Provider toolkit being updated//2004//

CISS: Health Systems development in Child Care Grant funds a public health nurse specialist to focus on the health and safety needs of children in child care settings. "Healthy Child Care Vermont" (HCCVT) builds state and local capacity to provide expert public health nursing consultation and training to child care providers. Services include workshops, education, resource, phone or on-site consultation and assistance in health and safety areas such as injury prevention, ill/sick child care, healthy eating and health environments, mental health, access and referral to health services and insurance, and emergency readiness and first aid. /2003/ The HCCVT initiative began a transition to a new HRSA/CISS grant for infrastructure development of an early childhood comprehensive system (ECCS), which includes early care, health and education focused integration. The ECCS grant is funded by the MCHB/HRSA through Title V, to ensure there is a health presence and leadership around five key areas: access to insurance and a medical home; mental health and social-emotional development; early care and education; parent education; and parent support. Simultaneously, Vermont received a Technical Assistance grant from North Carolina's Smart Start Initiative, to develop a strategic plan for creating a unified early childhood comprehensive system which would be unique to Vermont. This work was directed by a Governor's Cabinet Sub-Committee on Early Access to Care and Education, as well as four workgroups with diverse statewide representation: local/state governance, public engagement, finance and evaluation. These workgroups reported back to the Sub-committee and assisted in informing the final strategic plan for this unified system, including a 'new' name - Building Bright Futures: Vermont's Alliance for Children. /2004/ February 2004, plans for reorganization of the Agency of Human Services is announced. A new Division of Child Development (DCD) within a new Department for Children and Families will be created. A Direct Services Unit in the new DCD will house HCCVT/ECCS; Healthy Babies Kids & Families; Family Infant and Toddler (Part C); Success by Six; Welcome Babies; CUPS (mental health); and Parent Child Centers. June 2004, Smart Start Technical Assistance grant ends. //2005// HCCVT funds will end Jan. 31, 2005, however the program goals and health consultation infrastructure will continue for child care providers, as well as be reflected in a state strategic Preventive Health Plan, which will address the five priority areas above. //2005//

Nutrition Services Program (Non WIC and Non CSHN) The nutritionist position in the Department of Health Improvement continues to be vacant, although many activities continue, such as integrating nutrition into the Department of Education's Comprehensive School Health Guidelines and providing training curriculum for teachers. /2003/ The position of Chief Nutritionist remains vacant, position of Chronic Disease Nutritionist is filled - most of her time is focused on the WISEWOMAN program, (screening/education services for women aged 40-64 for breast and cervical cancer, cardiovascular disease, and diabetes). /2004/ Nutrition representation on the school health coordinating committee.//2005//CD Nutritionist is overseeing the governor's initiatives and CDC grant (see IIIA Overview/Priorities)//2005//

Dental Health Program provides dental consultation to the Medicaid/Dr. Dynasaur program by determining prior authorizations on several dental procedures, including orthodontics. A coalition coordinates Baby Bottle Tooth Decay (BBTD) prevention efforts among family practitioners, pediatricians, primary care providers, dentists, dental hygienists, and VDH. A fee under Medicaid has been established to reimburse dentists for oral hygiene instruction to parents of children under age 5. Community water fluoridation: provides promotion, TA, and surveillance. 2004: Fluoridated areas - 45 towns, 64 public water systems, and 245,233 population. Tooth Tutor, begun in 1996: see Priority Need 4.

Emergency Medical Services - Children (EMS-C) The VDH Office of Emergency Medical Services grant has three objectives: 1) Represent pediatric emergency care issues in all aspects of the emergency medical service system; 2) Assist with the delivery of the Family Practice Resuscitation Project to fifty family practice offices and 3) Develop a prehospital data

collection plan for the Vermont Emergency Medical Service System. (See discussion in Priority Need #6)

The Infant Mortality Committee, formed in 2001 by the Director of the Division of Health Improvement, includes representation from VDH, its partners in clinical care, hospitals, and the University of Vermont School of Medicine and the March of Dimes. The committee is examining the nature of infant mortality in Vermont by an in depth examination of the specific quantitative data which can serve to guide strategies.

/2003/ Planning continues for working with the Washington County MCH Coalition for implementing strategies for reducing IM risk factors (such as prevalence of prenatal smoking) using a QI approach. Poster presentation at APHA Annual Meeting about committee's strategies./2004/ Continued analysis to include biological as well as psychosocial factors associated with infant mortality and prematurely. Activity slowed this year due to time demands of smallpox planning and HIPAA //2005// IM Committee continues to meet to review trend data and coordinate on statewide activities that impact birth outcomes./2005//

Anti-Tobacco Programs for Youth and Pregnant Women: see discussion under P Need 3, SPM 6, NPM 15.

Vermont Department of Health Injury Prevention Program was established in 2000 with the hiring of a part time coordinator via CDC funding. The Vermont Injury Prevention Advisory Committee (VIPAC) was developed and the Injury Prevention Plan was released in 2002. Priority areas include motor vehicle crashes, violence, falls and hip fractures in the elderly, residential fires, and work-related injury. See also P Need 6 and NPM 10.

System of Care for Children with Special Health Care Needs:

PYRAMID LEVEL: DIRECT SERVICES

CSHN Clinics: a statewide network of multidisciplinary clinics for children with certain chronic conditions are managed by CSHN and include: Orthopedics (General Orthopedics, Spina Bifida, Muscular Dystrophy, and Hand), Child Development, Seating (assessment, prescription and fitting of mobility and positioning equipment), Cleft Palate/Craniofacial, Hemophilia, Cystic Fibrosis, Cardiology, Juvenile Rheumatoid Arthritis, Epilepsy, NICU High-Risk Developmental Follow-up, Interdisciplinary Leadership Education for Health Professionals (ILEHP, a UAP-LEND project), Community Clinics, and Feeding Team. (See NPMs) /2003/ No updates. /2004/ CSHN is collaborating with the Joshua project (community based team) in piloting interdisciplinary community assessment project (I-CAP) to provide developmental assessment and planning within the community team. //2005//CSHN is collaborating with FAHC to incorporate a new clinical setting and new specialty staff (pediatric urology and a to-be-hired pediatric neurosurgeon) into the Myelomeningocele clinic. An intensive review of Child Development Clinic is in process, to respond to increased referrals especially of children with autism spectrum disorders, the need for support to Part C, and its relationship to community-based services./2005//

Financial Assistance Program: CSHN provides after-insurance funding of medical services when these services have been pre-authorized by CSHN staff and when they fall within the range of services permitted by CSHN guidelines. CSHN has utilized an income-based Cost Share plan. /2003/ No updates /2004/ No updates //2005// Changes and increases in Medicaid premiums are of concern as some families find it difficult to maintain their enrollment in Medicaid. Loss of Medicaid affects access to comprehensive primary and specialty services, and shifts costs to other supports such as CSHN./2005//

PYRAMID LEVEL: ENABLING SERVICES

Special Services Program: CSHN offers care coordination and access to specialized services for Vermont children who have a condition that CSHN covers but for which no established clinic exists. CSHN pediatric nurses and medical social workers are based in regional offices and are involved in care planning and coordination, including transitions from one care setting

to another. Families are referred to CSHN from Medicaid's High-Tech program and CSHN medical social workers are also members of the regional Part C-IDEA early intervention teams (Family, Infant and Toddler Project, FITP.) /2003/ No updates /2004/ No updates //2005// Part C is transferring to a new department 7/04 because of AHS reorganization.//2005//

Respite Care Program: Families receive annual grants or reimbursements to defray the cost of hiring respite care providers. Allocations are based on the skill level of the care needed; eligibility is based on enrollment in CSHN, income and ineligibility for respite care from other programs./2003/ No updates /2004/ No updates //2005//A modest increase in the Respite Line item has allowed expansion of supports. Parent to Parent of Vermont receives funding from CSHN to support its statewide network of programs, which include supporting parents, outreach to community providers, pre-service and in-service training to medical and early intervention staff and students, continuing education, and participation in program and policy design for CSHN. Part of the funding specifically supports a parent as Children's SSI Coordinator, providing outreach information and referral.//2005//

In-Home Support Program: Medicaid funds Personal Care Services (PCS) for in-home support for children with severe disabilities. CSHN serves as one of several access points providing referral to PCS. /2003/ The CSHN Director participates in one of the six AHS "Policy Clusters" -- the cluster charged to improve interagency coordination and accessibility of respite and PCS supports. /2004/ No updates //2005//The PCS program and the Hi-Tech program are transferring to a new Department of Aging and Independent Living.//2005//

Nutrition Services: CSHN/Part C-IDEA and a state-level pediatric nutritionist who is developing and expanding the capacity of community-based nutritionists to provide local consultation to CSHCN. The state CSHN nutritionist reviews each client evaluation, assists in the development of the plan of care, and provides technical assistance in the treatment. CSHN also manages a nutritional formula program for children needing special formulas or "nutriceutical" treatment of their chronic condition. CSHN developed agreements with the major insurers and Medicaid to function as a clearinghouse for medical foods for children. /2003/ No updates. /2004/ A new funding arrangement with Medicaid for nutritional services is being implemented. //2005// No updates//2005//

Family Support Services: CSHN provides support to Parent to Parent of Vermont for its support of families, and for its annual Partners in Care family/provider collaboration conference. The respite care program described above is also one of CSHN's Family Support Services. /2003/ No updates /2004/ No updates //2005// see above//2005//

Family, Infant and, Toddler Project (FITP) is the statewide early intervention system of care for infants and toddlers with developmental disabilities, funded by Vermont's federal Part C-IDEA grant. FITP is centrally administered through CSHN, but is delivered regionally. Each of the 12 AHS districts has established its own regional planning team, designated host agency and developed programs that comply with Part C rules. The FITP director is supervised by the CSHN director. CSHN regional social workers are members of FITP regional interdisciplinary service teams, smoothing the transition at the child's 3rd birthday and offering some continuity in a child's team composition. The CSHN financial unit also handles FITP payments so that families experience a "seamless" funding system. /2003/ No updates. /2004/ No updates //2005// FITP is transferring to the new Department for Children and Families.//2005//

PYRAMID LEVEL: POPULATION-BASED SERVICES

Newborn Screening Follow-up: See discussion in NPM 1.

PYRAMID LEVEL: INFRASTRUCTURE-SYSTEM BUILDING ACTIVITIES

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

"Families have adequate insurance to pay for needed services" See NPM 4.
With the expansion of Dr. Dynasaur (Medicaid and CHIP) to 300%FPL, Vermont continues to improve the percentage of children who have a source of adequate health care coverage. As a payer of last resort for many necessary medical services, CSHN has developed and

strengthened its internal financial processes for helping families to apply for Medicaid, understand their own private health insurances, and pursue benefits to which they are entitled. In the gap, CSHN has continued to be a payer. For families using FITP, which is also administered within CSHN, payment is seamless and efficient. Medicaid has delegated to the CSHN director the responsibility for determination of the medical necessity and authorization of continuation of services for OT, PT, and speech services for children after they have received them for a year. Through its Seating Clinic, CSHN also reviews and facilitates the ordering of wheelchairs and other seating and positioning equipment, as well as the coordination of insurance and Medicaid coverage for the equipment. At the same time, the collaboration with Medicaid in the prior authorization of individual services also is the basis for systems-level solutions to coverage issues that arise with individual children. In 2000, the CSHN director began to meet regularly with the Medicaid Policy Chief, to discuss and resolve policy issues. The initial focus was on the variability from region to region in the accessibility of Medicaid transportation services. CSHN clinical medical staff met with the managers of the transportation programs and worked out procedures to smooth communication and timely access to services. CSHN is able to identify and define health care coverage issues for CSHN, and, in a small state, advocate informally and formally for solutions.

//2003/ In 2002, it is anticipated that CSHN will be able to access Medicaid reimbursement for these services when provided to Medicaid eligible children. //2005// CSHN will continue to administer seamless coverage including FITP, even after the transfer of that program to Dept for Children and Families.//2005//

"Children are screened early and continuously for special health care needs" See NPM 1 and 12 and P Need #1.

"Families are decision makers and satisfied with services" -See NPM 2

"Services are organized in ways that families can use them easily" -See NPM 5, P Need 1 and 9. Nutrition Services & FITP in Enabling Services. //2004/ The Vt State Legislature has mandated a major reorganization of AHS, focus being to improve coordination of services from multiple programs. Impact on CSHN is unknown at the time. //2005// CSHN remains in VDH; see above for other program relocations.//2005//

"Youth receive services necessary to transition to adulthood." See NPM 6 and P Need 2

See attached chart of 2004 Vt legislation

C. ORGANIZATIONAL STRUCTURE

The Agency of Human Services is the largest of the agencies of state government, and is headed by the Secretary of Human Services, who reports to Vermont's governor. The Vermont Department of Health (VDH), within the Agency of Human Services (AHS), administers the Maternal and Child Health (MCH) Block Grant, also known as Title V. Most Title V activities occur through two of the six divisions of the Vermont Department of Health: the Division of Community Public Health and the Division of Health Improvement. The Division of Health Improvement includes the programs of Children with Special Health Needs which are overseen by a medical director. The MCH Director, who is also the Director of the Division of Health Improvement, has the responsibility for the implementation of the entire Title V grant. As part of the oversight of the grant, the MCH Director meets regularly with the appropriate partners within VDH, with outside contractors receiving funds from Title V, and with state and community partners involved in MCH related activities. The Division of Community Public Health has oversight of the WIC Program, Healthy Babies, Kids, and Families, EPSDT, and the twelve VDH district offices. (See attached organizational charts.)

//2005// The Agency of Human Services is in the midst of a major reorganization effort which

was legislatively mandated by Act 45, passed in the spring of 2003. The new structure will be officially in place as of July 1, 2004, although it will long term before all the changes to services and coordination are fully implemented. A main purpose of this reorganization is to provide a more efficient, streamlined and responsive service to agency clients. A new Department of Children and Families will consist of the existing Social and Rehabilitatives Services, the Department of Prevention, Assistance, Training and Health Access (oversees benefits such as TANF, fuel assistance, etc.)and the offices of Child Support and Economic Opportunities. The following is a description of the new offices and divisions within the DCF: 1) Child Development Division which will oversee such programs as Family, Infant, Toddler, Head Start Collaboration Services, Healthy Child Care Vermont, Healthy Babies, Kids and Families, Children's UPstream Services, Parent Child Centers, and Success by Six programs. 2) Child Welfare and Youth Justice Division which will consist of such programs as social services (foster care and protective services) and youth justice services. 3) Economic Services Division will include non-Medicaid(OVHA) programs from PATH such as Welfare-to-Work, Regulatory and Planning and Economic Benefits, and Health Access Eligibility Unit. The Office of Vermont Health Access (OVHA) will become an independent office under the Secretary of AHS. 4) Field Operations Division will be comprised of the department's twelve newly-merged field offices. Four field offices will begin the the new coordinated structure this summer, with the other eight to follow in the next several months. This new structure is designed to encourage local decision making about client service programs. 5) Offices of Child Support, Disability Determination and Economic Opportunity will be housed within DCF.

In addition, the Department of Developmental and Mental Health Services will be dissolved, with Developmental Services going to the Department of Aging and Independent Living. The Department's mental health programs (such as children and adult community mental health systems) will be administered out of the Department of Health. VDH will also assume responsibility for the Vermont State Hospital(Vermont's mental health inpatient facility) and, in collaboration with Department of Corrections, will manage health care services in the state correctional facilities. A new position of Deputy Health Commissioner for Mental Health is being created within the Department of Health.

Under the DCF Commissioner's office, several cross-departmental functions will be managed, including the Business Office, Information and Technology, and Human Resource Development. Another change intended to meet the goal of enhanced and streamlined services is the availability to clients to apply for services over the web. This is planned to begin in Fall, 2004 and will include programs such as Medicaid and food stamps.

Note: There are several versions of organizational charts depicting the planned AHS structure that will result from the reoganization. In next year's Title V report, we will include the final versions of the organizational charts and a detailed update on the reorganization. //2005//

D. OTHER MCH CAPACITY

See also attached table of staff stationed centrally and locally.

Commissioner of Health

Dr. Paul E. Jarris, MD, MBA, was appointed Commissioner of the Vermont Department of Health in 2003. Dr. Jarris graduated from the University of Vermont and received his MD degree from the University of Pennsylvania School of Medicine in 1984. He interned at Duke-Watts Family Medicine Residency Program in Durham, NC and completed his residency at the Swedish Family Practice Residency Program in Seattle, Washington in 1987. Following residency training, he completed a fellowship in Faculty Development and received a Masters in Business Administration from the University of Washington in 1989. Dr. Jarris served as Medical Director for Vermont's largest nonprofit HMO; Community Health Plan, from 1992-1996. In this capacity he had responsibility for quality

improvement, resource management, practice relations, and medical affairs. He was President and CEO of Vermont Permanente Medical Group from 1998-2000 as well as CEO of Primary Care Health Partners, Vermont's largest statewide primary care medical group, from 1999-2000. Throughout his career, Dr. Jarris has maintained an active clinical family practice, including work in federally qualified health centers and a shelter for homeless adolescent youth. He is certified by the American Board of Family Medicine and the American Board of Medical Management.

Division Director of Health Improvement and Director of Maternal Child Health

Donald Swartz received his MD degree from West Virginia University in 1963. He interned at West Virginia University Hospital and then completed a residency in Pediatrics at Children's Hospital in Cincinnati, Ohio in 1966 and served as Chief Resident there until 1967. He was in private practice of pediatrics from 1968 until 1986 and then in private practice of Pediatric Pulmonology until 1999 when he was appointed to his current position. He directed the Vermont Cystic Fibrosis Program from 1968 to July, 2000. He is Board Certified in Pediatrics and in Pediatric Pulmonology, and holds an academic appointment at the University of Vermont College of Medicine where he is a Clinical Professor of Pediatrics.

Division Director of Community Public Health

Patricia Berry earned a BSN from Boston College in 1969 and a Master of Public Health (MPH) degree from Johns Hopkins University, School of Hygiene and Public Health in 1982. Ms. Berry's has eight years of public health nursing experience, served as Public Health District Director in Vermont (1978-1981) and as Public Health Planning and Policy Chief for the Vermont Department of Health (1982-1984). She has served in her current position as Director of the Division of Community Public Health at VDH since 1984, providing leadership and oversight of the state's local public health system and the WIC, EPSDT, Healthy Babies and other MCH programs.

Director of Children with Special Health Needs Programs

Dr. Carol Hassler graduated from Radcliffe College in 1972 and earned a MD from the University of Pennsylvania in 1976. Her residency in Pediatrics took place (in 1976-1978) at the University of Virginia, and Dr. Hassler held a fellowship in Child Psychiatry at the University of Virginia (1978-1980), where she also served as Chief Resident from 1979 to 1980. She has served as the Director of the Division of Children with Special Health Needs at the Vermont Department of Health from 1990-1995, and Director of Handicapped Children's Services at VDH from 1985-1990. She is Board-certified in pediatrics and is a Fellow of the AAP. Dr. Hassler also serves as Clinical Associate Professor of Pediatrics at the University of Vermont College of Medicine and as an Attending Physician at the Fletcher Allen Health Care Hospital.

Director of Dental Health

Dr. Roger T. Ivey retired as Dental Director in 2003. The position is currently under recruitment.

Nutrition Chief

This position is currently under recruitment.

MCH Planning Specialist

Sally Kerschner holds a Masters of Science in Nursing from the University of Vermont and is a Registered Nurse. She has twenty-five years of experience in maternal and child health and community health nursing. She has worked at the Vermont Department of Health since 1983.

CSHN/Parent to Parent

Through CSHN funding of Parent to Parent of Vermont, CSHN hires parents as Children's SSI Coordinators, providing outreach to Vermont families whose children are eligible for SSI. In addition, seven of the CSHN clinical staff are parents of children with special health needs.

E. STATE AGENCY COORDINATION

The Vermont Agency of Human Services consists of the Department of Health, Department of Social Welfare, Department of Social and Rehabilitative Services, the Office of Child Support Services, the Department of Developmental and Mental Health Services, the Department of Corrections, the State Economic Opportunity Office, and the Department of Aging and Disabilities. The Department of Health has 12 district offices that serve as local health departments and cover the entire state. The local district offices of the VDH work closely on case management and service coordination with the local state (such as those listed above) and community offices that provide social, health and welfare services. The local district offices also are developing close ties with the community health centers that provide services in their regions and the AHEC districts. At the state level, the community health centers are part of the Primary Care and Rural Health programs. Within the Department of Health, close working relationships exist among the divisions of Health Improvement (which includes the CSHN Programs), Community Public Health, Health Surveillance (epidemiology and statistics), Health Protection, and the Alcohol and Drug Abuse Programs. All VDH Division Directors meet at least monthly to coordinate VDH activities.

/2003/ As planning and program implementation activities have increased in their need for usable data, an increased coordination between the Health Department programs and divisions and the Health Department's Office of Information Technology has developed. Specific examples of these activities include the CSHN Measuring and Monitoring project and the SSDI grant activities.

/2004/ No updates.

/2005/ Significant reorganization efforts are changing the structure of AHS and VDH - refer to III C for discussion./2005/

The Vermont State Team for Children, Families, and Individuals:

Among the Departments within the Agency of Human Services, a unique collaborative relationship exists through the Vermont State Team for Children, Families, and Individuals. The State Team is a multidisciplinary, statewide collaborative effort comprised of representatives from the various state agencies and departments including Developmental and Mental Health Services, Social and Rehabilitative Services, Welfare, Health, Education, the University of Vermont, parent groups and community coordinating councils. Its mission is to "support the creation and maintenance of effective services for children and families through partnerships with families and communities." One feature of the State Team that is particularly advantageous for collaborative working relationships throughout the state is the presence and participation of Community Partnership groups from all 12 AHS districts, which closely mirror the health districts. Each of the 12 Community Partnership groups have a liaison member at the monthly State Team meetings. The State Team provides support to the Community Partnerships which coordinate health and human service efforts at the district/community level. In each district, the VDH district director is a key member of the Community Partnership team. The MCH Director and a number of other members of the MCH staff also serve on the State Team. One central focus of the State Team has been to formulate common desired outcomes shared by families, advocates, and service agencies, and to determine specific indicators that will allow progress toward achieving these outcomes to be tracked by community and state partnerships. State Team meetings focus on selected outcomes, reviewing interventions and programs that have been proven effective (compiled into a series of documents called "What Works") and activities that are taking place in Vermont to influence the selected outcomes. The Agency of Human Services collaborates with the VDH School EPSDT Health Access program to produce "What Works" documents, to summarize key findings on selected outcomes, and to

assist in the planning process for making further progress in Vermont with respect to each outcome. AHS also publishes Community Profiles for each of the School Supervisory Unions in the State. These profiles reflect the outcomes and indicators chosen by the State Team, allow for tracking of progress on outcomes, and also provide a basis for community planning. VDH district directors facilitate use of the data from these profiles and other resources in the community planning process. The State Team supports the community assessment process by providing data on outcomes, provides training and technical assistance, and whenever possible, provides financial support to help achieve agreed upon outcomes for children and families. /2004/ The State Team is acting as a one of the forums for information sharing and discussion about the AHS reorganization -- a study report will be prepared for the state legislature for January, 2004. **//2005// The State Team continues to be advisory in the planing for AHS reorganization, especially in designing a new and expanded role for the local partnership teams.//2005//**

The Vermont Primary Care Cooperative Agreement: Purpose is to coordinate state primary care activities that promote the development of innovative and progressive primary care health care services for the underserved. The Vermont PCCA provides opportunities for community-based providers of primary and specialty care to work together on state and regional issues and promotes the support and involvement of state agencies in primary care. The PCCA includes representation from the following organizations, agencies, and institutions: Vermont's Agency of Human Services (Department of Health and the Office of Minority Health, the Department of Developmental and Mental Health Services, Department of Prevention, Transition, and Health Care Access (Medicaid); the University of Vermont (College of Medicine, School of Nursing, Department of Dental Hygiene); Imani Health Care (serving the African American, Latino, Asian, and Native American populations); Bi-State Primary Care Association; Dental Society; Health Care Authority; Coalition of Clinics for the Uninsured; Vermont Association of Hospitals and Health Systems; Medical Society; Nurses Association; Northern Counties Health Care; the Vermont Longterm Care Coalition; and the Area Health Education Centers. **//2005/ Current focus is assessment and planning for oral health service needs in Vermont. Another major activity has been participation in the Healthcare Workforce Development Partnership, which has initiated a project to reveiw the current healthcare workforce status in Vermont, assess supply and demand problems for selected priority professionals and recommend strategies to address identified issues. The Partnership membership consists of key stakeholders in the training and employment of healthcare professionals in Vermont. A draft report has been circulated for comment and revision.**

Coordination of Health Components of Community and State-Based Systems: The Division of Community Public Health has strong liaisons with Head Start, Early Head Start, and other early childhood programs. Staff from the Immunization Program in the Division of Health Surveillance and staff from the Division of Community Public Health work collaboratively with the AHS Division of Child Care to increase the percent of children in child care who are fully immunized. Vermont Department of Health staff participate in the statewide Early Childhood Workgroup, which was established to coordinate efforts between a variety of state agencies and private, not-for-profit community organizations.

In past several years, two CISS grants from the Maternal and Child Health Bureau have been used to increase the capacity of the VDH to focus on child and adolescent health systems development. The first grant was used to update the Vermont EPSDT periodicity schedule, which is being used as a vehicle to promote new approaches to child and adolescent health supervision, in particular, emphasizing health promotion and the prevention of psychosocial morbidity. Specific goals include streamlining or eliminating

duplication in the delivery of child and adolescent health screening services and assisting VDH district offices in developing strategies to create, sustain or strengthen local systems of care and capacity to serve children, adolescents and families referred as a result of screening. The second CISS grant, Vermont Health Systems Development in Child Care increased the capacity of VDH to make health and child care a focal point in systems development efforts at the state level and created an interdisciplinary, community-based model for providing technical assistance to child care providers concerning health and safety issues. Staff from both projects continue to work (after the end of the formal grants) with the Early Childhood Work Group, Head Start, other state-level departments and agencies (e.g., the Department of Social and Rehabilitative Services, the Division of Child Care, the Department of Developmental and Mental Health Services, the Department of Education), and with private sector partners (e.g., the Vermont Chapters of the AAP and AAFP).

The Vermont Department of Health works closely with the tertiary care facilities that provide services to Vermonters (Fletcher Allen Health Care in VT, Dartmouth Hitchcock Medical Center in NH, and the Albany Medical Center in NY). Services are provided through the Newborn Intensive Care Units (NICU), the maternity service departments, health service providers through the Healthy Babies system of care and the CSHN programs.

In other activities, the VDH has student nursing placements from the University of Vermont (Baccalaureate and Masters level), Norwich University, and Castleton State College nursing programs. Student placements are also provided for the Master of Social Work program and the Nutrition program at UVM. Also, VDH coordinates with the Department of Developmental and Mental Health Services in the development of the periodicity schedule, in order to better address the mental health needs of families through the primary care system. The Director of the Division of Community Public Health serves on the state team for the children's mental health grant, the Children's UPstream Services (CUPS) project. The VDH is represented on Vermont's Interpreter Task Force. This is an interagency collaboration which develops and conducts non-English language interpreter and translator training activities. The task force monitors the need for interpreter services by Vermonters who don't speak English as their first language. VDH representation is via the Office of Minority Health and the Refugee Health Coordinator.

The VDH is represented on the state advisory team on welfare reform and continues to work with the Department of Prevention, Transition, and Health Care Access (PATH) in other ways as well. Improvements continue to be made to the WIC/Medicaid combined application and eligibility determination process, for example, and VDH and PATH collaborate to improve services and outcomes for parenting teens and their children.

The Vermont Department of Health has collaborated extensively with the Medicaid program in the implementation of the 1115 waiver, in meeting with managed care providers, and in planning for the CHIP benefits expansion. The state received a Robert Wood Johnson grant to improve outreach and enrollment of children in Medicaid and CHIP (Covering Kids).

VDH continues to coordinate efforts with the Department of Social and Rehabilitative Services (SRS) in the Fostering Healthy Families initiative, a program that addresses the health needs of children in state custody. Work between the SRS District Directors and the VDH District Directors is being done to stimulate closer relationships at the local level toward achieving the goal of improving the health of children in state custody. In addition, an initiative in one district that

co-locates a public health nurse in a state child welfare office (SRS) was launched in 2000. Expansion of this pilot is planned as capacity allows.

The VDH works with the Department of Education through the "Success by Six" and "Success beyond Six" programs. Another important collaborative relationship exists through the EPSDT School Access program. Each VDH regional office has a public health nurse/school liaison assigned to the task of improving access to health care for school aged children and strengthening the connection between VDH and the schools within their health district.

In the past two years, the Coordinated School Health grant from CDC has allowed a more comprehensive approach to coordination between VDH and the Dept of Education for all issues relating to a broad definition of school health. Goals of the program include increasing communication and collaboration between Education and VDH on all levels, especially at the state planning level and within individual schools. A statewide coordination committee has been established between the Dept of Education and VDH. Also, an internal VDH committee enables communication to streamline VDH actions in health programs in the school. In addition, each participating school or school district is encouraged to create a School Health Action Committee, that plans individual school responses to the nine components of the School Health Model (such as enhancing clinical services, supporting healthy nutrition, promoting staff wellness, etc.)

The VDH works with the Department of Corrections through local community partnerships, Domestic Violence Task Forces, and child protection teams. For families who have a family member assigned to probation and parole, services are provided through local case management and Community Partnership meetings. Also, in FFY 2004, new planning efforts are being encouraged between the VDH and Department of Corrections. VDH is taking a more active role in the planning and delivery of health care services to both men and women in correctional facilities - VDH being asked to provide QI oversight to existing clinical services. //2005//At this writing, funds are being sought to perform a needs assessment of the health needs of women in the correctional system, with special emphasis on reproductive health needs and referral to community based clinical providers after discharge from inmate status. //2005//

The VDH works closely with the Vermont Area Health Education Center (AHEC). Examples of collaborative activities are as follows: Office of Minority Health provides trainings to AHEC staff on cultural competency, VDH coordinates with AHEC in a variety of community activities, The Office of Tobacco Control coordinates with AHEC on provider training re: brief intervention for smoking cessation and collaboration on health care professional workforce issues.

The Office of Minority Health is engaged in a major statewide strategic planning effort and has assembled key state and local stakeholder who are involved in minority health. OMH is working with these advisory committee members (service providers, members of minorities, representatives of community based organizations)to: 1) define and promote an understanding of minority health issues, 2) to identify strategic goals, objectives, and action steps, and 3) to develop collaborative relations to increase ownership of the actions necessary to make improvements in the health status of minority populations. (See also IIIB. Agency Capacity)

Child Fatality Review Committee: is a multidisciplinary team that reviews the deaths of all resident children, ages 0-18, with particular attention to child protection/neglect issues and systems issues that may need to be addressed in order to prevent child and adolescent fatalities. /2004/ The Title V Planner and the Injury Control Coordinator are developing a system of data collection based on a uniform data set. For further TA and support on the the uniform data collection and overall approaches to child death review, TA funds have been requested to attend the Fall, 2003 conference of the MCH Center for CHild Death Review. //2005// Attendance

at the CDR conference by the MCH Planner enabled Vermont to become involved in the national planning for a web based child fatality data collection form.//2005//

State Agency Coordination for CSHN

CSHN participates in a variety of interdepartmental MCH planning and policy making settings. A special focus is the collaboration with the Children's section of the Division of Developmental Services, Department of Developmental and Mental Health Services, and with Medicaid. //2005// This division is relocating to the Department of Aging and Independent Living, 7-1-04, and takes on the responsibility for the Medicaid personal care services program and the hi-tech program. The coordination of care for children with hi-tech home care needs will be a focus of the early efforts of the AHS reorganization, and CSHN expects to play a major role.//2005//

F. HEALTH SYSTEMS CAPACITY INDICATORS

HSCI #01: The rate of children hospitalized for asthma.

The Asthma Program, begun in 2001 (via CDC planning grant) has achieved its initial goals of developing an asthma surveillance system and creating a state asthma plan. The largest number of children admitted for asthma are in the under 5 year age group. In this under age five group, twice as many are boys than girls. The program is now entering a 3 year implementation phase. Activities during 2002-03 designed to improve services to children include: 1) Creation of 3 brochures targeting children 0-5, 6-13, and teens, describing how to live a healthy life with asthma. They were distributed to all Vermont physicians, hospital Emergency Rooms, VDH clinics and school nurses. 2) Creation/distribution of Vermont Asthma Action Plan to all physicians and school nurses. 3) Development/distribution of radio spots. 4) Placing resources for parents on VDH website. Pending availability of funds, other activities such as education and support of childcare providers and a QI project for physicians and school nurses will be implemented. Increased surveillance capacity has enabled better data to be obtained from hospital discharge data system. Improvements include: obtaining counts of individuals vs. events of hospitalization, analysis of rehospitalizations, and inclusion of a question on the BRFSS about presence of children in the home with asthma. //2005// **Vermont is completing the first year of the three year implementation phase. Progress has been made in obtaining data on the following: 1) Medicaid - via a report on the PC Plus population from Vt Program for Quality in Health Care and 2) Emergency Dept data. Vermont continues to ask the question by proxy on the BRFSS (years 2001, 2002, 2003, and 2004) as to whether there are children in the home who were 1)EVER diagnosed with asthma and 2) if they still have asthma. There have been difficulties in weighting the data and therefore the only year of data that has been analyzed and released is for 2001. It was published in a report by the New England Asthma Regional Council in January, 2004 (available at www.asthmaregionalcouncil.org/documents/AsthmainNewEngland) Recent data analysis (supported by SSDI grant funding) has shown that the four leading reasons for emergency department visits for age groups birth to 19 years, are as follows: injuries and poisonings, respiratory diseases, ill-defined conditions, and diseases of the nervous system. Further analysis will enable a better understanding of the nature of category "respiratory diseases" and guide VDH asthma planning efforts. //2005//**

HSCI #02: The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen.

Vermont's generous Medicaid health insurance enrollment criteria and benefits does

not automatically insure that children will receive ongoing health care. Included in Title V measures are those concerning children who received a Medicaid-funded service, infants who received preventative visits, and children (aged 6-9) who received a dental service. Under the funding provided by SSDI, Vermont has expanded capacity to perform analyses of Medicaid claims files. Over the next year, Vermont will be able to perform a more sophisticated examination of the patterns of health care utilization of services by children and families enrolled in Medicaid as part of the SSDI grant activities.

VDH continues updating of the Provider's Toolkit for the dissemination of best-practice guidelines and screening tools to providers of pediatric care. VDH staff work with AAP and AAFP monthly to identify system, policy, clinical or reimbursement issues that might pose a barrier to medicaid-eligible children receiving routine, high-quality preventive care.

Continuing development of provider guidelines that clarify CPT coding procedures for providers to bill for the provision of routine EPSDT screenings. Previously, many services which are actually unbundled from the routine EPSDT visit were thought to be bundled. Clarifying of these procedures was an attempt to facilitate provision of these services.

HSCI #03: The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one initial periodic screen.

Vermont's SCHIP enrollees receive the same benefits as those offered by Medicaid, and the SCHIP data is contained within the Medicaid enrollment and claims data bases.

HSCI #04: The percent of women (aged 14-44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80% on the Kotelchuck Index.

In 2001, Vermont revised the method used to calculate weeks gestation to better match the methodology used by NCHS. Since weeks gestation is one of the variables used to compute the Kotelchuck Index of Adequacy of Prenatal Care, this change affected the Kotelchuck Index values. Values for the years 1998-2000 have been recalculated following these new definitions. The value for 2002 is 87.1 percent, reflecting a steady increase since 1998. VDH efforts such as prenatal outreach via Healthy Babies, Kids and Families and EPSDT efforts to increase access to medical care for pregnant women are geared to continually improving this percentage. Vermont received a Pregnancy Risk Assessment Monitoring System (PRAMS) grant in 2000 and recently received the first weighted data file. Questions from the PRAMS survey will be used to identify barriers to prenatal care in the state. Efforts can then be made to reduce these barriers. Additional work is being completed on the use of provider generated delivery data (OBNET) which will reflect more accurate count of prenatal visitation. Expansion of the OBNET program is planned for more VT hospitals to be able to directly download birth data and increase the accuracy of the information.

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

The SSDI funding has enabled increased capacity for VDH to obtain this data from several data systems, especially Medicaid and birth certificates. The data show a statistically significant higher rate for families with Medicaid versus those families using other insurance in the following: percent of pregnant women receiving prenatal care in the first trimester, and percent of pregnant women with adequate prenatal care. The indicator of infant death rate showed no statistical difference, due to small numbers. These results will be used for planning

and program priorities within VDH systems and for the Infant Mortality Committee. In addition, collaborating with VCHIP on Improving Prenatal Care pregnancy outcomes and injury prevention data elements will result in agreed-upon statewide standards and also data to demonstrate demographic differences.

HSCI #06: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants(0 -- 1) children, and pregnant women.

Vermont's eligibility for Medicaid and SCHIP are the same at 300% of FPL for infants and children up to age 18. Pregnant women under 200% FPL are also eligible.

HSCI #07: The percent of EPSDT eligible children aged 6 -- 9 years who have received any dental services during the year.

The Dental Unit continues to promote outreach and the development of a dental home. For activities, see discussion under Priority Need # 4, NPM #9 and SPM #2. In the fall of 2002, state monies enabled a survey of third grade children to determine the presence of sealants, resulting in a rate of 66% of those third grade children examined. Medicaid claims data shows that 62.4% of clients have received dental services during FFY 02, similar to the 61.2% of children reported for FFY 01. Continued collaboration with EDS and the developing data analysis expertise of dental staff and VDH statisticians enable an enhanced ability to obtain complete and accurate information from Medicaid claims and enrollment data. Also, using funding from RWJ, focus groups of low income families were conducted - themes addressed were among the following: dental home, insurance coverage of dental services, transportation, ability to attend appointments, knowledge of preventive oral health. The results of this data are now being analyzed and the findings will be used to create a public media campaign on preventive oral health and also will be used to guide recommendations for the state oral health plan.

HSCI #08: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN Program.

In VT, all children who receive SSI are also Medicaid recipients. Many are also enrolled in one or more CSHN programs, for care coordination, and for clinics and financial assistance where needed. Many also receive services from sister state programs within the Division of Developmental Services. The measurement of this outcome is cumbersome and involves cross-matching Medicaid claims data with CSHN enrollment data, as electronic cross matching is not yet available. CSHN programs include access to care coordination, and some include clinic visits and help with health care costs not otherwise met by Medicaid. Plans: To continue policy-level involvement and other current activities. ***//2005//AHS reorganization will bring partnering units (CSHN, Developmental Services, Part C) from new departments, but with common goals. Critical shortages in nursing and attendant care demand particular attention.//2005//***

HSCI #09(A): The ability of the States to assure that the MCH Program and Title V agency have access to policy and program relevant information and data.

The Vermont Department of Health (VDH) is committed to developing and evaluating programs based on data and analysis. Infant death certificates have been matched to birth records since 1979. These records are matched as the death records are received. WIC records have been matched to birth and fetal death records annually since 1994. This linkage was developed as part of CDC's Pregnancy Nutrition Surveillance System. Although CDC funding has ended, VDH continues to match records annually, and has extended this linkage to Healthy Babies data.

In the past two years, with support from the SSDI grant, Vermont began linking the metabolic screening records and Medicaid birth records to the birth certificate. We plan to continue to link these files on an annual basis.

On June 1st, 2004, Vermont implemented an interim tracking system for universal newborn hearing screening. Screening staff at the hospitals complete a form which is then sent to the Department of Health, where the information is entered into a database populated by the metabolic screening data. This system allows a closer monitoring of the hearing screenings performed and to further insure that no newborns are missed. **//2005// 12 months' experience with the database is the source of this year's data for NPM 12. We are continuing to refine and analyze the data.//2005//**

However, there are limitations to this system. The demographic information and some of the risk factors on the screening form duplicate information collected on the birth certificate. Some of the risk factors are contained on the mother's, rather than on the infant's medical record, and newborn screening staff do not always have ready access to the mother's medical record. The procedure of filling out a paper record at the hospital and mailing it to the Health Department where it is data entered is an inefficient one. Incorporating newborn hearing screening as part of the birth certificate will be more efficient for both hospital and Health Department staff. Vermont is planning to implement the revised birth certificate with a new web-based electronic system. We expect to integrate the newborn hearing screening information into the birth certificate system by January of 2006.

Hospital discharge data are available for all discharges from Vermont hospitals, and Vermont resident discharges from hospitals in New Hampshire, Massachusetts and New York from the early 1980s. Outpatient surgery performed in Vermont hospitals has been available since 1990. Beginning with the 2001 data year emergency department data has become available from all Vermont and New Hampshire hospitals. As part of the SSDI grant activities, detailed analysis of the hospitalizations and emergency room visits of children are being conducted.

Although Vermont has several data systems that can be used to identify and track medical conditions evident from birth, the state does not have a specific birth defects registry. In the fall and winter of 2002-2003, a legislatively appointed commission met to determine the best system for Vermont. An overall recommendation for a Birth Information System was set forth. In the past year, Vermont received a birth defects surveillance system grant from the CDC. A Project Coordinator has been hired and a pilot system will be implemented this coming year (2004-2005.)

Vermont began collecting data for the Pregnancy Risk Assessment Monitoring System in January of 2001. We recently received our first PRAMS weighted data file and have begun analyzing the data.

VDH is collaborating with FAHC on the development of the regional/statewide OBNet system. Planning for provider generated birth-related data downloaded directly into the birth certificate data system. Goal is to attain more accurate and timely birth data for such uses as clinical follow up, hospital-specific data, and for public health planning.

In June 2004, the CDC nutrition surveillance coordinator made a site visit that included these components: 1) Presentation & discussion with VDH district directors and supervisors on how to use and interpret nutrition surveillance data in planning and program monitoring. 2) Meeting with various stakeholder to review relevant research on childhood overweight and obesity. 3) Discussion with program and surveillance staff about potential improvements to nutrition surveillance systems. 4) Investigate and pilot test record linking for longitudinal monitoring of health status indicators in the WIC program population. Linkages would make it possible to look at health status indicators for women across pregnancies, and for children from prenatal influences to age 5.

HSCI #09(B): The ability of the States to determine the percent of adolescents in grades 9 -- 12 who report using tobacco products in the past month.

The Youth Risk Behavior Survey is conducted in grades 8 -- 12 every two years. Because of the strong interest in the data available from this survey from both educational and health professionals, approximately 94% of all eligible schools participate (HSCI 9B and 9C). YRBS data show a reduction from 21.8% (in 1999) to 12.7% (in 2001) to 11.1% (in 2003) for the percent of eighth grade youth who smoke. This dramatic decline is heartening, yet the VDH and its partners continue to work with youth on prevention and cessation programs (see discussion for SPM #6.) Vermont participates in the Youth Tobacco Survey. In 2002 only middle school aged children were surveyed, however in 2004 the survey will include both middle (81 schools) and high schools (32 high schools.) In 2006 the survey will be repeated with a more sophisticated approach to sample size and obtaining weighted data. The long term goal is to develop a comprehensive school health survey that would ask about such conditions as diabetes, nutrition, physical health and asthma.

HSCI #09C: The ability of States to determine the percent of children who are obese or overweight.

A grant request for obesity prevention has been submitted to CDC. The grant will allow for the creation of a statewide coalition to develop a comprehensive nutrition and physical activity plan for the prevention of obesity and other chronic diseases. The plan will include strategies for integration and collaboration between programs such as WIC, Comprehensive School Health and the Department of Education as well as strengthening data gathering capacity. A primary source of data at present is the YRBS. **//2005// The grant has been awarded to Vermont and will be received July, 2004. Planning will include expanding data gathering capacity beyond traditional sources such as WIC and YRBS.//2005//**

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

Vermont continues to work toward goals of promoting a comprehensive system of care for its MCH population which includes both clinical health care and population based services. The Vermont Department of Health has been working towards the overall goal of ensuring access to care for its MCH population. Along with this goal, comes the responsibility to build a comprehensive system of care that is of a high quality and responsive to the needs of the population. VDH has promoted the medical home concept for both medical and dental health care needs. To this end, VDH has worked to establish strong relationships with a myriad of organizations, such as professional groups, hospitals, community-based organizations, home health agencies, schools, and so forth.

Evidence of success in Vermont has been revealed though many of the Title V measures and similar data. Vermont has one of the lowest teen birth rates nationally (10/1,000 births to women aged 15-17) and recent unofficial data indicated a continued decline. VDH continues to work at providing support and prevention services to all teens and support services to pregnant and parenting teens. Recent coordination efforts, such as the Coordinated School Health Committee, are enabling an enhanced collaboration between prevention programs. These programs cover a variety of prevention activities, such as physical fitness, good nutrition, tobacco, drug and alcohol use, mental health and sexual activity, and are broadly aimed at supporting assets in teens and promoting healthy development. Other successes include Vermont's ranking as fifth lowest in its percent of low birth weight, there is more work to be done when comparing Vermont's LBW figures to white rates nationally. VDH planning and assessment is also focused on economic disparities, such as those revealed through the data found in HSCI #5, showing a more negative rates for the measures of low birth weight and rates of prenatal care utilization for women using Medicaid insurance.

The Infant Mortality Committee collaboration and services such as HBKF and WIC address the broad measures of perinatal health. In 2000, the infant mortality rate in Vermont was 6.0/1,000 live births. Although this rate fluctuates, it remains above the HP 2010 goal of 4.5/1,000 and is higher than the national white IMR. The leading cause of infant mortality in Vermont (for the years 1990-1998) is congenital anomalies (119 deaths) followed by SIDS (65 deaths). The next leading cause of death for this age group is short gestation (33 deaths).

Vermont is ranked # 2 in its percent of children who are fully immunized. A strong relationship with private providers and comprehensive outreach to families, and high Medicaid coverage aids in achieving this high coverage. The progressive implementation of the Immunization Registry over the next year will positively impact these rates, also.

Vermont child death rate (13/100,000 ages 1-14, 2000 census data) is low, but the activities described in Priority Need # 6 and NPM # 10 will contribute to preventing needless childhood deaths. Data now indicates that non-traffic motor injuries and fatalities (i.e. from all-terrain vehicles and other motorized vehicles driven off public highways, not including snowmobiles) for children may be as significant a cause of death and injury as traffic fatalities. Also, recent data (from SSDI grant activity) shows that injuries and poisonings are one of the four leading reasons for ED visits for age groups birth to 19. The MCH Planner and the Injury Prevention Coordinator will begin planning for strategies to identify and address public health risk factors associated with this data. Vermont is involved with the pilot project of the MCH Center for Child Death Review which is developing a web-based uniform data base on all child fatalities.

Vermont's prevalence of overweight and obese children is unacceptably high and beginning efforts are being put into place to reduce this condition. Programs via WIC (Fit WIC) and school health are directed at parent education and referral for children. In addition, other program such as Run Girl Run help children directly to learn about physical fitness and healthy eating. This issue is reflected in the state's ten priority needs (#10) and the newly established state performance measure #10.

Vt's YRBS indicates a significant drop in the % of students who reported smoking at least once in 30

days. This is especially true across 8th and 10th grades: from 1995 to 2003, cigarette use declined from 41% to 19% among 10th graders and 29% to 11% among 8th graders. Smoking prevalence in the 18-24 age group is 35%, a public health concern as these individuals will begin to become pregnant and form families. Programs in schools, the national QUIT line, and pilot intervention models for physicians offices are strategies to reduce smoking rates. Also, drug and alcohol use in pregnancy is a renewed priority for Vermont. The state is gradually implementing and expanding its offerings of methadone clinic services. Other efforts include the expansion of the Rocking Horse program for pregnant women who use alcohol and investigating funding to plan for the identification and service provision for children affected by prenatal use of alcohol.

Over the past several years, VDH has been able to strengthen its capacity to access and analyze data from several sources, such as vital statistics, Medicaid claims and enrollment data, and hospital discharge data. The funding from SSDI had supported these efforts, and complete accounting can be found in the SSDI grant report submitted July, 2003. Vermont's participation in the Measuring and Monitoring Program has also strengthened its ability to assess data needs and capacity for the population of children with special health care needs. The overall work on this project provided a background for the application and implementation of the MCHB Medical Home grant for CSHN. M & M has provided background for VDH planners and program directors to begin data analysis of the National Survey (SLAITS) data and for directing program objectives and activities to more fully address the 6 CSHN NPM's.

Although VDH has established many strong collaborative relationships within its organization and with outside groups, further efforts to enhance communications will be useful in addressing public health priorities. Planning has begun to strengthen planning between VDH divisions, address Title V capacity needs, and set the stage for the 2005 MCH strengths and needs assessment

B. STATE PRIORITIES

IV. B. State Priorities (refer also to discussions related to Performance Measures)

1. All children, including those with special health care needs, will receive continuous and comprehensive health services within a medical home. There are two strategies to achieving this goal, adequacy of insurance, and availability of Medical Homes. Data from the 2001 BISHCA survey indicate that 6,190 (4.2%) Vermont children do not have health insurance. CSHN program enrollment information in 2004 indicates that 20% of children in CSHN programs do not have any insurance, and SLAITS found that 31.3% reported inadequate insurance. CSHN staff encourage and facilitate Medicaid application for CSHN families, but CSHN does not require Medicaid application as a condition for program participation. VT Medicaid offers enrollment through the TEFRA option to children with the most severe disabilities, regardless of family income. CSHN is in the third year of its collaboration with VT-AAP in implementation of the Medical Home grant. Efforts at developing Vermont's Medical Home capacity are both general to all children, and specific to CSHCN. General capacity efforts include the Office of Rural Health and Primary Care, improving access to underserved populations through building of the rural health care system and strengthening a trained health care workforce. Programs such as Healthy Babies, Kids and Families that work with families with children aged birth to six and Part C assist families in obtaining health and wellness services and to become connected to a medical home.

Work continues with the Joshua Project in Franklin County (in Northwestern Vermont) to create a community based child development team (I-CAP) to support the role of primary care pediatricians in assessing and care planning for children with developmental concerns. See NPM 3.

2. Youth with special health care needs will receive the services necessary for a successful transition to adulthood.

SLAITS found that all states scored poorly on this goal. In VT, the indicators which are more directly "medical" appear stronger (doctors have talked about changing needs; doctors discussed shift to adult provider) than interagency measures reflecting collaboration among health, education, and vocational services. Specific plans within CSHN are to update a written agreement with Vocational Rehabilitation; expand the number of CSHN clinics with "adult medicine" collaborators; develop specific age-out activities for CSHN program, and add specific transition planning elements to the VT Medical Home Care Plan models through the activities of the MCHB grant. See NPM 6.

3. Youth and maternal rates of alcohol and tobacco use will be reduced.

The trends for these two rates show a decline from the previous YRBS data - see SPM 5,6. The 2001 Adult Behavioral Risk Factor Survey indicates that 21% of women report being current smokers and 22% of pregnant women smoke. In addition, 9.3% of women state they alcohol-binge drink, and 1.3 % state they chronically drink alcohol.

The Tobacco Control Program is working with schools and communities on a variety of systems and community based approaches for smoking prevention for youth. Pregnant women in WIC and HBKF are screened for smoking status and offered referral for cessation assistance. Pilot projects (with AHEC) training OB/GYN offices to use a Brief Intervention (BI) model to assist pregnant women smokers - using AHRQ's 5 A's model) Assistance for pregnant women who want to quit smoking via the national Quit Line. Also, nicotine replacement therapy is available to low income women via reimbursement through Medicare or Vermont Health Access Program. In Washington County, a pilot program is being implemented via assistance from a team at Brandeis University. The purpose is to provide TA to obstetricians to assist their pregnant clients who are smokers to quit. Clients will continue to receive support to stay smoke-free via the pediatricians' offices as they bring the infant in for well child care. Prenatal calendar showing fetal development month-by-month distributed to pregnant women via MD's, pharmacies, etc. In Sept 04, airing 2 week radio campaign targeting pregnant smokers called "Baby Translator" from American Legacy - enable tracking of calls from quit line. ADAP also working with prevention activities such as Life Skills Curriculum for school aged children. ADAP is also coordinating with Community Public Health and local community providers on programs that enhance screening and group support sessions for pregnant women who use alcohol. One of these programs, Project Rocking horse, is being expanded throughout the state from its original pilot sites.

4. All children will receive continuous and comprehensive oral health care within a dental home.

The Dental Health Services of VDH works in concert with dental providers to achieve a system which encourages quality dental care as provided in a dental office where comprehensive continuous care can be achieved. This is the main goal of the Tooth Tutor Program, begun in 1996, provides TA to schools (via trained dental hygienist to provide assessment and referral of students to a local dental home. In 2003/2004, 100 schools participating and able to get over 90% of their students into a dental home, regardless of payer source, including Medicaid. Each year, over 90% of eligible schools participate in the school-based fluoride mouthrinse program. In addition, Dental Health Services continues to assist dentists with grants, loan repayments, and recruitment and retention efforts in order to ensure adequate workforce for a dental home. These programs should serve as an incentive for dental practices to accept more Medicaid patients and for practitioners to view Vermont as a viable state in which to develop dental practices. In 2003, VDH received a grant from R W Johnson (State Action for Oral Health Initiatives) to further enhance these strategies of increasing service capacity and access for low income children. Vermont is now engaged in developing a statewide oral health plan working collaboratively with a broad based advisory

committee. See also discussion under NPM 9, SPM 2, and HSCI 7.

5. Fetal and infant death rates will be reduced.

The Infant Mortality Committee, formed in 2000 by the VDH, includes representation from the various offices of the VDH (CPH, Surveillance) and its partners in clinical care and the University of Vermont. The committee is examining the nature of infant mortality in Vermont by an in depth examination of the specific quantitative data which can guide strategies. Strategic planning will concentrate on risk factors such as inter-pregnancy interval, tobacco use, and pregnancy weight gain. Coordination of program and planning activities is occurring within several sections of the Vermont Department of Health as well as with statewide partners such as hospital systems, clinical provider associations, Planned Parenthood, March of Dimes, and community based organizations. These efforts include planning for strengthened systems of morbidity and mortality review, provider education and supports for quality improvement in clinical care systems. SIDS/SUDI program provides trained PHN's for families and community groups for grief counseling and education, linkage to support systems. Also provides training to police groups, emergency responders, and medical personnel. Ongoing public education campaign about Back-to-Sleep. Parents in WIC are asked about their baby's sleep position (see SPM 4)/2003/ A mailed survey collected data about counseling practices related to sleep positioning and sleep environment from primary care physicians and hospital nursery nurses. The results are informing statewide education efforts. /2004/ no updates //2005// **VDH workgroup is revising SIDS pamphlet to reflect all aspects of a safe sleep environment. //2005//**

6. Injuries and unnatural deaths in children will be reduced.

The Injury Prevention Program: priorities of childhood injuries related to motor vehicle crashes and residential fires described in Vermont Injury Prevention Plan (2002.) Injury surveillance capacity has increased in the following areas (following STIPDA recommendations: ED data sets, development of an injury data matrix, and appropriate assignment of e-codes for injuries. Planning is beginning to address the high rate of non-traffic motor vehicle crashes: In 2001, the rates for ages 14 years and younger was 11.7/100,00 and for ages 15-24 years was 20.3/100,000. The Suicide Prevention Team is working on a suicide prevention plan for youth: the 2003 YRBS indicates that fewer students have made suicide plans: 13% percent of students made a suicide plan during the previous year, the same number as in 2001, down from 16% in 1999, 18% in 1997 and 22% in 1995. The Injury Prevention Plan is partnering with a recently formed (spring, 2004) Deerfield Valley Suicide Education Prevention Committee in southern Vermont and has developed a youth advisory board and is researching the feasibility of establishing a "gatekeepers" training program. The Injury Prevention Program and CPH are revising the Pediatric Periodicity Schedules clinical guidelines on injury risk reduction. The Infant Mortality Committee collaborates with the CFRC and other appropriate organizations to optimize information exchange for examining the issues surrounding of all causes of infant death. The EMS-C grant programs will continue to enhance their system of prehospital data collection. Also, nine regional grants will be awarded statewide for providing community based pediatric emergency care training. EMS-C has partnered with UVM and Fletcher Allen Medical Center to to implement a project designed to examine and improve helmet use for the winter sports such as skiing and snowboarding. Healthy Child Care Vermont provides education and curriculum for injury prevention in child care settings. Other surveillance activities: 1) staff have been working with the Chief Medical Examiner to review and clarify issues on identification of injury-related deaths and associated factors, with special emphasis on fire-related deaths, suicide and SIDS; 2) participation on a committee developing and implementing a new motor vehicle crash reporting form; 3) preliminary exploration of emergency department data from a new statewide data collection system; and 4) continuation of three injury-related questions added to the Vt BRFSS, two on suicide attempts, one on

elderly falls. Working with MCH Center for Child Death Review to pilot web-based child death review data collection form.

7. Maternal and pediatric exposure to environmental hazards be reduced.

The main areas of focus in protecting maternal and pediatric health and safety due to hazardous exposures in the environment are indoor air quality (carbon monoxide, environmental tobacco smoke, radon, asbestos, and biological pollutants), water quality (lead, copper, nitrates, mercury, and biological contaminants), pesticides (food safety, poisonings), lead and sun safety. These are very broad areas requiring assessment/planning and education of families through dissemination of safety information and coordination of and access to resources for families. Education will be incorporated in home visiting protocols through VDH maternal child programs and via public education campaigns. Coordination between VDH and the Agency of Natural Resources for educational efforts to providers and the MCH population about the hazards of mercury in fish: ***/2005/ updated Mercury in Fish posters/brocures being finalized and to be distributed statewide. Proposed question to BRFSS on tuna consumption in women of childbearing age. Re; school health, the ENVISION program provides training and materials to schools who commit to implementing an environmental health policy and management plan, ie; addressing issues such as indoor air quality, etc. In 2004, 9 schools were recognized for their work with ENVISION program. In 2003, 68% of 1 year olds and 13% of two year olds were tested for Lead exposure. Of those tested, 5% of 1 year olds and 9% of two year old had an elevated BLL. The Childhood Lead Poisoning Prevention Program continues to work to further reduce these rates and to increase the numbers of children screened. CLPPP collaborates with clinical providers and the AAP to expand its clinical lead screening and home assessment services for families with young children. In addition, the VDH works closely with landlords and municipal staff to assist in lead reduction activities. In FFY03, planning began for the public health response for events of attacks on the public safety - such as biological or chemical - see discussion in III. A. Overview.***

8. The rates of unintended and adolescent pregnancies will be reduced.

A wide variety of services exist to fulfill a broad range of strategies to continue the reduction in these rates, such as the VDH based Healthy Babies, Kids and Families, Parent Child Centers, the Social and Rehabilitative Services, prevention programs offered by the state's educational system, and the services of Planned Parenthood of Northern New England. The VDH continues to coordinate needs assessment and program activities, such as working through each counties' MCH Coalition. See discussions in NPM 8, Overview and Priorities.

9. Families with children with special health needs will have access to individualized, comprehensive home and community based support services. ***This priority addresses the particularly critical shortage of home-based services for children with special health needs, such as trained nurses and personal care attendants. Under a new Medicaid option, families may choose to recruit and employ their child's care attendant directly, eliminating a middleman agency, and increasing modestly the hourly wage. The joining of the hi-tech program with Personal Care Services and Developmental Services in a new department may focus new energy on addressing this issue.***

10. The prevalence of childhood overweight and obesity will be reduced.

The Governor's Initiative is supporting many activities to address overweight and obesity (See IIIA Overview and Priorities, SPM 10) The VDH's Run Girl Run program, designed to increase physical activity, build self esteem, and reduce risk taking behavior in girls aged 8-14, is able to expand due to 2004 new state funding.

VDH and Education are developing programs and curricula on nutrition and physical activity, such as the National Health Education Assessment Project. A state plan for obesity prevention is being developed. The WIC program continues its education programs with families of children who are overweight. A CDC grant for a coordinated approach to obesity prevention will begin July 2004. Several community and statewide organizations, such as food shelves and Vt Campaign to End Childhood Hunger are working to decrease food insecurity. For Title V FFY 04 application, a new state performance measure (#10) was added to reflect Vermont's increasing activities in this area. The Vermont WIC Program continues with expansion of "Fit WIC", a childhood obesity prevention research & demonstration project funded by USDA and carried out by a 5 state consortium. The theme of Vermont's part of the project was "Play Every Day" and the project developed an "Activity Kit" containing simple toys and materials, accompanied by a parent guide to physical activity for children age 3-5. The kit and guide were pilot tested in 3 district offices and is now statewide. Non-WIC groups are inquiring about purchasing this kit and model.

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

- > Vermont continues to have a very high rate of metabolic screening for newborn infants. Panel consists of seven conditions and for additional disorders if requested by physician.
- > Metabolic Screening program insures that Vermont infants who are transferred soon after birth to an out-of-state hospital are screened and receive the necessary follow up. Also, coordination with out-of-state metabolic screening programs on infants who are Vermont residents and born out-of-state and need a repeat screen.
- > Family refusal is performed by "informed dissent" and parents sign a form acknowledging they have been counseled about the intent of the screens and potential health issues if conditions are not detected at birth.
- > VDH provides TA to birth hospitals to insure quality and compliance with current standards of practice.
- > NBS services are provided via contracts with Fletcher Allen Health Care and U Mass Medical Center.
- > Intense planning and preparation for upcoming screening panel expansion for 2003.

b. Current Activities

- > On November 1, 2003, Vermont implemented an expanded newborn screening panel for all infants born in the state. 14 conditions were added to the existing panel of 7, bringing the total number of conditions screened to 21. (see attachment to Section III. A, Overview) There were no confirmed positives among the newly added conditions during this reporting period.
- > Arrangements have been made through the New England Screening Laboratory to perform the "Vermont Panel" on any Vermont births who are transferred to and tested in New Hampshire, Maine, Massachusetts, or Rhode Island.
- > Re: the achieved level of 99.1% of newborns receiving the mandated metabolic screening

before hospital discharge (NPM #1)- The denominator of 6290 are the Vt occurent births. Of these 6290 births, 21 newborns died without screening and 37 had a documented refusal on file. Therefore, of the 6269 surviving births, all but 37 had a screening in Vermont or at a transfer hospital (out of state.) This allows for a screening rate of 99.4% (6232 out of 6269 eligibles.) However, 100% of the births were documented as to their screening status - not one infant slipped through the cracks.

> Infants born in Vermont but transferred out of state without screening are identified via birth certificate lists and/or through hospital birth lists and follow up for screening is insured by NBS Program Chief.

> General NBS program operations continue to be program development, maintenance of records, follow up out-of-range screenings, physician/parent referrals to specialty services, statistical reporting, TA to hospitals, laboratories.

c. Plan for the Coming Year

> Continue to operationalize the newly implemented newborn screening panel.

> Continue program activities to insure that all infants are screened or are offered screening and that no infant is "missed or lost to follow up"

> Continue implementation of procedures that enable all Vermont infants who are born in a New England Hospital to be screened with the "Vermont panel."

> Continue to refine and operationalize the new electronic data base for metabolic screening.

> As a result of the expanded panel, several associated activites are continuing such as: professional education, development of clinical mangagement protocols, creation of educational materials for professionals and families.

> General NBS program operations continue to be program development, maintenance of records, follow up out-of-range screenings, physician/parent referrals to specialty services, statistical reporting, TA to hospitals, laboratories.

> Continue coordination with Universal Newborn Hearing Screening database. An ACCESS-based system has been created - populated by weekly upload of newborn information from the NBS program files and the UNHS-specific data provided by the birthing hospitals, which is linked with each newborn's record.

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

> Continue to include family centered care goals in grant/contract work specifications.

> With the Medical Home grant, we hosted family focus groups around the state to gather information about satisfaction with medical homes and services such as CSHN.

> We continue to seek input from the Family Advisory Council about services and policies.

b. Current Activities

> As above.

> Focusing on understanding the essential niche for Child Development Clinic in the changing health care environment, in internal and external conversations.

c. Plan for the Coming Year

> Presently analyzing and interpreting the comments parents shared with us in the focus groups, together with the AAP and Marketing Partners, a public health relations/consulting firm which organized the groups.

> Plans for expanding the formal, periodic meetings with Parent to Parent and VT Parent Information Center leadership to gather their collective feedback about services and policies.

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 Family Advisory Council reviewed the Cystic Fibrosis Clinic, one program which includes adults as well as children.

> The adult pulmonologist established a separate but coordinated clinic for adults and the CF team developed strategies to transition older adolescents to the clinic.

b. Current Activities

> The CSHN director is a member of the recruiting committee for a second pediatric orthopedist. A focus of the interviews is the candidates' interest in adolescent care and the non-surgical aspects of care, promotion of ADL skills, rehabilitation therapies, etc.

c. Plan for the Coming Year

> The Medical Home Advisory Board hopes to recruit a new young adult member.

> Collaboration with other elements of the care system (Developmental Services; Personal Care) will be facilitated by their consolidation within one trans-generational department, Aging and Independent Living. See MCH Priority Need 1.

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

> CSHN continues to identify families who might be eligible for Medicaid and

encourage and support them in the application process.

> CSHN called attention to the potential negative impact of the new and expanded Medicaid premiums, and has been an important advocate--and role model--in the monitoring for the effects of premiums on family enrollment and coverage. We continue to identify coverage and procedural issues with Medicaid and work toward their resolution.

b. Current Activities

> As above.

> CSHN has just hired a pediatric physical therapist to help define policy and practice and to collaborate with Medicaid on criteria and coverage issues. He joins the CSHN nutritionist, and a to-be-hired OT.

c. Plan for the Coming Year

> With a radical restructuring of our umbrella agency, AHS, just now taking place, and the new leadership within Medicaid and other new departments, we expect that the coming year will include intense orientation, advocacy, and system re-design efforts with Medicaid, to benefit children with special health needs and their families.

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

> Initially with SPRANS support, CSHN expanded clinical nursing and social work staff to the 12 regions of the state, serving 12 from sites in 7 regions. Several clinics travel to sites around the state.

> CSHN continues to support a multidisciplinary team approach to care, including care coordination.

> Because of critical shortages in child psychiatry services, CSHN has contracted with a child psychiatrist with special expertise in children with disabilities, to provide consultation to CSHN teams and short term direct services, emphasizing return of care to the primary care physician when the child is stable.

> Flexibility in policies, access to agency-level decision-makers, utilization of special funds, and above all, family priorities as the driver of the support systems, are essential strategies.

b. Current Activities

> We are evaluating the delivery of services through our Child Development Clinic, examining staffing needs, geographic distribution of referrals, connections with community-based teams, to assure that CDC is as responsive to family and community needs as it can be, in a changing health care system.

> Parent to Parent of Vermont has expanded, through its Nexus project, support staff in regional sites.

> A particular emphasis in 2003-4 has been the coordination of care for children and families who are experiencing especially complex medical and social challenges.

c. Plan for the Coming Year

> CSHN will continue regional emphasis for services, with an emphasis on collaboration with Medical Homes and family support organizations.

> We will increase collaboration, specifically, with new Nexus staff from Parent to Parent.

> We will discuss service delivery regularly with Parent to Parent and Vermont Parent Information Center leadership.

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 Cystic Fibrosis clinic/program was reviewed by the CSHN Family Advisory Council, with input about many aspects of the service delivery model. A new adult clinic has just been implemented.

> The CF team has addressed the transition process for adolescents, and the composition of the adult team to assure that adults continue to have access to multidisciplinary supports, without depleting the supports for children.

b. Current Activities

> Recruiting and interviewing for a second pediatric orthopedist includes CSHN priorities as well as tertiary/academic needs. The committee recognizes that the non-surgical care of the child--and young adult--with orthopedic conditions needs comprehensive attention, and these strengths are being sought in applicants.

c. Plan for the Coming Year

> The Medical Home Advisory Board is seeking a young adult member to advise the project.

> The CSHN Family Advisory Council chair is participating in a statewide needs assessment effort for youth in transition.

> New orthopedic staff will improve the services which young adults most need, a focus on maximizing independence and mobility skills. See also MCH Priority Need 2.

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

> District Offices held monthly iz clinics, based on local demand. All 12 offices, as staffing permits, schedule immunizations based on the clients/family needs. Our intervention primarily comes when there are barriers to accessing the medical home, such as not having medical

insurance. Families contacted by phone/letter when due for next Iz.

- > Some Vermont practices do not carry varicella vaccine, so to accommodate the community the District Office can carry varicella.
- > It is expectation that all nurses working for VDH will routinely administer age-appropriate vaccine according to accepted protocol and with parental informed consent.
- > Primary Care Providers are notified of immunization(s) given at the District Office.
- > Vaccines are provided free according to the current Vermont Vaccine Availability. There was no charge for the vaccine or the administration of these immunizations, when administered by nurses working for the VDH. July 1, 2003 Vermont became a universal state.
- > Iz screening and follow up was conducted routinely for all children seen in WIC clinics. Follow up services included assistance in locating a regular health care provider, obtaining the child's most current immunization record from their primary care provider, in understanding Medicaid benefits related to immunization, and transportation assistance. When needed, vaccines were administered through the VDH District Office and the information is shared with the Primary Care Provider.
- > Wide distribution of a one page "Have Your Tots Had all their Shots" flyer, features a simplified immunization schedule and a toll free phone number to reach VDH Iz Program for more information.
- > Post cards with the 2002 and 2003 immunization schedule mailed to Medicaid parents at 3 months, 8 months, and 20 months reminding them their child was due for immunizations.
- > VDH works with Refugee Resettlement to facilitate Iz and informed consent for refugees.
- > Distributes Path to Parenthood to all pregnant mothers - includes section on Iz.
- > 2002 - Growing Up Healthy, new publication with information on Iz, is distributed to all parents while still in hospital after birth of baby.
- > Coordinate with Child Care programs to notify parents when their child is due for Iz. Overall data gathering to assess levels of Iz for children enrolled in day care.
- > Using CASA software, assess 2 year olds in VDH programs - identify and inform parents if their child needs Iz.
- > VDH staff stay informed on Iz topics via a variety of methods, including distance learning (CDC and California DL Health Network)

b. Current Activities

- > See activities from last year's accomplishments
- > DO's have worked on populating the Iz registry with information about the children who are enrolled in Iz-related programs. As of 12/03, all 12 district offices have been connected to the Iz registry. Many offices have been able to populate the registry with a large percent of their children who are enrolled in WIC.
- > EPSDT staff have been working with PATH ("welfare") to design a new informing letter to be sent annually to each Medicaid-eligible family describing the child's age-specific need for Iz. The letter has been designed with input from families in focus groups.
- > 20,000 of influenza vaccine were distributed for Vt children in the 2003-2004 flu season (13,500 doses were distributed for 2002-2003) The great majority of these doses were administered in public and private settings.
- > As of end Dec, 2003, 17 sites were enrolled in Iz registry - 5 private practices and 12 public VDH district offices.
- > Contract awarded to Vt Child Health Improvement Program to do outreach, recruitment, and provide TA to private practices for the Iz registry.
- > Contracted with a technical writer to review and edit the Immunization Registry User Manual and to develop a quick-reference 2 page instruction sheet.
- > October, 2003 - Information Technology staff presented the Vermont Iz Registry application and the integrated National Electronic Disease Surveillance System model at the National Immunization Registry Conference in Atlanta. (Vt is the only state building a registry using the NEDSS model.) Also, Vermont participated as an invited guest on a panel at the American Immunization Registry Association Annual meeting.

c. Plan for the Coming Year

- > See activities from last year's accomplishments - continue with these ongoing programs.
- > VDH staff will continue to populate Iz registry with information from program records such as WIC.
- > Iz Registry to continue plans to expand the registry via recruitment of providers and further development of data base and technical systems. Goal is for 50-75 sites by December, 2004 using the registry. Plan to bring on an additional 50 provider sites in 2005. For 2005-2006, to concentrate on working with school nurses to bring in schools as participating sites.
- > For CY 2005, concentrate on identifying new enhancements for the registry software, creating standard reports, and working to improve the data quality. Also to investigate options for importing immunization data from other sources (insurers, billing systems, Medicaid, etc.)
- > Continue with wide distribution of influenza vaccine for children.

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

a. Last Year's Accomplishments

- > Priority is given to outreach to pregnant teens and their families including: home visits, classes and support groups, transportation to medical appointments, labor support as needed, support with educational needs.
- > The Addison County Parent Child Center focuses on education and support around risky behaviors and pregnancy prevention, in particular targeting high risk teens (both male and female). This is done within the public school environment as well as with teens who utilize PCC services, e.g., teens who have a negative pregnancy test.
- > Teens enrolled in HBKF are strongly encouraged to finish high school or their G.E.D. and given support for prevention of second pregnancy.
- > Coordination with organizations such as Parent Child Centers, Department of Education, and Planned Parenthood to support prevention programs education efforts directed at teens and teens considered "at-risk"
- > Coordination with VCHIP, AAP, and Department of Education on broad prevention efforts using Assets-based approach to working with teens and their families.
- > Support for community and state wide activities to postpone subsequent pregnancies due to higher infant morbidity and mortality rates when pregnancies occur in younger women (15-18) and are spaced less than two years apart. (Supportive role of Infant Mortality Committee)

b. Current Activities

- > Priority is given to outreach to pregnant teens and their families including: home visits, classes and support groups, transportation to medical appointments, labor support as needed, support with educational needs.
- > The Addison County Parent Child Center focuses on education and support around risky behaviors and pregnancy prevention, in particular targeting high risk teens (both male and female). This is done within the public school environment as well as with teens who utilize

PCC services, e.g., teens who have a negative pregnancy test.

> Teens enrolled in HBKF are strongly encouraged to finish high school or their G.E.D. and given support for prevention of second pregnancy.

> Coordination with organizations such as Parent Child Centers, Department of Education, and Planned Parenthood to support prevention programs education efforts directed at teens and teens considered "at-risk"

> Coordination with VCHIP, AAP, and Department of Education on broad prevention efforts using Assets-based approach to working with teens and their families.

> Support for community and state wide activities to postpone subsequent pregnancies due to higher infant morbidity and mortality rates when pregnancies occur in younger women (15-18) and are spaced less than two years apart.(Supportive role of Infant Mortality Committee)

c. Plan for the Coming Year

> Priority is given to outreach to pregnant teens and their families including: home visits, classes and support groups, transportation to medical appointments, labor support as needed, support with educational needs.

> The Addison County Parent Child Center focuses on education and support around risky behaviors and pregnancy prevention, in particular targeting high risk teens (both male and female). This is done within the public school environment as well as with teens who utilize PCC services, e.g., teens who have a negative pregnancy test.

> Teens enrolled in HBKF are strongly encouraged to finish high school or their G.E.D. and given support for prevention of second pregnancy.

> Coordination with organizations such as Parent Child Centers, Department of Education, and Planned Parenthood to support prevention programs education efforts directed at teens and teens considered "at-risk"

> Coordination with VCHIP, AAP, and Department of Education on broad prevention efforts using Assets-based approach to working with teens and their families.

> Support for community and state wide activities to postpone subsequent pregnancies due to higher infant morbidity and mortality rates when pregnancies occur in younger women (15-18) and are spaced less than two years apart (Supportive role of Infant Mortality Committee)

> Continue to work with schools and the communities to provide esteem building and future directed programs for teenage girls.

> Support physical exertion initiatives eg Fit WIC, Coordinated School Health and Fit and Healthy Kids to build esteem and educate importance of personal health.

> Coordinate with new AHS Department of Children and Families to maintain pregnancy prevention theme in planning prevention programs for children and adolescents.

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

- > Ongoing collaboration with EPSDT for dental outreach and access to care activities.
- > Conducted survey of children during school year 2002-2003. Twenty-two school participated, 1,238 children in grades 1, 2, and 3 were surveyed.
- > Ongoing collaboration with Tooth Tutor (school-based , facilitates referral to dental home) and fluoride programs (school-based and community water systems). Expansion of these programs as capacity and funding allows.

b. Current Activities

- > Ongoing collaboration with EPSDT for dental outreach and access to care activities.
- > Published report of the oral health survey of 2002-2003. Distributed widely to clinicians, schools and other organizations concerned about children's oral health needs.
- > Ongoing collaboration with Tooth Tutor and fluoride programs (school-based and community water systems). Expansion of these programs as capacity and funding allows.
- > Begin participation in Oral Health Advisory Committee and the process for creating a statewide oral health strategic plan.

c. Plan for the Coming Year

- > Ongoing collaboration with EPSDT for dental outreach and access to care activities.
- > Complete Oral Health Strategic Plan and act on issues related to this PM - that of increasing percent of children receiving sealants.
- > Ongoing collaboration with Tooth Tutor and fluoride programs (school-based and community water systems). Expansion of these programs as capacity and funding allows.
- > Participation in creation of the Vermont Oral Health Strategic Plan and offer recommendations for addressing the need for children to receive protective dental sealants.

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

- > As part of KISS (Kids in Safety Seats) Program, VDH car seat technicians provide one-on-one instruction to families on appropriate installation and use of child safety seats and distribute subsidized safety seats to low income families. In April, 2003, this training was begun to be phased out as a result of state budget cuts and demands for redistribution of staff resources. Continue to provide information about local safety seat inspections to VDH clients.
- > Coordination within VDH and state government and community organizations on car safety issues, such as between VDH (Injury Prevention Advisory Committee, HI, CPH) Governor's Highway Safety Council, Child Fatality Review COmmittee, etc.
- > Improved surveillance activities such as working with Vt Association of Hospitals and Health Systems for ED data gathering. Continuing to develop the injury surveillance plan.

b. Current Activities

- > Coordination within VDH and state government and community organizations on car safety issues, such as between VDH (Injury Prevention Advisory Committee, HI, CPH) Governor's Highway Safety Council, Child Fatality Review COmmittee, etc.
- > VDH staff provide public education (along with Governor's Highway Safety and Dept of Education) about the newly passed occupant safety law which takes effect January, 2004.
- > Planning for the development and implementation of the Uniform Child Death Review web-based data form - use of this form will assist in gathering more complete information on associated factors involved with car crashes.
- > Coordination within VDH and state government and community organizations on car safety issues, such as between VDH (Injury Prevention Advisory Committee, HI, CPH) Governor's Highway Safety Council, Child Fatality Review COmmittee, etc.
- > Continue to develop the injury surveillance plan.

c. Plan for the Coming Year

- > Coordination within VDH and state government and community organizations on car safety issues, such as between VDH (Injury Prevention Advisory Committee, HI, CPH) Governor's Highway Safety Council, Child Fatality Review Committee, etc.
- > Reexamine other opportunities for collaboration with the Governor's Highway Safety Program, such as with car crash prevention and, specifically, in education of parents as they instruct their teen children on driving techniques.
- > Continue planning for the implementation of the web-based uniform child death review form. Pilot to be in January, 2005.
- > Implementing of the statewide injury surveillance plan.

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

a. Last Year's Accomplishments

Progress Toward Goal of 75% initiation rate and 45% for at least six weeks.

- > Breastfeeding initiation rate among WIC participants continued a slow, steady rise. Data from 2000 CDC PNSS shows breastfeeding initiation rate of 60.9%, up from 60% the previous year. While we still have far to go to reach the 75% goal, we have made significant gains in the past 6 years - the breastfeeding initiation rate in 1994 was 45%.
- > We met the 45% goal for breastfeeding duration of at least 6 weeks, with 20.1% of infants exclusively breastfed at the 6 week visit and another 29.3% receiving mixed feeds.
- > PedNSS data (2001) showed that 29% of infant and child WIC participants were breastfed for at least 6 mo, and 25% were breastfed for at least 12 mo. The comparable national figures are 21% at 6 mo and 12% at 12 mo.
- > Breastfeeding Friendly Employer Project - developed Breastfeeding Friendly Employer Designation.
- > Purchased/distributed manual and pedal pumps statewide. For women who have established

milk supply, who are returning to work or school and who are motivated to continue breastfeeding. In FFY 2002, distributed 89 pedal pumps.

- > Electric Pump Rental - expanded last year's rental contract pilot project statewide, making electric breast pumps available to lactating women who are returning to work or school and desire to continue breastfeeding their infants. Also provides electric breast pumps to lactating women who are in medical need that is not considered by their insurance providers to require a breast pump. The rental station bills the state directly, at a pre-determined monthly rate. So far, 170 women have used the program.
- > Best Start Conference held in 2002 for training community and VDH staff in the national Loving Support campaign. Granted funds for a Loving Support breastfeeding promotion campaign in 2003.
- > Ongoing local activities of Breastfeeding Coalitions
- > Develop local resource guides
- > Develop pumping stations in VDH office buildings and sites.
- > Breastfeeding classes at VDH offices
- > Training sessions for professionals
- > Local agreements to make electric pumps available for WIC clients
- > Annual activities for World Breastfeeding Week, including proclamation from Governor.

b. Current Activities

- > Ongoing activities as described above.
- > 37 employers recognized as "breastfeeding friendly"
- > Peer Counseling - The national WIC program has made a very small amount of funds available for developing breastfeeding peer counselor programs for WIC participants. Vermont staff attended training on establishing and managing a peer counselor program in June 2004.
- > Building Bright Futures: Vermont's Alliance for Children. Much work is being done to build a unified system of early care, health and education for families with young children that ensures children are ready for school. We can begin to make state and local connections among the early childcare community, Kids Are Priority One Campaign and the business community to promote economic development and increase worker productivity that include and promote health priorities as well. The Breastfeeding Friendly Employer designation is an example of this effort.

c. Plan for the Coming Year

- > Ongoing activities as described above
- > Establish statewide breastfeeding coalition
- > Implement applicable recommendations of the Legislative Report on Breastfeeding (2001)
- > Continue to encourage, support and sustain local breastfeeding coalitions.
- > Continue to reinforce prenatal breastfeeding promotion and counseling before issuing or increasing amounts of supplemental formula.
- > Implement activities for each of the four goals established through the "Using Loving Support to Build Breastfeeding Friendly Community" grant.
- > Continue to maintain contracts with local rental stations to provide hospital grade electric breast pumps to WIC participants returning to work and school.
- > Work to coordinate training opportunities with the Vermont Lactation Consultants Association (VLCA), Home Health Agencies, Parent-Child Centers, the Healthy Babies, Kids & Families Program and medical care providers.
- > Develop a small peer counseling demonstration project in one or more district offices.

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

a. Last Year's Accomplishments

- > As of May 1, 2003, all Vermont birth hospitals have implemented Universal Newborn Hearing Screening (based on building on the pre-existing Hearing Outreach Program, an outpatient hearing screening clinic held at 12 sites around the state)
- > As of June, 2003, all Vermont birth hospitals are reporting individual screening results to CSHN to assure tracking and follow-up, so that no infant is missed.
- > Grant supported CSHN provides support to hospitals in clinical technique and data gathering (CDC cooperative agreement and MCHB grant)
- > A new data base (See NPM #1) has been implemented, populated with Metabolic-Newborn screening information.
- > Follow up of each baby born in Vermont is carried out by a pediatric audiologist with CSHN.

b. Current Activities

- > Continue to build capacity with all Vermont birth hospitals in fully implementing Universal Newborn Hearing Screening. The indicator for 2003 shows that 94.8% of newborns have been screened before hospital discharge (see endnote for NPM #12.)
- > All Vermont birth hospitals continue to report individual screening results to CSHN to assure tracking and follow-up, so that no infant is missed.
- > Grant supported CSHN continues to provide TA support to hospitals in clinical technique and data gathering.
- > Continue to fully implement UNHS data base (See NPM #1) as populated with Metabolic-Newborn screening information.
- > Follow up of each baby born in Vermont is carried out by a pediatric audiologist with CSHN via outpatient secondary screening.

c. Plan for the Coming Year

- > All Vermont birth hospitals continue to participate in UNHS and to report individual screening results to CSHN to assure tracking and follow-up, so that no infant is missed.
- > Grant supported CSHN provides support to hospitals in clinical technique and data gathering (via CDC and MCHB)
- > Continue to implement the new data base (See NPM #1), as populated with Metabolic-Newborn screening information.
- > Promote improved and consistent screening and appropriate follow up for infants with risk factors.
- > Continue to organize and provide continuing education opportunities for audiologists and

early interventionists.

> Continue to work with parent colleagues to create and disseminate information for families and providers.

> Follow up of each baby born in Vermont is carried out by a pediatric audiologist with CSHN via outpatient secondary screening.

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

a. Last Year's Accomplishments

> Distributed Medicaid eligibility flyers to all school aged children with a postage paid return for information request card

> Monitored by town and AHS region the number and location of returned cards requesting an application for Medicaid. Tested as a follow up contact process with those families who were sent an application but did not apply.

> Continued efforts in working with schools to make health insurance status a component of the school emergency card, thus data can be submitted once per year to the VT Department of Education

> Screen all WIC applicants for health insurance status, provide assistance in completing joint application to expedite enrollment in Medicaid/Dr. Dynasaur if interested. All pregnant women, infants and children who meet WIC income guidelines are income eligible for Medicaid.

b. Current Activities

> Distributed Medicaid eligibility flyers to all school aged children with a postage paid return for information request card.

> Monitored by town and AHS region the number and location of returned cards requesting an application for Medicaid.

> Continued efforts in working with schools to make health insurance status a component of the school emergency card, thus data can be submitted once per year to the VT Department of Education.

> Reached a goal of 50% of Vermont schools reporting data on health insurance status to the Vt Dept of Education.

> Screen all WIC applicants for health insurance status, provide assistance in completing joint application to expedite enrollment in Medicaid/Dr. Dynasaur if interested. All pregnant women, infants and children who meet WIC income guidelines are income eligible for Medicaid.

c. Plan for the Coming Year

> Distribute Medicaid eligibility flyers to all school aged children with a postage paid return for information request card

> Monitor by town and AHS region the number and location of returned cards requesting an

application for Medicaid.

> Continued efforts in working with schools to make health insurance status a component of the school emergency card, thus data can be submitted once per year to the VT Department of Education

> Screen all WIC applicants for health insurance status, provide assistance in completing joint application to expedite enrollment in Medicaid/Dr. Dynasaur if interested. All pregnant women, infants and children who meet WIC income guidelines are income eligible for Medicaid.

> Continue statewide mechanism to follow up with families who were sent a Medicaid application, but who did not apply. The follow up will attempt to both identify possible barriers to applying and assist families in actually applying. Review lessons learned from prior year activities and identify new strategies (depending on funding for this activity)

> Continue 50% of Vermont schools reporting data on health insurance status to the Dept of Education.

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

a. Last Year's Accomplishments

> Work to improve the elements contained in the HCFA 416 report and break that data down by school supervisory union. Work with schools to increase percentage that report this information.

> Continue to improve the percent of schools that report well child visit information to the Dept of Education.

> VDH has provided federally-mandated outreach and informing services to Medicaid families regarding the need for well-child care

> VDH works closely with providers of pediatric care to improve standards, disseminate best-practice information and clarify coding and billing procedures for well-child care to Medicaid-eligible children.

b. Current Activities

> Continue work on improving the data elements contained in the CMS 416 report and to break down the data set into useful and manageable information.

> Continue to improve the percent of schools that ask a medical home question on the school emergency card as reported to the Vt Dept of Education.

> Improve the image of the correspondence of the VDH federally-mandated outreach and informing services to Medicaid families regarding the need for well-child care.

> Continue to work closely with providers of pediatric care (and PATH, AAP, AAFP) to improve standards, disseminate best-practice information and clarify coding and billing procedures for well-child care to Medicaid-eligible children.

c. Plan for the Coming Year

- > Work to improve the elements contained in the HCFA 416 report and break that data down by school supervisory union
- > Continue to improve the percent of schools that ask a medical home question on the school emergency card as reported to the Vt Dept of Education.
- > Improve the image of the correspondence of the VDH federally-mandated outreach and informing services to Medicaid families regarding the need for well-child care.
- > Continue to work closely with providers of pediatric care (and PATH, AAP, AAFP) to improve standards, disseminate best-practice information and clarify coding and billing procedures for well-child care to Medicaid-eligible children.

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

a. Last Year's Accomplishments

- > WIC: Screen all pregnant women for risk factors contributing to pre-term labor and low birthweight, refer to appropriate medical care follow-up. Recall women with specific risk factors for additional education and follow-up (pre-pregnancy underweight, poor weight gain and smoking).
- > WIC and HBKF: Assess all pregnant women who smoke for readiness to quit, make cessation services and support available.
- > WIC: On-going prenatal assessment for risk factors know to be determinants for pre-term and low birth weight; at-risk women referred to HBKF for home visits beyond WIC program support
- > Education for prenatal providers, pregnant women and their partners about management and behavior changes that moderate risks, e.g., identify and have a plan for follow-up for pre-term labor, smoking cessation, adequate prenatal weight gain, multiple births.
- > Case management across a system of care to ensure the appropriate community resources and support are available to at risk pregnant women
- > Infant Mortality Committee provides for a statewide communication with a variety of key collaborators such as FAHC, UVM, Perinatal Program, Planned Parenthood, March of Dimes.

b. Current Activities

- > The Department of Health continues to investigate the factors contributing to the low birth weight rate in Vermont, and to look at methods for addressing these factors.
Based on our findings that women with risks that included more than one of three critical

factors (pre-pregnancy weight status, weight gain in pregnancy and smoking) had much higher low birthweight rates, we modified our monthly mailing of participants needing specific follow up. Women with two or more of the risks are highlighted, and district staff receive a reminder with the list that these women are very likely to have poor outcomes. Our current recommendations for follow up include:

- > Identifying women who are at risk to deliver low birthweight infants as early in pregnancy as possible
- > Referring all high risk women for nutrition follow up, medical interventions and home visiting programs as appropriate
- > Providing women with an appropriate weight gain goal, based on pre-pregnancy weight status and adjusted for multi-fetal gestation if necessary
- > Monitoring women who present with poor weight gain throughout pregnancy, and providing counseling and referrals as needed to help women gain an appropriate amount
- > Encouraging all pregnant women who smoke to quit and refer to appropriate community resources for support. Women who cannot or do not want to quit are encouraged to cut down the number of cigarettes to the minimum possible. More tobacco related activities are described in the reports on smoking cessation and environmental tobacco smoke goals.
- > Infant Mortality Committee provides for a statewide communication with a variety of key collaborators such as FAHC, UVM, Perinatal Program, Planned Parenthood, March of Dimes.

c. Plan for the Coming Year

> The Department of Health continues to investigate the factors contributing to the low birth weight rate in Vermont, and to look at methods for addressing these factors. Based on our findings that women with risks that included more than one of three critical factors (pre-pregnancy weight status, weight gain in pregnancy and smoking) had much higher low birthweight rates, we modified our monthly mailing of participants needing specific follow up. Women with two or more of the risks are highlighted, and district staff receive a reminder with the list that these women are very likely to have poor outcomes. Our current recommendations for follow up include:

- > Identifying women who are at risk to deliver low birthweight infants as early in pregnancy as possible
- > Referring all high risk women for nutrition follow up, medical interventions and home visiting programs as appropriate
- > Providing women with an appropriate weight gain goal, based on pre-pregnancy weight status and adjusted for multi-fetal gestation if necessary
- > Monitoring women who present with poor weight gain throughout pregnancy, and providing counseling and referrals as needed to help women gain an appropriate amount
- > Encouraging all pregnant women who smoke to quit and refer to appropriate community resources for support. Women who cannot or do not want to quit are encouraged to cut down the number of cigarettes to the minimum possible. More tobacco related activities are described in the reports on smoking cessation and environmental tobacco smoke goals.
- > Infant Mortality Committee provides for a statewide communication with a variety of key collaborators such as FAHC, UVM, Perinatal Program, Planned Parenthood, March of Dimes.

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

a. Last Year's Accomplishments

> EPSDT staff have actively participated in the VCHIP Adolescent Health Initiative designed to improve the quality of preventive health services to Vermont adolescents. A series of focus groups were conducted with groups of adolescents and families regarding their experiences and perspectives on preventive health care.

> Suicide deaths continued to be monitored by the Child Fatality Review Committee

b. Current Activities

> Staff continue to work with VCHIP Adolescent Health Initiative. One of the goals is to assure that adolescents are screened for risk and protective factors during preventive health visits.

> Suicide deaths continued to be monitored by the Child Fatality Review Committee

> Injury Prevention Coordinator supports efforts of community coalition in southern Vermont (Deerfield Valley Suicide Prevention and Education Committee) to establish school and community programs to educate about suicide.

> VDH currently collects and monitors data on suicide attempts and completions.

c. Plan for the Coming Year

> Staff will continue to work with VCHIP Adolescent Health Initiative. One of the will be to assure that adolescents are screened for risk and protective factors during preventive health visits and that materials pertaining to emotional well-being are developed for the Provider's Toolkit

> Suicide deaths will continue to be monitored by the Child Fatality Review Committee

> Injury Prevention Coordinator supports efforts of community coalitions in southern Vermont (Deerfield Valley Suicide Prevention and Educaiton Committee) to establish school and community programs to educate about suicide.

> VDH collects and monitors data on suicide attempts and completions.

> VDH participation in the MCH Center for Child Death Review child death review pilot project will enable collection of more detailed data about completed suicides.

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

a. Last Year's Accomplishments

> Assessment of all pregnant women in WIC clinics (and HBKF) for risks of VLBW and education on available resources for prenatal care. Appropriate referral for high risk clinical care.

> Collaboration with the Regional Perinatal Training Program and the March of Dimes to facilitate the training for transport of pregnant women in PTL and the transport of infants born in community hospitals to regional medical centers.

> Communication of issues and strategies around maternal infant transport via Infant Mortality Committee.

b. Current Activities

> Assessment of all pregnant women in WIC clinics (and HBKF) for risks of VLBW and

education on available resources for prenatal care. Appropriate referral for high risk clinical care.

- > Collaboration with the Regional Perinatal Training Program and the March of Dimes to facilitate the training for transport of pregnant women in PTL and the transport of infants born in community hospitals to regional medical centers.

- > Communication of issues and strategies around maternal infant transport via Infant Mortality Committee.

c. Plan for the Coming Year

- > Assessment of all pregnant women in WIC clinics (and HBKF) for risks of VLBW and education on available resources for prenatal care. Appropriate referral for high risk clinical care.

- > Collaboration with the Regional Perinatal Training Program and the March of Dimes to facilitate the training for transport of pregnant women in PTL and the transport of infants born in community hospitals to regional medical centers.

- > Communication of issues and strategies around maternal infant transport via Infant Mortality Committee.

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

a. Last Year's Accomplishments

- > HBKF program staff manage and facilitate a comprehensive referral system, which puts entry into early and adequate prenatal care as a top priority.

- > Follow-up and outreach is done with individuals through Health Department staff and home visitors to ensure first trimester connection with a prenatal care provider

- > Contact with providers to facilitate referrals into the HBKF system of care and other services.

- > Collaboration re: statewide systems issues with the Infant Mortality Committee

b. Current Activities

- > HBKF program staff manage and facilitate a comprehensive referral system, which puts entry into early and adequate prenatal care as a top priority.

- > Follow-up and outreach is done with individuals through Health Department staff and home visitors to ensure first trimester connection with a prenatal care provider.

- > Contact/outreach with providers to facilitate referrals into the HBKF system of care and other services.

- > Conducting a thorough review of program objectives with HBKF partners, including first trimester prenatal care.

- > Vermont has nearly met the Healthy People 2010 goal & HBKF objective for entry into prenatal care in the first trimester. The rate in 2002 was 89% (goal is 90%).

> Collaboration re: statewide systems issues with the Infant Mortality Committee

c. Plan for the Coming Year

> HBKF program staff manage and facilitate a comprehensive referral system, which puts entry into early and adequate prenatal care as a top priority.

> Follow-up and outreach is done with individuals through Health Department staff and home visitors to ensure first trimester connection with a prenatal care provider.

> Contact with providers to facilitate referrals into the HBKF system of care and other services.

> Continue review of program objectives with HBKF partners, including first trimester prenatal care, as program is transferred to the new Department of Children and Families.

> Continue to monitor BC data and associated descriptive data to assess progress toward goal of 90%.

> Collaboration re: statewide systems issues with the Infant Mortality Committee

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. Utilize and refine new metabolic-UNHS integrated tracking database.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Address quality-of-data issues with tracking database	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Create and disseminate updated materials for parents, PCPs, and hospitals to include expanded screen	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue visits to hospital nurseries for TA (coordinate with UNHS visits)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue intensive follow-up and tracking to assure no baby is "missed"	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Continue to operationalize the newly expanded screening panel.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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"/>

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. Continue to include family centered care among the "performance expectations" in grants to providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue to work with CSHN Family Advisory Council -systematically examine CSHN programs/services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Promote dialogue among families, PCP, and specialists to improve communication and services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Analyze and apply information gathered from focus groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Establish regular meetings with Parent to Parent and VT Parent Information Center leadership	<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. Focus on medical home/CSHN/Part C relationships in the CSHN Family Advisory Council.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Improve CSHN communications with PCP around referral questions, reports, and next-steps planning.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Analyze and apply information from focus groups with respect to CSHN/Medical Home communication and collaboration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue CSHN database improvements, and expand Medical Home-related elements.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue to participate with AAP and VCHIP in establishing Medicaid reimbursement for "incident to" events and care plans.	<input type="checkbox"/>	<input checked="" 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
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. Continue direct and P2P outreach efforts to increase Medicaid enrollment.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Continue policy dialogue with Medicaid around interpretation of policy for CSHCN.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue cost-share database refinements to document insurance status of CSHN-enrolled children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Assist AHS in documenting the impact of new Medicaid premiums	<input type="checkbox"/>	<input checked="" 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. Continue 12-region CSHN presence.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue multi-site clinics.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Implement Joshua/I-CAP pilot; plan for expansion to other regions with advocates' advice.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Complete CDC review and implement improvements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Establish collaborative relationships with new Nexus parent staff around the state.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Focus on interagency improvements in care coordination for children with hi-tech needs.	<input type="checkbox"/>	<input checked="" 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"/>

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. Update written agreement with Vocational Rehabilitation.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Expand number of clinics with "adult medicine" collaborators.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue work with Respite Policy Cluster or its successor under AHS reorganization.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Work to develop specific age-out transition planning for CSHN programs.				

	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Add specific transition planning element to VT Medical Home Care Plan models.	<input checked="" type="checkbox"/>	<input checked="" 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
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. Continue to process of establishing Immunization Registry - populating with data and expanding provider participation.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue local immunization clinic services and referral to medical home.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Continue assessment of local services capacity.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Continue Vermont vaccine program services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Vaccine screening and referral via WIC clinics.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Continued distribution of "Have Your Tots Had All Their Shots?" flyers.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Continue various parent ed activities such as informing at birth hospital and via EPSDT letters	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Continue collaboration with state daycare facilities	<input checked="" type="checkbox"/>	<input checked="" 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. Target high risk teens for prevention and intervention services via HBKF.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Coordination with prevention and intervention activities of community based organizations.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Continued surveillance and analysis of population and program based data	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Support broad prevention activities with Dept of Ed, Planned Parenthood, PCC's, etc.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Work with Dept of Children and Families for continuing prevention focus in programs.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Work with nutrition/exercise program (Fit WIC, Run Girl Run) in prevention strategies	<input checked="" 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"/>

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. Follow up on Fall, 2002 survey findings to direct outreach and program development activities.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Continued outreach via EPSDT/HBKF	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Enhanced outreach via RWJ grant activities and focus group results	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Enhanced surveillance and program evaluation from RWJ grant	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Enhanced service capacity (resulting from RWJ activities) will allow development of Dental Home.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Collaboration with Coordinated School Health Committee on dental services and outreach from schools.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Collaboration with Tooth Tutor program	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Collaboration with fluoridation programs	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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. Provision of safety seat use information in WIC/HBKF	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Provision of education to the public about the new safety seat law (Act 28, in effect Jan, 2004)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Improve morbidity surveillance via new capacity for accessing statewide emergency room data.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Enhanced coordination between state and community groups to insure distribution of safety seats.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Development of the Child Death Review uniform data base for the state of Vermont	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Develop planning initiatives with Governor's Safety for public education about crash prevention and safety belt use.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Planning with Governor's Safety Program for education of parents of teen drivers.	<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"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. Continue with WIC/HBKF general activities for promotion of breastfeeding with mothers and families.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Continue ongoing VDH and community staff training.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Continue local support/coordination of breast feeding coalitions.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Continue with WIC pump rental program.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Continue with activities to promote breastfeeding friendly employer program.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Continue maintenance of VDH website with breastfeeding information.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Continue Loving Support grant activities.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Establish statewide breastfeeding coalition.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Ongoing community and state celebrations of World Breastfeeding Week.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Peer counseling demonstration project	<input checked="" 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. Continue to provide technical assistance to hospital nurseries, by the project pediatric audiologist	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue to provide outpatient secondary screening through HOP.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Fully implement the EHDI tracking database.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Promote improved and consistent screening and appropriate follow-up for risk factors.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue to organize and provide continuing ed opportunities for audiologists/early interventionists	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Continue to work with parent colleagues to create and disseminate information for families/providers	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
13) Percent of children without health insurance.				
1. Continue long standing EPSDT functions of informing and outreach.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Continue improving Medicaid data analysis-hence better understanding of access/utilization.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue WIC screening of clients and provision of information and referral via joint application.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Continue data gathering on health insurance via school records (health emergency card, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Follow up with families who decline Medicaid	<input checked="" 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. EPSDT informing and outreach. Improve outreach letter.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Continue data gathering via school health records.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue building solid system of sending informing letters and follow up.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. HBKF family assessment of health needs and referral to services.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Continue to improve Medicaid data analysis for better information on access/utilization.	<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
15) The percent of very low birth weight infants among all live births.				
1. Continue surveillance and analysis by statisticians and planners.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Infant Mortality Committee continue interpretation of data and collaboration with partners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. WIC screening/referral of high risk pregnant women, esp those with risk factors such as smoking, poor weight gain, short interpregnancy interval.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. HBKF identification and referral of pregnant women with risk factors for LBW/VLBW	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Continue Quit Line resources/counseling for pregnant women who smoke.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Develop prevention and medical care systems to support preconceptional health.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Continue pilot project to support pregnant/postpartum women to stop smoking (Washington County)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Continue support of Vermont Regional Perinatal Program in training of				

health care providers, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Numerous prevention programs for teens so as to prevent smoking and optimize health when reach childbearing ages.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Pilot program with AHEC to train providers in Brief Intervention techniques for pregnant smokers.	<input checked="" type="checkbox"/>	<input checked="" 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. VDH/VCHIP tools for health care providers to screen teen for depression.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Vermont Injury Prevention Program action plan.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Injury Prevention Coordinator support of southern Vermont coalition	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Data gathering on suicides and attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Pilot of Child Death Reveiw data collection tool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Reveiw of suicides and trends by Child Fatality Reveiw Committee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Broad prevention stratgies by a variety of community organizations	<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
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. Continued support of Vt Regional Perinatal Program training and TA to community hospitals.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Infant mortality committee collaboration for systems issues.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Referral from WIC/HBKF of women needed medical high risk services	<input checked="" 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
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				
1. HBKF identification and referral of pregnant women for first trimester care.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. HBKF collaboration with OB providers re: systems issues hindering early entry into care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Infant Mortality Committee collaboration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Monitoring of population and program based data describing elemnts of prenatal care utilization.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Coordination of HBKF goals and activites as program is transferred to new Department of Children and Families	<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"/>

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *The percent of Medicaid infants from birth through 12 months who receive home visits through the Healthy Babies, Kids and Families system of care.*

a. Last Year's Accomplishments

> Ongoing program administration and development. Program oversight includes quality assurance and fiscal management.

> Risk assessments and referrals are made from any provider in the system of care to the local Health Department MCH Coordinators. Referrals sources include primary care settings, hospitals, WIC, home health agencies, Parent Child Centers, schools, etc. Home visits and care coordination are offered as a benefit of the program, particularly for high risk clients.

> As part of a HBKF Expansion initiative, four (out of twelve) communities have implemented an intensive home visiting pilot. This pilot incorporates best practice guidelines for community teams in the integration and collaboration around the delivery of services to clients, including re-structuring of billing and reimbursement mechanisms.

b. Current Activities

> Continuing with ongoing program oversight and implementation.

> The percent of eligible clients accepting home visits (~50%) has remained the same. However, the percent of clients who are at higher risk and require a more intensive level of services has increased. Also, there has been a greater shift to the provision of more nursing than family outreach & support visits, resulting in demand for more services than the program budget can support. A case management and prior authorization of home visit process has been implemented to assure appropriate services, based on risk criteria and program objectives as well as management of the program budget.

> Vermont is embarking on a re-organization of the Agency of Human Services and the development of a unified system of early care, health and education for families with young children. A new Department of Children & Families will house the Division of Child Development, which will include the HBKF program (which currently sits in the Dept. of Health). A transition period in which to make these changes will begin July 1, 2004.

c. Plan for the Coming Year

> Continued transition of the HBKF program to the new Department of Children & Families, Division of Child Development. The goal is to improve service coordination for families through co-location of providers, increased provider collaboration, blending of funding streams and increased flexibility about use of resources for families,

State Performance Measure 2: *The percent of low income children (with Medicaid) who utilize dental services in a year.*

a. Last Year's Accomplishments

> Continue to administer and expand Tooth Tutor programs as capacity allows. Expansion possible via RWJ grant.

> Continue to monitor, via the school health emergency card, the number of children reporting they do not have a dental home.

b. Current Activities

> Continue to administer and expand Tooth Tutor program as capacity allows.

> Continue to monitor, via the school health emergency card, the number of children reporting they do not have a dental home.

c. Plan for the Coming Year

> Continue to monitor, via the school health emergency card, the number of children who report that they do not have a dental home.

> Continue with development of oral health state plan and implement recommendations appropriate for this measure, ie; those that address outreach and dental home for children who use Medicaid.

State Performance Measure 3: *The percentage of Vermont Department of Health districts that have a community-based hearing and diagnostic follow-up program (Hearing Outreach Program) for children.*

a. Last Year's Accomplishments

> We continue to have Hearing Outreach Program sites in the 12 regions. We have increased the numbers of clinics and numbers of children seen, by increasing pediatric audiology staff time.

> HOP has, as hoped, become the follow-up method of choice for infants needing follow-up to UNHS.

> Head Start Programs are partnering with HOP to achieve their own programmatic hearing screening mandates.

> Implementation of third party billing has been difficult; the process has been added to CSHN

staff, after difficulties with outsourcing the process.

b. Current Activities

- > See activities from previous years.
- > Continuing focus on capacity adjustment for the increasing referrals to HOP.
- > Focus on increasing third party reimbursements.
- > Completed a draft protocol for infant audiologic diagnosis; it is being circulated for comment.

c. Plan for the Coming Year

- > Continue to stabilize the system for third party reimbursements.
- > Begin work with an information systems contractor to improve the linkage between the UNHS database and the HOP clinical activities so that follow-up occurring in HOP is automatically linked to the UNHS record, thus closing the loop.
- > Disseminate the diagnostic protocol to medical homes and other community partners.
- > Promote hearing screening as a standard element of Part C evaluation.

State Performance Measure 4: The percent of primary caregivers in the Women, Infants and Children program who report placing infants to sleep on their backs as the usual sleeping position.

a. Last Year's Accomplishments

- > Goal is reduce the risks of infant death from SIDS through caregiver education and influencing parenting practices.
- > On-going collection of caregiver information about infants' primary sleep position at the 6 week and 6 month WIC certification. This information is reported out from WIC data, and contributes to a more comprehensive analysis and inquiry of SIDS sleep position and sleep environment factors. This, in turn, informed targeted statewide interventions to reduce infant deaths.
- > National and state SIDS/Back to Sleep brochures and parent educational materials are available to caregivers through WIC clinics, primary care practices, hospitals, home visiting programs, parenting classes, private insurance informational packets. These materials are used to augment provider education and recommendations around safe infant sleep position and other protective factors, e.g., no smoking, breastfeeding.

b. Current Activities

- > Continuing activities as listed in previous year
- > Coordinate with VDH Medical Examiner and Child Fatality Review Committee on collecting Vermont-data describing incidents of SIDS where there were identified risks of unsafe sleep environment.
- > Begin review of national brochures advising parents of safe sleep environments

c. Plan for the Coming Year

- > Continue activities as described for previous years.
- > Review research about risks of sleeping in adult beds and overall safe sleep environment to be reviewed and a Vermont-specific brochure to be developed.
- > An evaluation and revision of the current Vermont SIDS program is underway.

State Performance Measure 5: *The percent of youth aged 12-17 who use alcohol.*

a. Last Year's Accomplishments

- > EPSDT staff have worked closely with Vermont Child Health Improvement Project (VCHIP, an organization designed to work with physicians to improve the quality of preventive health services to adolescents. Collaboration to set guidelines for well-adolescent visits for screening for risks/assets to determine potential for alcohol use and abuse. Use of CRAFFT.
- > Associated work on prenatal alcohol use via the WIC/Rocking Horse collaboration.
- > Collaboration with Office of Drug and Alcohol Abuse programs and community based New Directions programs.

b. Current Activities

- > EPSDT staff have worked closely with Vermont Child Health Improvement Project (VCHIP, an organization designed to work with physicians to improve the quality of preventive health services to adolescents. Collaboration to set guidelines for well-adolescent visits for screening for risks/assets to determine potential for alcohol use and abuse. Use of CRAFFT.
- > Associated work on prenatal alcohol use via the WIC/Rocking Horse collaboration.
- > Collaboration with ODAP and community based New Directions programs.

c. Plan for the Coming Year

- > EPSDT staff have worked closely with Vermont Child Health Improvement Project (VCHIP, an organization designed to work with physicians to improve the quality of preventive health services to adolescents. Collaboration to set guidelines for well-adolescent visits for screening for risks/assets to determine potential for alcohol use and abuse. Use of CRAFFT.
- > Associated work on prenatal alcohol use via the WIC/Rocking Horse collaboration.
- > Seek opportunities for collaboration with Mental Health Programs, as a result of the AHS reorganization and the combining of Department of Mental Health with the Department of Health.
- > Collaboration with ODAP and community based New Directions programs.

State Performance Measure 6: *The percent of 8th grade youth who smoke cigarettes.*

a. Last Year's Accomplishments

> Continue with Vermont Kids Against Tobacco (VKAT.) Peer leadership program provides training, TA, and funding for middle school aged youth to educate peers and younger children about tobacco, marketing, and to promote a tobacco free lifestyle. In the 2001-2002 school year, there were 56 VKAT sites. Over 400 youth participated in the annual state house rally, where they marched in the state capital and spoke with legislators.

> Our Voices Exposed (OVX) is the peer leadership program for high school aged youth. Emphasis on peer leadership, community organizing, media literacy, and research based prevention activities. In 2001-2002 school year, there were 29 OVX sites.

b. Current Activities

> Continue with VKAT activities as described above.

> Continue with OVX activities as described above.

> Youth from 24 OVX sites attended training to learn about tobacco industry marketing tactics and ways to influence their peers. Also attended one-day summit with other youth to further learn about the dangers of tobacco.

> Developed the "Butts of Hollywood" campaign to focus on the issue of smoking in the movies - use of three commercials that air around the state on TV and in eleven theaters, letter writing campaigns, educational activities at the movie theaters.

c. Plan for the Coming Year

> Continue with VKAT activities as described above.

> Continue with OVX activities as described above.

> Continue with "Butts of Hollywood."

State Performance Measure 7: The percent of Women, Infants and Children (WIC) program families who use feeding practices that prevent Baby Bottle Tooth Decay (BTD).

a. Last Year's Accomplishments

> In July of 2002, a query of risk factors assigned to currently active infants and children showed that 92 percent had feeding practices that prevent baby bottle tooth decay, leaving only 8 percent who take a bottle to bed, walk around all day with a comfort bottle or routinely drink liquids other than breastmilk, milk or formula from a bottle.

> WIC: Ongoing provision of sippy cups to each WIC-active infant at the six month re-certification visit, and a new toothbrush for the one year visit. Use of a targeted nutrition education message as items are given to families.

> WIC: Ongoing education of all parents about the need for water testing to determine whether or not fluoride supplements are needed. Offer information about the causes of early childhood dental caries, ways to prevent caries, and early signs of dental decay.

> To facilitate referrals and follow-up for dental problems, WIC uses a pediatric referral form to communicate issues that either need immediate follow-up and an expedited dental appointment (such as active decay or white spot lesions), or that need to be discussed at the next pediatric well-child visit (such as maternal tooth decay, older siblings with early childhood

decay, bedtime bottle feedings or the need for fluoride supplements).

> WIC: BBTD initiative includes agreements with dentists who will give priority appointments, with little or no waiting time and without regard to source of payment, to young children who have been referred by their pediatrician.

> Close coordination with VDH Dental Health Unit to improve educational materials for both parents and dentist.

> WIC distributes a dental health newsletter to pediatric and general dentists.

Actions:

> WIC: COordinate parent education and family referral systems with child care providers.

b. Current Activities

> Continuation os actions listed for previous year.

> WIC continues to provide sippy cups to each WIC-active infant at the six month re-certification visit, and a new toothbrush for the one year visit with a targeted nutrition education message for each item. As an alternative to sippy cups, we would like to provide a small cup with a tight-fitting lid but no spout. Thus far, we have been unable to locate an appropriate cup but we continue to explore options.

> Continue close coordination with VDH Dental Unit during transition time of recruitment for new Dental Health Director (former Director retired July, 2003).

> As part of our current special project grant WIC Services in the Medical Home: Improving Early Feeding Practices, three control districts and three provider practices are collecting detailed information on feeding practices. While the purpose of the data collection is to determine whether the WIC-MD model is effective in changing feeding practices, the information gathered in the control offices will also help us identify the most commonly used practices that are not evidence-based. We can use this information focus nutrition education materials and interventions to assist those specific practices.

> Began participation in the Oral Health Advisory Committee; Role is to advise on status and recommendations directed at achieving goal of 95% of WIC families using feeding practices that prevent BBTD.

c. Plan for the Coming Year

> Continuation of activities as listed for previous years.

> Review detailed feeding practice data collected as part of WIC in the Medical Home Special Project grant to determine future planning and strategies to work with clinical practices.

> Continue participation in the Oral Health Advisory Committee and advise on recommendations directed at achieving goal of 95% of WIC families using feeding practices that prevent BBTD.

State Performance Measure 8: *The degree to which an accessible, comprehensive data system supports CSHCN policy making, planning, and activites.*

a. Last Year's Accomplishments

OMH began strategic planning process andneeds assessment - part of acitivities will be to assess cultural competency needs of AHS staff and community health care providers. AHS is revising approach to training for staff and training session are no longer offered routinely. SPM #8 is retired for this report year.

b. Current Activities

AHS training unit is performing a survey of state mangers and supervisors about education needs of staff around issues of cultural competency.

c. Plan for the Coming Year

Office of Minority Health will collaborate with AHS training unit to design comprehensive cutural competency training for AHS staff. OMH will also address this issue for community-based providers of health care statewide during the strategic planning process. Title V will reflect OMH findings in the FFY06 MCH Needs Assessment.

State Performance Measure 9: *The percent of youth in grades 8 through 12 who are overweight or obese.*

a. Last Year's Accomplishments

- > The CSHN Cost-share database continues to be stabilized and made accessible to all staff.
- > A symbolic milestone this year has been the removal of the decades-old paper patient card file. Referrals have been added as a linked table. While useful as an accessible source of information about CSHN enrollment, the database does not include clinical activity records. Encounter and diagnostic data continues to be entered into a 1031 format, which is accessible only to a very few IS staff at the department level.

b. Current Activities

- > The reorganization of the Agency of Human Services includes a plan to centralize the Information Systems supports across departments. We are uncertain at this point what the impact of IS centralization will be on CSHN programs' ability to improve its patient care and program data.

c. Plan for the Coming Year

- > Continue to focus on improvement of data quality, access and utilization by program staff for clinical and planning purposes.
- > While access to and linkage with Encounter data and Accounts Payable data would be of tremendous benefit to the program, we suspect that the AHS reorganization efforts will absorb much IS attention in the immediate next year. We will continue to articulate our program needs.
- > Parent to Parent of Vermont has developed a magnificent database reflecting parent concerns and needs, and in this year we will explore how it may contribute to the CSHN needs assessment.

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 Medicaid infants from birth through 12 months who receive home visits through the Healthy Babies, Kids and Families system of care.				
1. Outreach to providers and community services for collaboration and referral	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Provision of home visits or care coordination for home visiting services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Quality assurance activities for home visiting services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Intensive home visitng in four pilot areas and expansion	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Expanded emphasis on prevention services and early child development	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Data gathering and assessment for program evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Management of transition to Department of Children and Families	<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"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The percent of low income children (with Medicaid) who utilize dental services in a year.				
1. Continued outreach via EPSDT/HBKF	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Enhanced outreach via RWJ grant program	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Enhanced service capacity via RWJ grant will allow development of dental home system for preventative care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Enhanced evaluation and surveillance via RWJ grant and follow up from focus groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Collaboration with Coordinated School Health Committee on dental services and outreach via schools.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Collaboration with Tooth Tutor prgrams	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Collaboration with fluoridation programs	<input checked="" 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"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) The percentage of Vermont Department of Health districts that have a community-based hearing and diagnostic follow-up program (Hearing Outreach Program) for children.				
1. Continue 12 regional sites	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Collaboration with Head Start for addressing program mandates.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Maximize insurance reimbursement, for sustainability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Improve linkage between HOP database and UNHS records	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

5. Promote hearing screening as standard protocol for Part C evaluation	<input checked="" 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 percent of primary caregivers in the Women, Infants and Children program who report placing infants to sleep on their backs as the usual sleeping position.				
1. Continue WIC-based survey of parents of 6 week and 6 month infants about sleep positions and practice	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue Back-to-Sleep campaign via distribution of pamphlets and parent/provider education.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Assess and plan for appropriate activities on publicity, media campaign on issues of safe sleep environment	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Monitor VDH infant death data for SIDS/SUDI and elements of safe sleep environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Work with media contractor to develop a media message for educating parents on safe sleep environment	<input type="checkbox"/>	<input checked="" 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
5) The percent of youth aged 12-17 who use alcohol.				
1. Continue VCHIP activities involving screening of youth for risk factors in provider settings	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue Rocking Horse program for pregnant and parenting women (and teens) who use/abuse alcohol	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Continue with New Directions community based activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Continue surveillance via systems such as YRBS and program data	<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
6) The percent of 8th grade youth who smoke cigarettes.				
1. Continue surveillance via YRBS and program data.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue with VKAT activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Continue with placements of public media campaign ads in movie theaters	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Continue with OVX activities	<input checked="" 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"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) The percent of Women, Infants and Children (WIC) program families who use feeding practices that prevent Baby Bottle Tooth Decay (BBTD).				
1. Continue WIC program data gathering about risk factors for information on BBTD practices.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue WIC BBTD prevention activities such as providing education to clients and incentives (sippy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Continue system of pediatric referral forms (in WIC clinics) and written agreements with local dentists	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue distribution of dental health newsletter	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Coordination of outreach and education activities with child care providers	<input type="checkbox"/>	<input checked="" 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 degree to which an accessible, comprehensive data system supports CSHCN policy making, planning, and activities.				
1. Continue implementation of policy that all AHS employees attend cultural competency training.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Coordinate with OMH to apply concepts of culturally competent care to VDH services.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Coordinate with OMH to educate the provider community in techniques	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

of culturally competent care (pl				
4. Provide support and TA for providers of health care to refugees, especially the newly arriving Bantu	<input checked="" 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
9) The percent of youth in grades 8 through 12 who are overweight or obese.				
1. Continue to improve completeness and accuracy of CSHN database	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Expand staff training in CSHN database	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Progress in integration of CSHN database with Part C, Medicaid, and accounts payable.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Collaborate with Parent to Parent database in needs assessment	<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"/>

E. OTHER PROGRAM ACTIVITIES

MCH Toll Free Line: Vermont's toll-free, confidential telephone MCH information and referral service is called "Help Your Baby, Help Yourself," nicknamed the HelpLine (see Form 9 and endnote). Funding for this program was eliminated in the state budget and the hotline ceased operation via the Agency for Human Services in November, 2002. The Pregnancy Hotline Calls are now managed by VDH/Division of Community Public Health which provides coverage for the entire state. Callers are referred to the appropriate district office and assisted by a public health nurse or nutritionist. Ongoing statewide PAL calls are answered by United Way who receives funding from a variety of sources, including AHS. Calls responding to the sexual abstinence media campaign are also handled by the United Way. In 2005, the United Way is planning to solidify funding and offer a statewide comprehensive response service (via 211 system) and is collaborating with various programs in VDH which are interested in a public toll free education/advice system.

Refugee Program: Health evaluation for newly arriving refugee families takes place within 30 days of arrival and is conducted by the Community Health Center in Burlington and private health care providers. VDH recruits and orients primary care providers for assessment, treatment, and ongoing management of refugee health needs. The Refugee Health Coordinator, the State Coordinator, and the District Office staff work closely with the Vermont Refugee Resettlement Program, the Office of Minority Health, and private providers to assure that care is available, accessible, and culturally appropriate. Interpreter services are arranged through contacts with the local resettlement agency, as

well as with the LLE (Language Learning Enterprises.) Between 1994 and 2003, Vermont received 2,469 refugees. In 2003, ninety seven refugees arrived in Vermont; 24 from Somalia, 17 from Azerbaijan, 15 from Congo, 9 from Sudan, and another 8 from varying countries. The goals of the refugee health program continue to be developing and obtaining training materials and supporting tools for further provider education on international health risks of incoming refugees. The program plans to further expand the refugee health website to include additional VDH translated educational materials. Additional efforts will be made to research and secure educational materials for LEP clients on health related topics.

Children's UPstream Service (CUPS) a Services Initiative Grant from the federal Center for Mental Health Services. Key project objectives are: 1) Enhance the ability of Vermont's existing Community Partnerships to improve linkages of services for school aged children with SED with the early childhood system of care, 2) Statewide expansion of key services aimed at strengthening the behavioral health of young families. A sixth year of funding enables program continuation until June, 2004 with possibility of continuation beyond that time.

State Incentive Cooperative Agreement (New Directions): One of five states funded via the National Youth Substance Abuse Initiative. The goal is to reduce use of alcohol, tobacco, marijuana and other drugs by teens (aged 12-17). See discussion SPM 5.

The Office of Rural and Primary Care receives funds from the Bureau of Primary Health Care and the Federal Office of Rural Health Policy to improve access to health services for underserved populations. This is done through planning, technical assistance, grants, coordination and advocacy. An advisory group guides the work of the Office. Activities of the Office include the development and administration of medical and dental loan repayment programs, grants to community organizations for services and/or infrastructure development, training and technical assistance to community based health care organizations, assessment of the need for health services in communities, workforce coverage analysis and trends, and application for Federal designations of underservice. The Steering Committee is composed of a broad range of provider groups concerned with access to care including the Medicaid program, Mental Health Department, Department of Aging, Hospital Association, Medical Society, Primary Care Association, Dental Society and Area Health Education Center. Recent projects are the development of a set of criteria to identify Vermont communities at high medical need in order to seek Governor Designations of underservice and expand the opportunities for participation in the Federally Qualified Health Centers programs and reassessment of the State Loan Repayment Program for primary care providers. A loan repayment system for nurses was enacted by the state legislature in 2002 - Nursing loan repayments and loan forgiveness have been added to the cadre of loan repayment programs. The Primary Care Loan Repayment Program is in the last stages of updating, final policy recommendations will be complete in June, 2002. With the closure of the USDA Waiver program, the State Conrad 20 Program has become much more active. Some of the current state activities include: using the new governor's designation criteria to identify areas for the development of RHC's and FQHC's, working with the UVM Office of Nursing, the Nursing Board, regional colleges and universities as well as community hospitals to develop a curriculum and infrastructure to facilitate the reentry of nurses whose licenses have lapsed back into the field. ***/2005/ The Office is working with the Medicaid Office, Dept of Developmental and Mental Health and the Office of Alcohol and Drug Abuse programs to examine policy, programming and funding to support the integration of behavioral health and primary care. Additionally, the Office is collaborating with the Office of Women's Health to apply for a grant from the Federal Office of Rural Health Policy to develop a network to improve outcomes related to incarcerated women. Finally, the Office received a grant from the RWJ Foundation to increase access to oral health services for Medicaid/SCHIP eligibles. This grant has been used to: develop reimbursement strategies to improve access to dental care, expand school based oral health programs, provide consumer prevention education and enhance oral health provider recruitment and retention.***

F. TECHNICAL ASSISTANCE

Request: Funding up to \$5,000 to support conducting statewide key informant interviews of MCH leaders. Funds will be used to support a contractor who will be chosen to coordinate with VDH personnel to conduct interviews, analyze data and compile a final report to be included in Vermont's MCH Strengths and Needs Assessment.

Background: All Title V programs nationally are required to submit an MCH Needs Assessment with the FY 2006 grant application. Vermont is planning to approach the Needs Assessment project by expanding the "needs assessment" focus to assessment of the state's strengths as well as the needs. Status indicators will be revealed by such methods as analysis of population based data, program evaluation, and consumer input. (Vermont is collaborating with MCHB Region 1 to accomplish this expanded focus.) Presently, there is much quantitative data being gathered which will be included in the needs assessment (supported by SSDI grant.) Qualitative data from focus groups and consumer surveys is also being gathered. A key addition to complete the basic data and information will be focused interviews with several key MCH leaders in the state: physicians, nurses, mental health professionals, insurers, and so forth. These interviews will contain questions designed to elicit the informant's personal knowledge about systems issues and population-based strengths and needs. The focus will not be on strategies for change, but will ask about the underlying problems that need to be solved. A contractor with experience in qualitative data gathering and analysis will be hired to perform many of the activities, such as certain functions around data gathering, data analysis, and compiling the final report.

Objective: To conduct a series of key informant interviews with MCH leaders statewide so as to amass qualitative data for the 2005 MCH Strengths and Needs Assessment.

Outcomes: Data from the key informant interviews will be combined with other types of data (both quantitative and qualitative) to create a comprehensive pool of data, thus fully informing the Strengths and Needs Assessment.

Related Performance Measures: Not directly related to performance measures. Designed to gather information for the MCH Strengths and Needs Assessment which will be used to determine the Priority Needs for focus of MCH planning and program development for the next five years.

V. BUDGET NARRATIVE

A. EXPENDITURES

A. Expenditures.

Expenditure documentation. Beginning with State Fiscal Year 2002, the state of Vermont has been using a new accounting system. The expenditures reported here for Federal FY 2003 are the first time Vermont has reported an entire year of Title V expenditures that were entered in this new accounting system. The system is named "VISION," which is an acronym for "Vermont Integrated Solution for Information and Organizational Needs". The accounting package includes the Financial and Distribution modules contained within PeopleSoft's software suite for Education and Government (E&G) version 7.5. It is designed to be an integrated financial and management tool. While most transactions are entered into VISION directly, payroll information is currently run on a separate system and summary payroll data are extracted from the Human Resource Management System (HRMS) and uploaded into VISION. The HRMS software is also a PeopleSoft product and is compatible with VISION. Upgrades to both VISION and HRMS will be implemented in tandem. The VISION system was implemented with as few Vermont-specific characteristics as possible so that future upgrades could be accepted with relatively minimal retrofitting work. VISION contains a number of modules that allow for a variety of functions, such as asset management, as well as expenditure tracking.

The implementation of VISION, especially during FY02, was fraught with difficulties. By SFY04, the difficulties diminished somewhat although the inherent problems of this system remained. In addition to the unintended implementation difficulties, there is a problem created by the intended goal of producing accrual-based accounting statements. The system specifications of an accrual-based accounting system make it difficult to produce the cash-based reports that are required for virtually all federal programs in the health and humans services areas. The Title V expenditure reports here, for instance, are cash-based reports.

While these problems have created difficulties and initially caused us to be later than desired in our financial reports, the integrity of the financial data was never compromised. We were eventually able to extract the Health Department's transactions from the VISION system and load the data into the Health Department's own software. From there, it was possible to perform Cost Allocation procedures entirely consistent with our approved Cost Allocation Plan. We have been able to demonstrate that the expenditure data that we use in the Health Department's extract is reconciled to the original VISION data. Under both the previous accounting system and the new VISION procedures, the Vermont Health Department can confidently provide assurance that we have established "such fiscal control and fund accounting procedures as may be necessary to assure proper disbursement and accounting" [Sec 502(a)(3)].

One of the key chartfields in the VISION system is "program code." There was a similar code in the system that preceded VISION. The program code is used to link every transaction to a federal grant, if there is one. It is also used to track separate costs within a funding source. For costs related to the Maternal and Child Health Block Grant, there are series of program codes that designate the populations served, using the population definitions established in statute. Multiple program codes are used for some populations; the expenditures on behalf of children with special health care needs, for instance, are tacked based on the specific diagnosis-based clinic enrollment (orthopedic, metabolic, etc.). The Maternal and Child Health Block Grant never requires financial reporting of this detail. However, this level of specificity in our coding structure allows us to better monitor expenditures and to be accountable to the populations that we serve.

Cost Allocation. The Vermont Health Department operates under a Cost Allocation Plan approved by the DHHS Division of Cost Allocation. This Plan determines how we will collect certain general overhead costs into cost pools and how those overhead cost pools will be allocated to the various programs and funding sources, such as the Maternal and Child Health Block Grant. Because we have

an approved Cost Allocation Plan, Vermont does not have an indirect rate agreement, which would be the alternate method for charging overhead costs to programs. It is our understanding that Cost Allocation Plans--instead of indirect rate agreements--are relatively rare among Health Departments in the country, but it seems to serve us well with a variety of funding sources. Basically, the approved methods collect general overhead costs on a monthly basis into cost pools at the division level and also at the Department-wide level. Allowable charges from the Statewide cost pool are also determined. These three overhead cost pools (division, department and statewide) are then allocated to all of the programs in the department (including state funded programs as well as federally funded programs). The allocation process is based on the relative direct salary costs of each program in the quarter.

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

Single State Audit. The State Auditor of Accounts arranges for an annual audit in compliance with the Single Audit Act, as well as in conformity with Section 506(a)(1) of the Maternal and Child Health Block Grant. The audit is performed by KPMG under contract with the Auditor of Accounts. The fieldwork has been entirely completed for FY 2003. While the audit findings have not yet been distributed, the exit interview occurred in June, 2004 and we are aware of all of the areas of concern to the auditors, none of which affect the MCH Block Grant. Although the Maternal and Child Health Block Grant does not qualify as a "major" program for audit purposes, transactions may be tested as part of a general review of management control. There were no findings related to expenditures funded by the Maternal and Child Health Block Grant in SFY 2002 or in 2003.

Year-to-year expenditure variations. For the last several years we have noted that the hours coded to the Maternal and Child Health Block Grant by Community Public Health staff has consistently decreased. In prior years, the data showed that this did not mean a decrease in services to this population but instead it meant a change in funding. Hours were still being spent working with this population, but more of the hours were charged to Medicaid rather than MCH. In the last couple of years there was a continuation of the trend of reduced hours charged to MCH. However, there was also a slight reduction--instead of a slight increase--in the hours charged to Medicaid. Taken together, the MCH hours and the Medicaid show a small and irregular, but noticeable, decrease. See the chart, "Community Public Health Hours for MCH and Medicaid," attached. This change follows a reduction in State General Funds in the Health Department beginning in FFY02. This reduction was not as serious as the reductions in most states, but the funding reductions that the Department experienced had the effect of modestly reducing MCH staff hours.

B. BUDGET

B. Budget.

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

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

30%-30% Requirement. The Health Department calculates the amount expended on each category. For FFY 2003, 38% of expenditures was made in Component B and 58% was made for Children with Special Health Care Needs. Since these costs are tracked using "program codes," it is easy to determine whether the state is in compliance with the 30%-30% requirement.

Administration costs. Administrative costs are defined in the same terms that they were defined in 1989: administrative costs are the extra-departmental costs that are allocated to the Health Department and to the programs within the Health Department. These costs are that component of the allocated costs that are attributable to the support services of payroll, buildings, etc. The definition of "administration" costs does not include costs such as the policy direction activities of the Health Commissioner, etc. The administrative costs of the Maternal and Child Health Block Grant can be readily determined by analysis of the allocated costs, and these costs are tracked on a quarterly basis to ensure that there is no increase in the costs that would exceed the allowable maximum. Administrative costs for FFY2002 were 3% of total costs.

Maintenance of effort. [Sec. 505(a)(4)] The maintenance of effort amount for Vermont, based on the amount of unmatched State expenditures reported in 1989, is \$167,093. In prior years, we projected our total MCH expenditures throughout the year to ensure that we would be in compliance with the maintenance of effort requirement, and then made the adjustment for maintenance of effort at the end of the year, rather than quarterly. Beginning with FY2002 and continuing into the current (FFY04) year, we have been deducting one quarter of the maintenance of effort amount from our allowable claims each quarter. Our understanding is that quarterly reductions of our allowable costs are more consistent with federal cash management directives than an end-of-year adjustment.

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

Consolidated health programs. [Sec. 505(a)(5)(B)] Funds are used to support certain programs that were initiated under the provisions of the consolidated health programs, as defined in Section 501(b)(1). MCH Block Grant funds are used to support the Regional Genetics Program, which was initiated under a section 1101 grant prior to 1981, and is referred to as a consolidated health program in Sec 501(b)(1)(C). The Regional Genetics grant is \$140,056. MCH Block Grant funds are also used to support the adolescent pregnancy program at the Addison County Parent Child Center, which was initiated under a Title VI grant prior to 1981, and is referred to as a consolidated health program in Sec. 501(b)(1)(D). The Addison County Parent Child Center grant is \$32,820.

Other Federal funds. The other Federal funds used to support MCH-related goals are listed in Form 2 and 4. There is no significant change in the type or total amounts of other Federal funds. Relatively minor changes in amounts for various funding sources are usually related to the timing of grant payments, etc. The one very major change in the mix of other Federal funds is in Medicaid, and the

important data are actually hidden within a larger number. The Medicaid line on the Other Federal Funds table show an amount of about \$10 million. This includes reimbursement for a variety of projects. Included here, for instance, are the Federal Medicaid receipts for the Healthy Babies program, for the School-based EPSDT program, and a variety of others. The one portion of the Medicaid receipts that has a direct and immediate impact on the Title V program is the payments for CSHN clinic services.

Medicaid payments for CSHN clinics have increased remarkably. This is the largest change in the expenditure pattern related to MCH services, and it leads to a reduction in our charges to the Maternal and Child Health Block Grant. Our reduced MCH claiming pattern is not a result of changes in total gross program costs. Rather, it is due to shifting a larger amount of the burden of the cost away from Title V and into Medicaid. This increase in Medicaid payments is due partly to improved billing procedures, partly to obtaining more favorable reimbursement rates, and partly due to the ability to obtain Medicaid reimbursement for a larger percentage of Medicaid children, especially those with other insurance coverage. This pattern has been noted in the last several years, but the impact became larger in FY 2002 and 2003, and it therefore is apparent in our FY2004 report and FY2005 estimates. See the attached chart, "Medicaid Payments for CSHN Clinic Costs," which shows the long term trend of Medicaid payments, going back to 1991. This long-term view demonstrates the dramatic increases of the last couple of years. Our hope is that this trend will continue, and that we can continue to divert a large amount of direct medical costs to Medicaid.

Source of State matching funds. The State match consists entirely of cash payments of State General funds or State Special funds (e.g., tobacco settlement funds, foundation grants, etc). The State match is exclusively from non-federal funds. These non-federal funds are appropriated as described above and the use of these non-federal funds is monitored by the Agency of Human Services as well as the Health Department, as noted above.

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.