



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

**State Narrative for  
Vermont**

**Application for 2009  
Annual Report for 2007**



Document Generation Date: Monday, September 22, 2008

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## **I. General Requirements**

### **A. Letter of Transmittal**

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

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

### **B. Face Sheet**

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

### **C. Assurances and Certifications**

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; expires May 31, 2009.

### **E. Public Input**

Ongoing public input for Title V programs takes a variety of forms that allows direct Title V input and also input into general MCH programs of the VDH. The public budget process is one opportunity, as the VDH budget is publicly available (on request and via publications on the website.) An annual legislative committee session is purposely advertised for public attendance to allow for input into Title V and other federal grant applications. Focus groups and surveys for the WIC and EPSDT programs are conducted to assess satisfaction with services and to solicit input for suggested improvements as well as additional services. The Office of Dental Health has conducted focus groups with low income consumers about access, satisfaction and awareness of oral health care services. The VDH/VCHIP Program for Opioid-exposed Newborns uses mothers who have experienced addiction as advisors for their program. The ECCS/Building Bright Futures planning processes both statewide and regionally have included parents of young children on the planning committees. The VDH Newborn Screening Advisory Committee has several parents of children with metabolic conditions as members. CSHN partners with parents (including parents of CSHCN who are not served or are not eligible for CSHN programs) through Parent to Parent and its facilitated focus groups, surveys and interviews. The CSHCN Family Advisory Council is composed of parents. In addition, several CSHN staff members are parents of CSHCN. As of 2007, the Title V grant application is being reviewed annually and the comments have been incorporated into the grant narrative and are considered for improvement in case management and clinical services. In Vermont, the VDH Title V partners comprise a large group of state and community leaders who advise and collaborate regularly on MCH public health and service delivery issues. These partners participated in the needs assessment process in 2005 and are regular members of VDH advisory committees and collaborative efforts (School Health, Birth Registry, Early Childhood Comprehensive Systems, Department of Children and Families, Newborn Screening, Comprehensive Integrated Services, Department of Mental Health, etc) See attached Public Input Table, individual program descriptions, and Sec 111E for further information.

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

## **II. Needs Assessment**

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

*An attachment is included in this section.*

### **C. Needs Assessment Summary**

See Attachment for II C of Vermont Strengths and Needs Assessment summary and updates.

### **III. State Overview**

#### **A. Overview**

Section III A Overview Vt TV FFY09

Entry for July 2008

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

Vermont is a scenic and mountainous state, located in the New England (NE) region of the United States, sharing its northern border with Quebec, Canada. It is a rural state with the 2005 revised census showing a population of 623,050, up 2.3% from the 2000 census count of 608,827. Chittenden County has the largest population concentration with about 150,000 residents, almost ¼ of the state's population. Burlington, in Chittenden County, is the core of the state's only Metropolitan Statistical Area, which extends into parts of Franklin and Grand Isle Counties. Addison County also has strong connections to the MSA. The fringes of this region still have strong ties to Vermont's agricultural industry, which sometimes causes conflict over land use planning and policies. The estimated population of this MSA is 166,126, representing approximately 27% of the state's population. Of the 255 towns and cities in Vermont, nine have total populations that exceed 10,000. These nine sites account for 25.2% of the state's population. Vermont has 14 counties.

While racial and ethnic minorities are only 3.3% of Vermont's population, in general, these populations are growing at a much faster rate than the non-Hispanic white population. The non-white population of Vermont was 14,330, up 11.4% since July, 2000. The number of persons of Hispanic origin was 6,414 in 2004, up 15.1% from July, 2000. The Asian and Pacific Islander population has increased 16.6% since July, 2000 and the Black population has increased 17.1% in that time. The racial and ethnic minority populations in Vermont are heavily concentrated in Chittenden County. While Chittenden County has 24% of the total population of Vermont, 42.9% of the non-white population and 28.6% of the Hispanic population resides in Chittenden County. However, Franklin County has the largest numbers of American Indian population.

Aging of Vermont's population is similar to the changes nationally, - the median age for Vermont was 39.3 years in 2003, compared to a national median of 35.9 years. From 2000 to 2003, there was a significant increase in the proportion of the population aged 55-64, as the "baby boom" generation ages. The fastest growing segment is the 45-64 year olds and there has been a slight decline since 2000 in the under 15 and in the 30-39 age groups. A declining birth rate is now considered a main reason for the decrease in school enrollment: 1995 enrollment of 98,361; 2006 enrollment of 96,363.

Household composition is changing, 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 2003 there were 5,988 marriages and 2,495 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. In 2004, there were 1,397 civil unions and 14 dissolutions.

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, 2006 election, a Republican governor was elected to his third two-year term in office. The 2006 legislative elections created Democratic majorities in both the state House and Senate. Vermont has no county health departments, but 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). The 2005 government reorganization created regional field offices of the state's human services offices, with which the VDH offices collaborate closely.

Vermont is the home to many long established businesses such as IBM and C&S wholesalers, but the economy is diversified with industries in manufacturing, tourism and services. Agriculture is still a vital part of the economy, but its importance has diminished over the several decades. Vermont's rural nature and areas of poverty presents the issue of sparse populations having ready access to resources and services. Residents living in isolated areas of the state may have special difficulties accessing services and medical care (particularly in the harsh winter months) due to their remote locations and the less than optimal road conditions. A sizeable proportion of Vermonters are living either in poverty or are living very near the poverty level. In 2005, Vermont's per capita income (PCI) was \$30,534, which was the 22nd highest in the nation. Between 1995 and 2005, Vermont's PCI increased 28%, whereas the nation's PCI increased 46%. It is important to note that the poorest fifth of Vermont families had an average annual income of \$18,846, while that of the richest fifth was \$112,505. Vermont's median household income averaged over 2002-2004 is \$45,692. ***//2009/ Indicators of economic stressors include a jobless rate of 4.9%, the highest rate measured since 1994 //2009//***

Vermont's poverty rate was 8.8% for 2002-2004 (6th lowest nationally.) The rate has not changed substantially over the last fifteen years. Of these families who live below the FPL, 24 % have a female head of household. Approximately 1 in 8 Vermont children lives in poverty. Unemployment rates range from 3.2% for Chittenden County (Vermont's most populous county) to 5.0% percent in Orleans County (Vermont's second most rural county), resulting in a state average of 3.5 %. Five percent of Vermont's population has less than a 9th grade education; eight percent have 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.) In other poverty measures, the Hunger in Vermont 2005 Report indicates that a 54% increase from 2003 in the number of families with minor children using food shelves, representing over 51% of the food shelf caseload.

Using other measures of health status, the 2005 Family Health Insurance Survey conducted by the Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA), shows Vermont's uninsured rate as being 10.3%, an increase from the 2001 rate of 8.4%. Almost 4% of children age 0-9 and 6% of children age 10-17 are uninsured -- this is a slight increase from 2000. About  $\frac{3}{4}$  of these children live with adults who are employed. ***//2009/ A new BISHCA survey is planned for Fall 2008. //2009//***

Vermont ranks first nationally in the ratio of students to teachers in the public schools: 11.7 pupils to one teacher vs. a national ratio of 15.9. In addition, 87.5% of Vermont students complete high school. Of the high school graduates, 63% continued in school, compared to 44% in 1978. In other indicators, in 2004, 3,361 Vermont children (264 out of every 10,000) were reportedly abused or neglected. The national rate was 478, and Vermont ranked third lowest among 48 reporting states. In 2004, Vermont's rate of violent crime (the number of crimes known to police per 100,000 population) was 113, less than one-fourth of the national average of 466.

Since 1980, the Refugee Resettlement Program has relocated over 5,000 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. Initially, resettled refugees arrived primarily from Vietnam, Cambodia, and the Balkans. More recently, refugees from sub-Saharan Africa have settled in Vermont. 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. ***//2008/*** The health needs of migrant farm workers are becoming evident as this population is rapidly growing in Vermont. Estimates show there are about 2,500 migrant farm workers with concentrations in Franklin, Grand Isle, and Addison Counties. District offices and community groups are assisting workers and their families to access health services such as WIC and community clinics. Broader state and regional responses are

being planned//2008//

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 2005 Dentists Survey indicates that, as compared with the 2003 survey, there are 10.7 fewer FTE's in primary care. Although the decrease is distributed across the state, the largest decreases are in Bennington, Caledonia, Rutland, Washington, and Windsor counties. There has also been an overall decrease in specialty care FTE's especially in Rutland and Washington counties. The Office of Rural and Primary Care is tracking these trends and coordinating with the VDH Office of Oral Health on activities to recruit new providers to the state. See Section 4.1 of Strengths and Needs Assessment (SNA.)

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. A key part of this effort is the nursing loan repayment program out of the Vermont Department of Health and administered by the Area Health Education Centers. Early successes in ameliorating the nursing shortage 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. ***/2009/ UVM notes that the key limitation in expansion of student enrollment is the shortage of nursing faculty. /2009//***

Vermont Health Care System of Publicly Funded Insurance:

In July of 1995, Vermont's Medicaid 1115 Research and Demonstration Waiver application to create and implement the Vermont Health Access Plan (VHAP) was approved. The waiver allowed for a basic package of insurance coverage for previously uninsured adults with incomes up to 150 percent of the federal poverty level (FPL). In February, 1999, eligibility for previously uninsured adults was expanded to include parents and caretaker relatives of Medicaid-eligible children up to 185% FPL. In October 1998, the children's Medicaid program, Dr. Dinosaur, 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.)

/2008/ In the fall of 2005, Vermont secured approval for a Section 1115 Medicaid waiver, known as the "Global Commitment waiver," that allows Vermont to fundamentally restructure its Medicaid program. The waiver imposes a cap on the amount of federal Medicaid funding available to Vermont for nearly all Medicaid expenditures except for SCHIP and Nursing Homes.

It also includes all Medicaid administrative expenses. In combination with a second, long-term care waiver, the Global Commitment waiver makes Vermont the first state in the nation agreeing to a fixed dollar limit on the amount of federal funding available for its Medicaid program. In exchange for taking on the risk of operating under a capped funding arrangement, the waiver allows Vermont to use federal Medicaid funds to refinance a broad array of its own, non-Medicaid health programs, and a greater level of program flexibility. Such flexibility includes changes in cost sharing, plan design, and possible caps on enrollment for "non-mandatory" Medicaid beneficiaries. Global Commitment's stated goals are to: 1) provide the state with financial and programmatic flexibility to help Vermont maintain its broad public health care coverage and provide more effective services; 2) continue to lead the nation in exploring new ways to reduce the number of uninsured citizens; and 3) foster innovation in health care by focusing on health care outcomes. Also cited are state fiscal problems and the desire for more flexibility to change the Medicaid program without federal review. Despite the small size of Vermont's Medicaid program, the Global Commitment waiver is being watched by policymakers across the country because it contains some of the key elements of a block grant--capped federal funding and elimination of some federal standards governing benefits, cost sharing, and the entitlement to coverage for many beneficiaries. There are 4 key elements: 1) Imposes a global cap that limits the state to drawing down federal Medicaid matching funds on no more than a total of \$4.7 billion in Medicaid spending for acute care services over a 5 year period. If, however, Vermont reaches the \$4.7 billion cap, it will not receive any additional assistance from the federal government for Medicaid costs. This is a marked contrast to the regular Medicaid financing structure, which provides states with guaranteed federal matching Medicaid funds for all Medicaid services provided to Medicaid beneficiaries with no set limits. 2) Allows the state to establish itself as a managed care company -- allowing Vermont to pay itself a premium for each beneficiary that it serves. If the state can deliver care for less than the premium revenue, it can use the "excess" revenue for a broad array of purposes. Within limits, the state controls the amount it pays itself, which means it can ensure that "excess" premium revenue arises by paying (with the assistance of matching federal funds) more than needed to operate its Medicaid program. 3) Provides new flexibility to use federal Medicaid funds for non-Medicaid health programs. Through the "excess" premium revenue, Vermont can replace some of its own spending on various state-funded health care initiatives. Some 50 initiatives have been identified, such as tobacco cessation, domestic violence, and the state's medical school and public laboratory. Estimates are that Vermont may be able to secure up to \$335 million in new federal Medicaid matching funds under the waiver that it does not need to use in providing care to Medicaid beneficiaries. Instead, it can use the "extra" federal funds for fiscal relief or to expand non-Medicaid health initiatives. 4) New flexibility to reduce benefits, increase cost-sharing, and limit enrollment or set up waiting lists for most of the "optional" and "expansion" populations (groups that the state covers at its option with the assistance of federal Medicaid funds.) These populations include many children and parents in low-income working families and all other adults who are not disabled or elderly covered by the Vermont Medicaid program. Under the Global Commitment waiver, the federal government has given the state significant authority to decide if and when it will impose reductions or cost sharing increases. For example, the state can reduce the benefits of optional and expansion populations by as much as 5% over the life of the waiver or impose substantial new cost sharing on them without further CMS review. The authority given by the federal government is bestowed upon the governor and the legislature. Cost sharing, premium adjustments, and plan design must all be approved by the Vermont legislature.

**//2008// /2009/ *Global Commitment waiver reapplication process to begin next year. H.887 passed in Spring 2008 adds many significant elements to original Health Care Reform legislation. Examples: requires inventories of school nutrition and physical activity programs with recommendations on how to improve and build on these programs and how to organize grant funding for future programs based on best practices, updates on recommendations for nutritious foods available in schools and school nutrition policies, review of best practices in primary care settings for treatment and prevention of overweight in children and recommendations for insurance policies that reimburse those practices, review of practices to encourage the availability of healthy foods (esp local foods) to communities, review of best practices in policies that encourage worksite wellness and employee health management. In development of these reviews and***

**recommendations, much coordination will be required between wide variety of public and private health groups such as insurers, Medicaid, VDH, Depts of Education, Agriculture, and the Banking, Insurance, Securities, and Health Care Administration. //2009//**  
**/2009/ Parent to Parent reports that 61% of the families contacting P2P have Medicaid coverage. In the first half of FY08 P2P provided 498 hours of direct parent information, assistance and outreach about Medicaid. //2009//**

The MCH Director, the CSHCN Director, and other key MCH staff continue to be involved in the administration of the Medicaid program. For example, through EPSDT, the MCH Director, the Director of the Division of Community Public Health, and other key program managers continue to assure that children and youth have access to quality health care through the dissemination and updating of the Vermont-specific pediatric periodicity schedule and the provider toolkit that accompanies it. The VDH managers work very effectively and collaboratively with Vermont American Academy of Pediatrics and American Academy of Family Physicians to continuously review, develop, and distribute best practices for pediatric care. Also, the EPSDT program has enhanced its system of regular contact with Medicaid families to inform them of their child's health needs within the pediatric periodicity schedule. /2008/Recommendations for best practice will be updated to reflect the revised Bright Futures, Guidelines for Health Supervision when they are published in Fall, 2007.//2008//**/2009/ Regional meetings have begun, bringing together the regional Building Bright Futures leadership, AAP/AAFP, primary care providers, community-based providers of home health and early intervention, Community Public Health, the MCH director and CSHN medical director, to present the new AAP Bright Futures guidelines and to promote PCP participation in their regions' BBF planning. The goal is to promote evidenced based standardization for pediatric screening. In addition, a Vermont --specific oral Health periodicity schedule is being developed in accordance with the recommendations of the America Academy of Pediatric Dentists. //2009//**

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./2008/The impact of prospective, monthly premiums on enrollments for Dr. Dynasaur has been of some concern. Medicaid tracks the disenrollments, and the CSHN program monitors the Medicaid disenrollment of CSHN clients monthly and notifies CSHN staff. In FY 2008 however, the Dr. Dynasaur premiums are to be reduced by half. //2008// **/2009/ Premiums will rise again in SFY09; CSHN efforts to help families maintain continuity of coverage will need to intensify. We continue to meet with Medicaid leadership to understand and improve collaboration with the new Medicaid case management initiatives, which, although targeted to adults with certain chronic conditions, do include some CYSHCN, especially those with respiratory illnesses. //2009//**

The Child Health Insurance Program (Title XXI)

There are approximately 3,100 children in 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 engaging in strategies to promote enrollment and utilization in these expanded insurance opportunities for children, such as conducting an oral health public education campaign and sending informing letters to families who use Medicaid. The FFY 2004 Vermont state budget included 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. Vermont's comprehensive health care programs for children can offer nearly universal coverage for families. In the state legislative session of 2005, more efforts were made to

expand coverage to a universal, state funded system of health care. The proposed legislation did not pass, but a legislative committee was created to examine possible solution for Vermont in the financing of universal coverage for its citizens.

//2007//In May, 2006, the legislature and the governor agreed on a compromise bill to establish increased health care coverage by establishing premium assistance to low income Vermonters that will allow them to purchase the newly created Catamount Health or an employer sponsored health insurance.//2007// /2008//By October 1, 2007, the Catamount Health Plan will be available to Vermonters who are not currently eligible for the state's other funded programs. Catamount will offer Vermonters the choice of private health plans, which offer basic and uniform benefit packages. In certain circumstances, some Vermonters may be eligible for premium assistance. In addition, Vermont is proceeding with a plan to require those adults on state insurance programs who currently are offered health insurance but do not take it to take their employers option. The state will make a benefit analysis to determine if it is more cost effective to assist the individual with premium assistance and move them off state rolls or to keep them on the state insurance.//2008// **/2009/ Catamount enrollment continues. Initial enrollment numbers are less than anticipated. VDH DO's performing informing and outreach. Statutory changes to original legislation to ensure that pregnant women are protected from pre-existing condition exclusions under Catamount Health. //2009//**

Current Priorities: ( See Section IV)

The "Vermont Blueprint for Health" initiative is dedicated to achieving a new health system for Vermont, based on the Chronic Care Model. The goals are 1) To implement a statewide system of care that enables Vermonters with, and at risk of, chronic disease to lead healthier lives. 2) To develop a system of care that is financially sustainable, and 3) To forge a public-private partnership to develop and sustain the new system of care. The Model envisions an informed activated patient interacting with a prepared, proactive practice team, resulting in high quality encounters and improved health outcomes. Six components: community, health system, decision support, delivery system design, self management education and clinical information systems. Intense planning for implementing the Blue print began in 2004 - presently two Vermont communities are piloting key components of the Blueprint.

//2007//State legislation was passed to codify Blueprint as part of health care reform and enable its provisions to be in line with the Medicaid Global Commitment. Four new hospital service areas were added to those two already participating in the Blueprint initiative: Central Vermont Physician Hospital, Fletcher Allen Health Care, Mt. Ascutney Hospital and Health Center, Springfield Hospital. These communities will begin to offer Healthy Living workshops, develop community physical activity programs and assist local physician offices in adopting best practice protocols and implementing improved clinical information systems. By 2009, all hospital service areas in Vermont will be participating.//2007// /2008//These four pilot areas continue to develop the depth and breadth of their Blueprint deliverables. The date for all Vermont communities to begin participation has been extended so as to allow for a more gradual and controlled expansion of quality services. Statewide Blueprint conference was held in April, 2007. Two national consultant firms have been hired to 1) address the task of communicating Blueprint plans and strategies with health care providers (including pediatric care providers) and 2) to develop Blueprint payment models and systems. Through a shared vision of improving the quality of health care delivery for Vermont's children and families, the MCH leadership will follow a similar model in its strategic planning process(See Section IV G), especially with respect to evaluating and redesigning services provided to children with special health care needs.//2008// **/2009/ Three new pilot areas to be added this year: St Johnsbury for community care coordination, electronic medical records at certain sites. Fletcher Allen Health Care for electronic medical record and quality improvement planning. Third site yet to be selected. Plans to coordinate BP with other Agency programs such as mental health services, elderly services, etc. //2009//**

**/2009/ Vermont has been awarded a CSHCN State Improvement Grant which will support an inclusive, comprehensive process for examining needs, refocusing priorities, and, above all, integrating the several complementary and overlapping redesign efforts for children and families being undertaken by the Agency of Human Services--in effect,**

***integrating the integration. Two of these efforts--the blending of three early childhood programs (Part C, Healthy Babies, and Early Childhood Mental Health--now called Children's Integrated Services), and a new initiative to redesign services for children with disabilities, headed by the MCH director and a special assistant to the AHS Secretary--have particular affinity for CSHN redesign. //2009//***

Child Lead Poisoning Screening and Prevention: See Section IVB and SPM#10.

Initiatives for mental health needs of children and families: see Section IIIB and SPM #9.

Healthy Babies Kids and Families and ECCS: See Section IIIE and SPM#2.

Nearly ten years ago, the VDH in coordination with providers, schools, insurers, and others, developed a model Health Screening Recommendations for Children and Adolescents, also known as the Vermont Periodicity Schedule (funded by CISS grants.) Although the federal law requires that the VDH EPSDT program determine the scope of services for children using Medicaid, Vermont developed this well child screening instrument for all children, regardless of insurance payor. The 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, health care providers, and QI experts continuously update the clinical guidelines and the providers' toolkit./2007/Planning and implementation of an obstetric clinical guidelines/periodicity schedule is underway./2007// /2008/After consultation and surveys of the effectiveness of the Tool Kit, providers and consumers urged VDH to go to an on-line communication vehicle. In FY 07, an on-line tool kit was developed. Although certain elements of the toolkit will remain via hard copy, the majority of the information will be web-based./2008// ***/2009/ Toolkit became "live" in Fall 2007 and is accessible via VDH website (healthvermont.gov) Ongoing outreach to providers, school nurses, etc to encourage its use as a tool for using best practice in clinical care. //2009//***

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 opened at Fletcher Allen Health Care in collaboration with Howard Mental Health Services. Mobile methadone clinics were introduced in Newport and St Johnsbury in 2005. See SPM #3.

The VDH 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 chemically addicted pregnant and parenting women. Identified women are eligible for referral to Fletcher Allen Health Care/University of Vermont's 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 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 VDH

district offices (ie Brattleboro) have also taken the lead in their communities to organize identification and follow up systems. Goals include the development of community response teams in all districts, design protocol implementation teams to work with the Central Office and district offices to develop curricula and competencies, identify barriers and train on location as needed, hold ongoing conference calls/meetings with districts to identify services barriers, foster communication and support and make recommendations for service delivery and system change. ***/2009/ VDH/Vermont Child Health Improvement Program (VCHIP) and Vt Regional Perinatal Health Project coordinate with birth hospitals on transport procedures and protocols for opiod exposed mothers and newborns. Systems approach being developed to coordinate between all community and regional groups involved in treatment of addicted/recovering mother and opiod exposed infant. CME presentations on Neonatal Abstinence Syndrome were made to providers at several forums, including the Northern New England Rural Pediatrics Association (NNERPA) annual meeting, which attracts attendees from VT, NH and ME. 2 trainings held in Brattleboro for local MCH clinical providers. //2009//***

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 2003, Vermont's governor requested the Department of Education and VDH collaborate in strategies to counteract the problem of increasing incidence of overweight children and youth, resulting in the Fit and Healthy Kids initiative. Key strategies for implementation and funding for staff were allocated in the SFY05 budget. 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) and expand the Fit WIC program to include non-WIC families. (Fit WIC encourages physical activity in preschool children by providing parents and child care providers with age-appropriate games and activities designed to promote exercise.) In addition, in July, 2004, Vermont received 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, Coordinated 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. In 2005, the new Obesity Burden Document describes the issue of women of childbearing age who are overweight or obese. Of the women who delivered in 2003, 26% were obese and 13% were overweight. Planning has just begun to address this issue - see also Title V Strengths and Needs Assessment. ***/2007/The Fit and Healthy Vermonters Obesity Prevention program has produced Vermont's Obesity Prevention Plan and Obesity and Health, an Obesity status report to assist in state and community planning. A statewide Advisory Committee has formed and is meeting regularly to coordinate action steps from the state's obesity Fit and Healthy Vermonters strategic planning document. Projects include: development of a resource guide for schools working to implement wellness policies guidelines as required by federal law, development of worksite wellness guidelines, and a toolkit for pediatric and primary care providers for the identification, assessment and treatment of overweight and obesity in children and adults. Also, a pilot of a community based intervention for families and young children -- including a family education component in addition to community wide policy and environmental changes. An executive order from the governor created a statewide Hunger Task Force to address issues of hunger and food insecurity. A variety of community/school based physical activity programs are offered by state-community coalitions - See SPM #6.//2007// /2008/Fit and Healthy Vermonters advisory group continues to meet quarterly. Priority objectives include Health Care--the provider practice resource Promoting Healthier Weight in pediatrics and adult primary care uses a strength based approach to encourage youth and adults to set goals for behavior change. These tools have been completed and are being disseminated to health care providers statewide. The worksite and schools workgroups have completed resources for policy change in schools and worksites. Fit and Healthy Vermonters staff continue to provide training and technical assistance for implementation. In coordination with the Blueprint community group physical activity and walking***

programs have been implemented in each of the 12 local health offices. A pilot peer support physical activity program has been implemented several communities. A second community has been awarded funding to implement comprehensive nutrition and physical activity interventions focusing on policy and environmental changes. //2008// **/2009/ Vt receives AAP 2010 grant designed to connect Vt-AAP members with school and community teams to support health education in the area of obesity prevention. A main goal is to integrate or incorporate best practices into the variety of projects now in place in communities across Vermont. Vt-AAP will provide selection of best practices for communities to choose from when planning interventions. VDH and VCHIP develop and test practitioner toolkit "Promoting Healthier Weight in Pediatrics." 2008 Fit and Healthy Vermonters //2009// /2009/ State plan implementation activities continue in collaboration with public and private partners with Fit and Healthy Vermonters staff providing oversight, training and technical assistance. The Vermont prevention model is being used as the framework for all community based initiatives. Communities are asked to develop initiatives targeted towards families with young children. The pediatric provider toolkit has been completed and will be integrated into trainings and office practice system in the upcoming year. The toolkit along with other program resources and tools developed can be found on the FHV website <http://healthvermont.gov/fitandhealthy.aspx>. FHV staff worked closely with the Legislative Health Care reform commission to prepare background and recommendations for the Healthy Lifestyles component of H.887 the Health Care Reform bill passed this legislative session. Farm to School grants increase locally produced foods to be used in school food service programs. //2009//**

The Injury Prevention Program was established in 2000 with the hiring of a 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. The Prevention Plan, 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. An injury surveillance plan is also being created. The Program coordinates closely with MCH Planning, Community Public Health, the Child Fatality Review Committee, and Women' Health. 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 for the identification, treatment, and referral of women who are experiencing inter-partner violence. A parent education pamphlet about infant safe-sleep environment has been created and plans are being made to distribute to medical practices and child care facilities. In 2005, legislation was passed updating requirements for CO monitors in all buildings where people sleep. //2007/ The Injury Prevention Coalition is now known as the Vermont Injury Prevention Community Advisory Group addressed the following issues: legislative support for fire-safe cigarettes, surveillance for occupational injuries, updates on motor vehicle injuries by the Governor's Highway Safety Commission, a review of the most current injury data including childhood fall data, and planning for a July 2006 symposium on prevention of teen driving deaths and injuries. The Vermont Sexual Violence Strategic Plan was released. Community based action plans for the Suicide Prevention Platform are being created. //2007// //2008/As a result of the Teen Driving symposium, a booklet for parents of teens with guidance on how to teach teens to drive safely was created and is being distributed via drivers' education classes and the Department of Motor Vehicle offices. A symposium on falls prevention is planned for July 2007. Legislative support for proposed bills of distracted driving, primary seat belt use enforcement, cell phone use prohibition while driving. Surveillance activities: occupational injuries, motor vehicle injuries, childhood injury, teen driving, elderly falls. Many collaborations such as with Northeast Injury Prevention Network and Vermont TBI Association. //2008// **/2009/ Newly created Injury Burden Document. September 2008 Symposium on poisoning using broad definition -- planning with Office of Drug and Alcohol Abuse. Other areas of focus are motor vehicle crashes, ATV injuries, falls prevention. Advocate community focuses on fire-safe cigarettes legislation, occupational injury surveillance. Participation on Office of Rural Health Farm**

### **Safety Task Force. //2009//**

The Office of Women's Health's goals: Improving the health status of women, assuring access to high quality, comprehensive and coordinated health services, promoting healthier lifestyles, improving public policies that affect women's health. Specifically, the OWH oversees programs supporting breast and cervical cancer screening, referral and clinical systems. The Title V planner works closely with OWH to coordinate on women's health issues with a variety of community based programs such as the network of women's crisis clinics and Planned Parenthood of Northern New England. New planning is focusing on the health needs and reproductive health needs of incarcerated women. Long term planning (as capacity allows) will center around working with PPNNE on needs assessment, development of services for women in correctional facilities, outreach to refugee women, and counseling for women who are overweight or obese. The Ladies First program works to improve access to preventative health screening services, including screenings for heart disease and breast/cervical cancer screening for low income/underinsured women 40-64 yrs if age./2008/District Offices continue work with AHS Incarcerated Women's Initiative//2008// **//2009/ Spring 2008 legislation sets forth requirements for insurer coverage of mammograms and caps the amount that any one woman would pay for mammogram at \$25.00. //2009//**

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. /2007/Vermont produced a Strategic Plan for reducing smoking in pregnancy-See IVA//2007// /2008/New funding allows a vigorous program focus on low income Vermonters, smoking prevention/cessation programs via employers, and programs focusing young men aged 18-24 years of age. Programs for youth continue via Vermont Kids Against Tobacco(middle school age) and Our Voices Exposed (high school age) SeeIVA//2008// **//2009/ See HSCI 9b. //2009//**

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. Vermont receives CDC funding to upgrade state and local jurisdictions' preparedness for and response to bioterrorism, other outbreaks of infectious disease, and other public health threats and emergencies. Particular progress has been made in communication and information systems, laboratory capacity, and epidemiology and surveillance. As a small state, there is a close relationship between VDH Central, the local offices, and other state and local agencies, professional and voluntary organizations, hospitals, and the National Guard. Vermont is also developing cross border collaborations with neighboring states and Canada. Local action planning which includes plans for the needs of the MCH population, is happening via the Local Emergency Planning Committees (LEPC) of which VDH District Offices are a major participants. In 2003, VDH participated in the national preparedness campaign related to smallpox. Vermont vaccinated 130 civilian health care workers, and all PHN's were trained in smallpox vaccination techniques. Also, chemical and biological agent identification capacity has been added to the Department of Health State Laboratory. A three day emergency response training was held in August, 2004, designed using the Incident Command System for Public Health. All District Offices have a disaster plan in place. Planning and preparation have been ongoing to address special populations in potential public emergencies. Beginning plans to vaccinate, prophylax, and care for those who have special needs or other barriers to care include accommodations for non-English

speakers, homebound persons, children and elderly populations, and those with mental illnesses. /2007/ A statewide pandemic flu summit was held in January, 2006 in conjunction with HHS. As follow up, Local Emergency Planning Committees (LEPC) are holding regional planning summits throughout the spring. A major emergency preparedness exercise for pandemic flu is planned for July, 2006. This is a full scale exercise and will focus on overall response and decision making as well as on detailed readiness and response procedures and the integration of response plans from the federal, state, and local levels. Planning has also begun around the specific needs of the MCH population, including CSHN and pregnant women.//2007// /2008/VDH and Vermont Emergency Management are working with key partners in 12 workgroups to expand statewide plans for bird flu and pandemic flu. **/2009/ Take the Lead initiative designed to engage community groups such as schools and civic groups in conjunction with health care organizations to organize for pandemic flu preparedness. Spring 2008 a regional simulated exercise was held as training for state pandemic flu response. May 2008 simulated exercise for emergency evacuation within Vt Yankee nuclear power plant emergency planning zone. //2009//**

Infant mortality reduction and improving birth outcomes continues to be a high priority for the Health Department. The infant mortality rate in Vermont for 2004 is 6.5/1,000 live births. Although a low rate, our MCH surveillance reports indicate that the rates overall, tend to not be significantly different year to year. However, surveillance continues to monitor these rates that, although low, may be slightly increasing and the two leading indicators related to infant mortality, low birthweight and preterm delivery, are increasing (see discussion in Strengths and Needs Assessment.) These data will be monitored by the VDH in order to guide strategic interventions. VDH continues to focus on the prevention of preterm deliveries and identification of psychosocial risk factors that put women at risk for preterm delivery. In 2002, the legislatively mandated Birth Information Council 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 support the position of a Birth Information System Coordinator who is planning for the implementation of the Birth Information System. 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. **/2009/ Birth Information Network (BIN) has focused on 2006/2007 data. Future funding for continuing the program is uncertain. VDH grant to Vermont Child Health Improvement Program (VCHIP) for a variety of deliverables on improving birth outcomes, including training for neonatal health care providers, QI assistance for birth hospitals, and a web-based data registry (OBNet) collecting information on maternal-fetal risk factors, interventions and outcomes. //2009//**

/2007/Initial planning has begun around Improving Birth Outcomes within the framework of a lifecourse approach to women's health and preconceptual health. Infant mortality reduction via SUDI and injuries is becoming more coordinated between the VDH Injury Prevention Program and the Child Fatality Review Committee. The Birth Information Council has met several times. The VDH Coordinator of the Birth Registry is establishing the list of selected medical conditions to be followed and setting up the process for communication with hospitals, clinicians, and parents//2007// /2008/Lifecourse session to be held at the Boston University School of Public Health in October, 2007. Birth outcomes to be a focus of the planned MCH strategic planning. See Section IV G.//2008// **/2009/ Lifecourse conference held in Boston for Region 1 MCH leaders. Arranged by Boston University School of Public Health with speaker Dr. Neal Halfon. VDH represented by 11 program directors and staff. Concepts applied to VDH realignment planning and also to be used in 2010 Strengths and Needs Assessment. Follow up session planned for Region 1 for the coming year. See TA request Form 15. //2009//**

In 2002, VDH and the Department of Education received an infrastructure and expanded school health coordination grant from CDC. At both the DOE and VDH there is a designated coordinator whose purpose is to work with community schools to move forward the CDC coordinated school health model forward -- by working with the statewide School Health Coalition working toward coordinated school health services, programs, and policies in schools under the broad definition of school health. Each participating school or school district is encouraged to create a School Health Action Committee, that plans individual school responses to the nine components of the School Health Model (such as enhancing clinical services, supporting healthy nutrition, promoting staff wellness, etc.) Goals of the program include increasing communication and collaboration between DOE and VDH on all levels, especially at the state planning level and within individual schools. In addition, the School Health Coordinating Council, comprised of DOE and VDH decision makers, and also representatives of the School Principals' Association, Vermont School Boards' Association, and the Vermont School Superintendents' Association, meets monthly to coordinate statewide health related activities and policies for school aged children. The 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. /2007/Activities from this grant continue to focus on coordination and consultancy projects with local school districts designed to assist in implementation of local school health plans.//2007// /2008/The VDH/DOE support for the coordinated school health planning continues with emphasis on creating a statewide school health plan under newly hired coordination staff at VDH.//2008// ***/2009/ VDH did not receive grant renewal for the Coordinated School Health Grant from CDC. Efforts are underway to maintain the gains made during the 7 years of the grant-funded programs utilizing existing resources. EPSDT school data system now allows for ready access to school nurse reporting on various elements from school nurse survey. For school year 2007-08, 80% of students report having some sort of health insurance, 55% report having a well child exam in the last year, and 62% report being seen by a dentist for a dental checkup. //2009//***

In 2000, the Vermont legislature passed Act 125, which directed the Departments of Health, Education, and Buildings with the implementation of interventions to create safe and healthy school buildings. An Act 125 Task Force was created, with representation from many organizations addressing asthma in particular. The work of the Task Force led to the development of the Envision Program at the Health Department. The Envision Program provides grant funding to schools to participate in a model school environmental health program that is based, in part, on EPA's Tools for Schools. Technical assistance provided includes information about implementing measures like safe cleaning practices, regularly scheduled heating and ventilation maintenance, and alternatives to pesticides to reduce asthma triggers. All of the schools participating in the Envision program are at different stages of incorporating the best practices to reduce exposure to environmental triggers /2008/To date, Envision has partnered with 146 Vermont schools, 43 receiving grant funding//2008//

The Office of Minority Health addresses the minority health and cultural competencies as a VDH priority -- See Section IVF for discussion

After the AHS reorganization, the CSHN director is now a participant in the interagency/consumer committee reviewing home care programs now clustered in the new Department of Disabilities, Aging, and Independent Living; these include Medicaid Personal Care Services, High-tech program, and the Medicaid Home and Community Based Services Waiver for Developmental Services (all of these programs are Medicaid-funded). The focus is on improving the PCS application process for children and maintaining supports in a year of severe budget cuts in Medicaid.

/2007/CSHN is also exploring assuming the responsibility for clinical determinations of Katie Beckett Option (TEFRA option; in VT also known as the "Disabled Children's Home Care Program"--DCHC) eligibility. CSHN is also represented on the VT Developmental Disabilities

Council; the DOE Regional Autism Centers Initiative; the Autism Task Force; the TBI board; the ICC for Part C.//2007//  
/2008/CSHN spearheaded an interdepartmental committee to reassign responsibilities for Katie Beckett (KB) determinations. The Disability Determination Unit within the Department for Children and Families, which already determines SSI eligibility and also the first step towards KB eligibility, began, in November 2006, to complete the institutional level of care determinations for KB as well. The CSHN program feels this change has been working very well. The Regional Autism Center discussion prompted a new legislative directive, S. 121, creating a statewide, inclusive study process, to result in a report and a plan-for-a-plan. CSHN also participates in the re-design process for the Hi-tech home care program for children (Medicaid-funded, within the Department of Aging and Independent Living). UVM's VCHIP program added a new focus on chronic disease in children; the CSHN medical director is the liaison to VCHIP for these projects. //2008// The CSHN medical director joins the VT Developmental Disabilities Council in June, 2008, replacing her membership on the ICC for Part C. The new process for Katie Beckett determinations works well, according both to CSHN staff and Parent to Parent. The Hi-tech redesign effort has been subsumed into the larger new redesign effort for children with disabilities (see above.) VCHIP has completed its first year of specific quality improvement consultation to children's diabetes, cystic fibrosis, and renal programs at FAHC.

Vermont Department of Health Planning Initiatives (See also III B Agency Capacity and III E State Agency Coordination)

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.

/2007/Examples of other ongoing major planning initiatives: Oral Health Plan, Obesity Strategic Plan, Injury Prevention, Prenatal Smoking Cessation, Domestic Violence Prevention (via AHS), Prenatal Smoking Cessation, Blueprint for Health, Suicide Prevention, Cancer Prevention, Asthma Prevention//2007// /2008/ These planning initiatives are continuing -- updates are included within the various sections of this grant application.//2008//

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

## **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 now located in the Department of Children and Families with collaboration with VDH. See III E.

Sudden Infant Death Syndrome (SIDS) and Sudden Unexplained Death in Infancy (SUDI) Goals:  
1) 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 services. /2007/Continued planning for parent education via health and community providers. Periodic trainings on SUDI and systems response given to recruits at state police academy. //2007// /2008/ Procedures and protocols for VDH public health nurses and other nurse home visitors have been updated and distributed to offices statewide. Safe sleep environment pamphlet for parents is being distributed to medical practices and child care providers.//2008// **/2009/ Medical Examiner's Office held two statewide trainings for health care professionals and first responders about sudden infant death events and best practice procedures for death scene investigation //2009//**

Addison County Parent Child Center - Prevention of Teen Pregnancy Program -- partially supported by Title V funds - provides outreach and prevention services to Addison County pregnant teens, young parents, and their families.

Family Planning Program provides 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 and private insurance 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. Special funding from the Office of Population Affairs is supporting an outreach/education program for men -- at [www.themanphone.org](http://www.themanphone.org). The Man Phone program supports a variety of strategies for educating men ages 18-22 such as: hiring of two male outreach workers, ongoing updates to website containing reproductive information for young men, information placed on date service websites, public media campaigns. In addition, a 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./2007/ Beginning collaboration with VDH on procedures for screening and counseling for PPNNE clients who are overweight or obese.//2007// /2008/The Manphone is being restyled into The Men's Health Garage website. PPNNE is revising their wellness visits to use a strengths-based approach -- collaboration with VDH to include AAP/Bright Futures recommendations for teens into family planning wellness visits. //2008//

The Sexually Transmitted Disease Program within the Division of Health Surveillance monitors prevalence of STI's and collaborates with state and community organizations such as Planned Parenthood, American Red Cross, Department of Education and many local groups (such as Vermont CARES) to direct efforts at prevention and treatment../2008/New initiative with Dept of Education and community partners to enhance youth HIV prevention education. PRAMS data on HIV being analyzed for use in planning//2008//

Pediatric Genetic Services are provided through a VDH contract with Children's Health Care Service at Fletcher Allen Health Care, which operates the Vt 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. The Geneticist provides extensive TA to the Birth Information Council and to the metabolic/NBS programs. Special "travel clinics" 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.) The pediatric geneticist continues to participate in the CSHN Metabolic Clinic and Newborn Screening Program and recently began participating in the CSHN Craniofacial program

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. Thus, of the 29 ACMG recommended conditions, Vermont screens for 28 in all birth hospitals. The fee has increased from \$27.50 to \$33.30. Vermont uses the New England Newborn Screening Laboratory at University of Massachusetts for processing specimens. See NPM 1. /2007/ Organizationally, NBS is a program within CSHN and includes both "heelstick" and hearing screening components. The NBS Advisory Committee recently recommended adding cystic fibrosis to the screening panel. We are developing a new fee structure to support both heelstick and hearing lab and follow-up components, to be proposed to the legislatures' rule-making committee.//2007// /2008/ Continue efforts to add CF to the panel and update the fee structure - See NPM 1//2008// **/2009/ Screening for CF began in March, 2008 //2009//**

Vt Regional Perinatal Program at UVM (partially funded by Title V) provides professional education, transport conferences, and statistical analysis for individual hospitals and providers who treat medically high-risk pregnant women and neonates. Close collaboration with many statewide initiatives, such as the Birth Information Council, and QI efforts with birth hospitals **/2009/ Program is now within Vt Child Health Improvement Program, new title of Vt Regional Perinatal Health Project. Allows closer coordination with VDH and the QI initiatives of VCHIP //2009//**

The 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. Via contracts with local vendors, WIC provides home delivery of selected foods tailored to individual and risk factors. Group nutrition education is offered at least twice during the client's certification period. Individuals with specific nutrition-related concerns receive additional personalized counseling from public health nutritionists. Programs such as the EPSDT Program, Immunizations, Healthy Babies, Kids and Families, and the Childhood Lead Poisoning Prevention Program are integrated or coordinated with WIC. VDH uses a joint WIC/Medicaid application form that automatically assesses and identifies Medicaid eligible clients to expedite Medicaid enrollment.

/2007/Farm to Family Program continues. 2 districts participate in medical home pilot via FNS grant in which WIC nutritionists are out-stationed in pediatric practices to provide nutrition education to families, WIC enrollment of eligible clients, and foster collaborative relationship with the provider and office staff. Work with UVM College of Medicine to incorporate information about the science of breastfeeding into the medical school curriculum. Vt has one "breastfeeding friendly" hospital, another birth hospital is considering this designation - WIC program staff are providing TA. Beginning program to increase the consumption of fruits and vegetables in WIC toddlers by enhancing nutritional counseling via group and phone counseling sessions.//2007// /2008/Value Enhanced Nutrition Assessment (VENA) planning to enhance the quality and efficiency of the WIC clinic visit. Staff training in motivational interviewing and participant-centered service are key concepts. WIC is beginning a pilot to place nutritionists in OB practices such as in pediatric practices as described above. //2008// **/2009/ WIC food package revisions to align with updated dietary guidelines - adding fresh fruits, vegetables, whole grains, alternative calcium options (soy milk, tofu.) UVM dietetic interns rotate through public health and WIC at district and central office level. Breastfeeding peer counseling program in 2 districts continues to improve initiation and duration of breastfeeding. Breastfeeding activities at NPM 11. WIC staff at certain OB providers offices to enroll and provide nutrition ed //2009//** Office of Women's Health: See Sec IIIA.

Preventive and Primary Care Services for Children:

Division of Mental Health: The Child, Adolescent and Family Unit (CAFU) oversees aspects of the mental health system which serves child and their families. There are 10 community based designated agencies (DA) and 1 specialized agency (SA) DMH is responsible for the oversight in these agencies to meet the standard of care for the state of Vermont. CAFU oversees and

monitors the children's home and community based mental health waiver for children identified as having a serious emotional disturbance and are at risk of hospitalization -- children can receive intensive services designed to keep them in home/community and out of psychiatric inpatient. DMH oversees the psychiatric hospitalization of Medicaid children, is part of the Case Review Committee responsible for the oversight of any Medicaid child going to a residential treatment facility and works with mental health agencies to assure community plans address all the mental health needs of the child and family. Contracts with psychiatrists offer psychiatric consultation to pediatricians' offices in order to address the shortage of psychiatrists. CAFU is working with CPH and VCHIP to develop a depression screening tool to be used for youth when seen for well child checks in primary care settings. CAFU works closely with Dept. of Education, Developmental Services, Family Services and Field Services to assure children are getting coordinated plans to address all their treatment needs./2008/In 2005, the DMH was incorporated structurally into the Department of Health. In 2007 new legislation re-created a separate Department of Mental Health with retaining several infrastructure elements to foster continued coordination on issues of physical, mental health and substance abuse and creation of an integrated service model for children and families - recognized by CDC as national model//2008// **/2009/ See SPM 9 //2009//**

**Office of Alcohol and Drug Abuse Programs: See SPM # 3 /2009/ Major initiatives to increase child treatment capacity and quality. Collaboration with VCHIP to increase youth who are screened via strengths based approach and referred for substance abuse and co-occurring problems by PCP Collaborate with DCF and Student Assistance Program. Establishing 12 Centers for Excellence for Adolescent Treatment. //2009//**

Immunization Program: See NPM 7, SNA. Vaccine Purchase and Distribution Program purchases vaccines, conducts assessment of immunization coverage, conducts surveillance of vaccine preventable disease, assists in outbreak control, provides education and TA for clinical providers and the public, and develops policies and plans that support immunization strategies and evaluate effectiveness and QA activities. The vaccines purchased by this program are provided without charge to physicians who participate in the Vaccines for Children program. Vt has a system of universal vaccine accessibility for children. 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. The VFC Program has 532 providers enrolled at 177 sites statewide. The Assessment, Feedback, Incentives and Exchange (AFIX) Program has evaluated immunization coverage rates for 19-35 month olds in 103 private provider sites in partnership with the Vermont Child Health Improvement Program (VCHIP) to identify barriers to full immunization of children in their practices with the goal of reduction or elimination of barriers. /2007/In 2005, all VFC sites were visited for QA to assure proper storage, handling, documentation and allocation of vaccines. VDH now fully implements the AFIX program. Planning for systems to make available new vaccines such as HPV, Menactra, and Rotovirus. Developed system of case management for infants of mothers who are Hepatitis B positive -- notifications to birth hospital and physicians about mother's status and infants need for vaccination.//2007// /2008/Catamount Health Care legislation requires all Vermonters have access to immunizations: Steering Committee established to implement via 1) Staged plan for implementation 2) Establish universal vaccine procurement and management system 3) Medical home a primary method of service delivery 4) Public health as safety net provider. Cervical cancer planning workgroup formed via legislative statue. HPV available to VFC eligible girls 9-18 years. Continue efforts to make HPV available to all eligible women. Proposed regulatory changes for immunization school entry requirements, to be finalized this coming year//2008// **/2009/ New system of pooled state and federal funding allows HPV available for 11-18 year olds by usual VFC system. As of 7/1/08, state funding allows Vt resident females aged 19-26 to receive HPV at no cost. Rules changes require Pertussis for Kindergarten entry, Tdap booster for seventh grade, meningitis for residential facilities (including colleges.) Encouraging Tdap for parents of infants so as to increase pool of immune adults who interact with infant s and children - Brattleboro Memorial Hospital providing Tdap for fathers of newborns. Varicella required**

**for school entry unless parental statement that child had the disease. VFC system being adapted for distribution to all ages per Catamount legislation -- beginning of system for universal vaccine access for Vermonters. System of ordering and distribution to provider sites to be organized out of VDH Immunization Central Office -- vaccines no longer to be distributed from VDH district offices. Begun web-based immunization reporting system for school nurses tapping into Medicaid Administrative electronic claim systems already used by school nurses. HPV recommended and is available at no cost via VDH vx programs to women ages 11-26 via federal and state funding //2009//**

Childhood Immunization Registry records immunizations and tracks eligibility for the VFC. Birth data is entered automatically within ten days via the Vital Births data system. Goals are higher immunization levels, generate immunization records and corresponding documents for child care operators and school personnel, and provide easier assessment of current immunization status by health care providers. Intent is to decrease missed opportunities to bring children up to date with their immunizations. All of the core data elements recommended by the National Immunization Program and approved by the National Vaccine Advisory Committee will be recorded electronically. /2008/41,702 children entered. 58% of children under age 7 and 31% under age 18 have records in the registry//2008// **/2009/ 83,979 children entered. 73% of children under age 7 and 63% under age 18 have records in the registry. 74% of practices participating //2009//**

Childhood Lead Poisoning Prevention Program (CLPPP) - IVB State Priorities, SPM#10.

Early Periodic Screening, Diagnosis and Treatment (EPSDT) coordinates closely under an interagency agreement with the Department of Children and Families and 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. A key EPSDT initiative that focuses on vulnerable children is the Fostering Healthy Families project. This project involves co-locating a public health nurse (either full or part-time, depending on local needs and capacity) in the child welfare office at the local level. The nurse works with child welfare staff to complete a Health Intake Questionnaire on each child or adolescent who enters state custody. This document informs a health plan for the child and is the basis for assuring that the child is seen for health supervision visits either by their ongoing primary care provider or by a new medical home. Program staff at VDH and the Family Services Division of the Department of Children and Families have enlisted the expertise of VCHIP (University of Vermont's Child Health Improvement Project) to implement the use of this standardized Health Intake Questionnaire in four pilot districts in Vermont. The overall goal is to implement statewide so that every child entering custody will have a child welfare case file with important health information as well as a medical and dental home. Children in need of behavioral health care will also receive needed assessment and services. VDH nurses may be actively involved in finding medical or dental homes for this population and may also work with the medical home to update immunization records and collect other information necessary for ongoing quality primary health care. /2007/ In 2005, the state expanded the Health Intake Questionnaire (HIQ) to all 12 VDH offices. Currently, VDH is working with VCHIP and DCF to establish a web-based HIQ.//2007// /2008/ Web-based periodicity toolkit developed and on-line- See IIIA//2008// **/2009/ In early summer 2008, DCF went live with a web-based HIQ being piloted in 3 district offices. Anticipate the remaining 9 offices will go live within the next year //2009//**

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, providing training curriculum for teachers, activities related to reducing obesity as funded by CDC and planning around Fit and Healthy Vermonters, the state obesity prevention plan.

/2008/Nutrition Chief appointed in 2006. Primary responsibilities include oversight of Fit and Healthy Vermonters Obesity Prevention Plan (funded via CDC.) Also facilitate and coordination of nutrition services across the Department, serving on the Governor's Hunger Task Forces, working with community coalitions to promote nutrition and physical activity interventions, and identifying policies and best practices for environmental changes to support health behaviors//2008// **/2009/ CDC Fit and Healthy Vermonters CDC grant was not refunded. Re-prioritized activities continuing using a variety of other funding sources and collaboration with programs such as Blueprint //2009//**

Office of Oral Health provides dental consultation to the Medicaid/Dr. Dynasaur program by determining prior authorizations on several dental procedures, including orthodontics. There are several early childhood caries prevention efforts among family practitioners, pediatricians, primary care providers, dentists, dental hygienists, and VDH. The School-based Fluoride Mouthrinse Program has been in existence for 30 years, providing free weekly fluoride mouth rinse to children in schools that do not have community water fluoridation. Over 90% of eligible Vermont schools participate. Tooth tutor, which began in 1999, reaches out to low income children via Early Head Start, Head Start and elementary schools to facilitate enrollment in a dental home. An extensive state oral health plan was created in 2004-2005. The "Oral Health Plan resulted in a legislatively approved program called the "Dental Dozen" -- 12 targeted initiatives to improve access, quality of oral health services, assure adequate dental workforce for Vermont's future and increase Medicaid fees for dentists participation in the Medicaid program. **/2009/ See Section III F HSCI 7/NPM 9/SMP 8 //2009//**

Emergency Medical Services - Children (EMS-C) VDH Office of Emergency Medical Services grant 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 3) Develop a prehospital data collection plan for the Vermont Emergency Medical Service System.

VDH Injury Prevention Program: See Section IIIA.

System of Care for Children with Special Health Care Needs:

PYRAMID LEVEL: DIRECT SERVICES:

Please see Strengths and Needs Assessment section on direct and enabling services for CSHCN; the SNA describes CSHN efforts for primary care services and the communication between primary and tertiary care.

CSHN continues to manage and subsidize a statewide network of multidisciplinary services for Vermont children with many chronic conditions. Clinics/Programs which are directly staffed and managed by CSHN include: Orthopedics (including also Hand and Myelomeningocele); Child Development Clinic, Metabolic, Craniofacial, and Feeding Clinics, and the Seating, Nutrition, and Hearing (Hearing Outreach Program and Hearing Aid Purchase) Programs. Clinics/Programs which are supported through grants and contracts, and which CSHN staff (nursing and/or social work) attend are: Cystic Fibrosis, Juvenile Rheumatoid Arthritis, and Neurology/Epilepsy. Clinics/Programs which we support through grant and contracts and with which we collaborate but do not attend staff directly include Dartmouth Child Development Program (CSHN and Dartmouth co-fund the clinic coordinator), Hemophilia, FAHC NICU medical follow-up (providing the developmental screening component) and the Community clinic of Vermont's LEND program (Interdisciplinary Leadership Education for Health Professionals--ILEHP). In the last year CSHN has become a direct provider of "Therapy Clinic" services under Medicaid, through which community based PT, OT and SLP are enrolled as credentialed providers, contractor-employees of CSHN, which, in turn, is able to bill Medicaid. The "Clinic" is not a site, per se, but delivers therapy services directly to children in their homes and communities. CSHN continues its intensive review of the Child Development Clinic, redefining its proper niche as a provider. Between October 2004 and October 2005, three key staff members will have been retired, and

another has announced his intention to retire in 2007. Recruitments are active. /2007/We have hired a nurse practitioner, and have contracted with a developmental pediatrician on an interim basis.//2007/ /2008/ After the retirement of another developmental pediatrician, the Child Development Clinic physician staff include: A half-time (state employee) pediatrician, two half-time contractor developmental pediatricians, a part-time child psychiatrist, and the CSHN medical director has just begun to see CDC patients half-time as well. We are expanding our contracts with Dartmouth, and continuing our contracts with UVM for this purpose. The St. Albans CDC site has been active for about a year, with the lowest no-show rate in the state and much positive feedback from providers and families. The state continues to lack a pediatric neurosurgeon; UVM is actively recruiting. A pediatric urologist just arrived in April 2007. We have added a pediatric physiatrist (physical medicine and rehab), contractor, part-time, as a part of our orthopedic program.//2008// **/2009/ A full-time pediatric neurosurgeon began her practice at FAHC/UVM in Spring, 2008. Her responsibilities include participation in the CSHN Myelomeningocele program. Our Child Development Clinic developmental pediatrician time has stabilized (FTE=about 2.0). However, planned reductions in the number of state government positions have affected all areas, including direct services in CSHN and elsewhere. CSHN has not been able to fill most of the year's nursing and social work retirements/resignations at this time (3 FTE MSWs; 2 FTE RNs). These positions serve both on direct clinic teams and in regional family support/coordination functions //2009//**

#### PYRAMID LEVEL: ENABLING SERVICES

CSHN Financial Assistance Program: CSHN continues to provide after-insurance funding of medical services when these services have been pre-authorized by CSHN clinical staff and when they fall within the range of services permitted by CSHN guidelines. Changes (largely reductions) in Medicaid accessibility (increased premiums; tighter interpretations of medical necessity) have resulted unavoidably in some costs shifts to CSHN, but more importantly, loss of coverage of other services for CSHCN, such as primary care. CSHN staff work diligently to help families apply for and maintain their children's Medicaid coverage. **/2009/ All three of the independent PT/OT/ST agencies providing services to children have experienced major setbacks this year. One is closing June 30, 2008; one is no longer willing to bill Medicaid, which will result in a cost shift to CSHN for services CSHN prescribes; and one has decided not to enter any agreements to bill insurance (and has never accepted Medicaid). Other regional therapist shortages have also complicated service coordination and access for families with CYSHCN //2009//**

Special Services Program: CSHN continues to provide medical care coordination, through regional social work and/or nursing, and financial access to specialized services, for VT children who have a condition that CSHN covers but for which no established clinic exists. CSHN pediatric nurses and medical social workers are based in regional offices and are involved in care coordination. Families are referred to CSHN from hospitals, Medicaid high-tech program, and others; CSHN MSW's are also members of the regional Part C Core teams (direct service teams); this role has continued, even though the Part C program has been transferred to the new Department for Children and Families in the AHS reorganization. **/2009/ State position cutbacks (see above) have strained our capacity to cover all FITP regions. //2009//**

See SNA concerning CSHN care coordination. /2008/CSHN maintains its collaborative role also in FITP core teams.//2008//

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. In 2004, a modest increase in the Respite Line item allowed expansion of supports. **/2009/ The allocation for CSHN respite services has been decreased in SFY2009 to \$250,000, from**

**\$350,000.**

**Allocation amounts to each family are being reduced proportionately, in order to allow respite to be provided to as many families as possible, rather than restricting respite enrollments //2009//**

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. **//2009/ Parent to Parent (P2P) and VT Parent Information Center (VPIC) are merging 7/1/08 to form the Vermont Family Network (VFN). Both agencies receive infrastructure support from CSHN and provide CSHN parents with support and information about health care (P2P) and education, including health related services (VPIC); both also provide CSHN with valuable data gleaned from parents for needs assessment. As the merger matures, with greater efficiencies and expansions into areas of unmet needs, our CSHN support reflect the changes. P2P and VPIC leadership both provide input and editing to our annual Title V document. //2009//**

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. **//2007/CSHN has expanded its role in providing clinical assessments and updates for PCS eligibility.//2007//. //2008/CSHN CSHN staff have greatly increased their role in helping parents apply for Medicaid Personal Care Services. Each annual application (and renewal) takes about 90 minutes. In 2005, CSHN completed 110 applications (when renewals were every 6 months; in 2006, 130 (annual); and, in the first 6 months of 2007, 101 already. These require extended interviews with parents/caregivers, and observation of the child. On average, families are approved for about 20 hours per week of attendant care.//2008// //2009/ We are forced to reevaluate our time commitment to PCS applications and renewals, given the loss of staff. We are working with**

**the PCS program director to identify other sources of this activity. //2009//**

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. **//2009/ In a small state with few nutritionists, it is often a struggle to maintain staff continuity in each of the 12 AHS regions. The CSHN nutrition consultant fills in, as she is able, while recruiting local dieticians to join the network. In addition, as the VDH reorganization settles, we will explore how we might contract/collaborate with regional WIC nutritionists, and look at the possibility of raising educational/experience requirements for future WIC staff so that they may be prepared for CSHN care**

**//2009//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. P2P highlights: 62% of families served have Medicaid and 300 hours of staff time in July 06 -- Dec 06 were devoted to Medicaid information and assistance, another 150 hours were devoted to Medicaid outreach. 122 hours went to assistance with personal care and nursing issues, 1,124 hours to individual support and 724 our for referrals to resources. These efforts were significantly underwritten by funding from CSHN. The respite care program described above is also one of CSHN's Family Support Services.**

**//2007/The annual PCP conference was not held in 2005.//2007// //2008/ VDH/CSHN continues its support of Parent to Parent of Vermont and the VT Parent Information Center. The two**

organizations have just agreed to merge, effective in 2008. The annual Partners in Care conference will be held in December, 2007, after a two-year hiatus. //2008// **/2009/ See updates in NPMs below //2009//**

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 was transferred to the new AHS Department of Children and Families for continued administration and for delivery of services 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. 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. /2008/CSHN maintains its collaborative role also in FITP core teams.//2008// **/2009/ State position cutbacks have strained our capacity to cover all FITP regions. //2009//**

#### PYRAMID LEVEL: POPULATION-BASED SERVICES

See also the Strengths and Needs Assessment.

Newborn Screening Follow-up: See discussion in NPM 1. Vermont has strong newborn screening programs, assuring that over 90 percent of all newborns are screened in a timely way and receive timely followup. Vermont recently expanded the number of congenital conditions for which babies are screened, from 7 to 21 conditions. Since July 2003, all VT birth hospitals have screened all newborns for congenital hearing loss. CSHN is responsible for the assurance and follow-up, overseen by a full time pediatric audiologist (through a grant to UVM; not a state position as yet), and largely implemented through the direct service of the Hearing Outreach Program, also by pediatric audiologists. As with many states, we are charged with sustaining these population-based efforts through fees, rather than grants. We utilize third party billing for HOP, and are examining asking the legislature to increase the newborn screening fee to cover the remainder. The VT legislature has passed the Birth Information Network statute, and the CDC has funded its initial development and implementation, with the goal of earliest possible identification of certain congenital conditions and the assurance that identified babies have access to needed early intervention and health services. CSHN also participates in population-based screening (by referral) through HOP for older children up to age three, or those of any age who are difficult to screen by other methods.

/2007/The CDC has funded a new cooperative agreement with CSHN/VDH to integrate the screening and tracking information currently housed in MS Access databases into the emerging VDH "SPHINX" information system. We are working actively with a requirements manager in this phase of the project. NBS/UNHS will join ERBS and the immunization registry in a child health status integrated database, with web-based inputs and outputs. We are very appreciative of the support from CDC staff, and from the RI Kidsnet and RITRACK programs.//2007//

/2008/Significant progress has been made in the development of the CDC funded integrated database supporting newborn hearing and metabolic screening assurance. CSHN is awaiting final approval, via legislative rule making and public approval process, on an increase in the screening fee charged to birth hospitals, to support the public health assurance and follow up functions for both screening processes. Also, CF, upon approval, will be added to the panel October, 2007//2008//**/2009/ Statewide CF screening, implemented on March 1, 2008,**

#### **Preparation**

**included protocol development with three tertiary care centers who will provide follow-up sweat testing and counseling for positive screens, outreach education to PCPs, and cross-state-border discussions. //2009//**

#### PYRAMID LEVEL: INFRASTRUCTURE-SYSTEM BUILDING ACTIVITIES

See Strengths and Needs Assessment.

"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, Vt 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. 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. Via 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.

/2007/Medicaid resumed the direct responsibility for PA for therapies last year. We are working closely with Medicaid to bring our respective medical necessity policies and practices into congruity. At the same time, we continue to collaborate well in the planning and authorization of services for individual children, a benefit of being a small, family-centered state.//2007// /2008/ Productive discussions and advocacy with Medicaid have resulted in (1)a less-frequent renewal necessary for children with chronic therapy needs; (2)independent Medicaid medical necessity determinations for children whose primary private insurance has denied coverage for an essential service and all appeals have been exhausted; (3)advocacy for coverage of previously uncovered items and services. //2008///2009/ **We continue to note the impact of CSHN families' need to pay monthly premiums prospectively as a source of dis-enrollment from Medicaid. As described elsewhere, CSHN reviews all 4-5,000 enrolled children's medicaid status monthly, notes whose medicaid coverage has lapsed or is about to lapse, notifies the families' CSHN clinical contact person, and attempts to support families with maintaining continuity. We have received staff training/information on the complex options available to young adults to transition to adult forms of health insurance (VHAP, Catamount, COBRA, etc.).** //2009//

Community Capacity/Statewide Building: /2007/A tenth site for our Child Development Clinic was opened, Fall 2005, in St. Albans, in response to the family-inclusive, community based planning initiated by the community itself through the Joshua Project.//2007/ /2008/ VDH/CSHN continues its support of Parent to Parent of Vermont and the VT Parent Information Center. The two organizations have just agreed to merge, effective in 2008. The annual Partners in Care conference will be held in December, 2007, after a two-year hiatus. //2008//2009/ / **2009/CDC continues in 10 statewide sites; a new Vt site at Dartmouth begins 7/08.** //2009// **An attachment is included in this section.**

## **C. Organizational Structure**

Section III C Organizational Structure Vt TV FFY09  
Entry for July 08

The Agency of Human Services is the largest of the agencies of state government, and is headed by the Secretary of Human Services, who reports to Vermont's governor. The Vermont Department of Health (VDH), within the Agency of Human Services (AHS), administers the Maternal and Child Health (MCH) Block Grant, also known as Title V. Most Title V related activities occur through two divisions of the Vermont Department of Health: the 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. CSHN contains the programs of Newborn Metabolic Screening and also

Newborn Hearing Screening. 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. Emergency Medical Services for Children is sited in the Division of Health Protection. The STD/AIDS program is in Health Surveillance. The Division of Community Public Health has oversight of the WIC Program, Healthy Babies, Kids, and Families, EPSDT, and the twelve VDH district offices. As a result of the 2005 state government reorganization, the oversight of Healthy Babies Kids and Families is shared with the Department of Children and Families (also under the Agency of Human Services.) The Department of Children and Families also manages the Family, Infant, Toddler Program (FITP) and Childrens UPstream Services (CUPS). Another result of the reorganization is that the former Department of Mental Health is now a part of the Department of Health. Thus the Commissioner of Health oversees three deputy commissioners: 1) Public Health, 2) Mental Health Services, 3) Substance Abuse Services. See attached organizational charts. /2008/In the Spring, 2007 session, the Vermont State Legislature voted to re-create a Department of Mental Health with a separate commissioner. The two Departments of Health and Mental Health will remain collocated within the same office building in Burlington and the significant collaborative efforts that have begun over the past few years will be continued. Also, as of December, 2006, the VDH embarked on a major process to realign traditional offices and divisions to create a more efficient and effective organizational structure. Acting Commissioner Moffatt invited and challenged all VDH employees to become involved and to contribute to this major endeavor. This effort is in response to the recent reorganization to the overall Agency of Human Services and also is intended to further the VDH mission of delivering quality public health services to the people of Vermont. During the past six months, workgroups of staff and administrators have met regularly to create new concepts of organizational structure that would best enhance communication across programs and offices. Issues reflecting the complex nature of public health have been tackled, such as the need to communicate and coordinate across many different grant-funded programs and public health issues, such as MCH, chronic disease, mental health, etc. At present, the workgroups' recommendations are being considered for the creation of a new VDH structure to complete the realignment planning. Implementation of these recommendations for the full VDH realignment will happen over the coming year. It is anticipated that the MCH Planner (responsible for Title V coordination) and the CSHN will be brought together under a new MCH division, headed by the MCH Director. The previous offices and programs of the Division of Community Public Health will be reorganized into an Office of Local Health (with oversight of the twelve district offices) and the new MCH Division (including WIC, EPSDT, and School Health.) The overall purpose and end result will be that the various staff and programs involved with MCH services and planning will be sited within one single Division of Maternal and Child Health. This likely consolidation of MCH programs offers the opportunity to engage in a thorough MCH strategic planning process which will be combined with the upcoming Title V 2010 Strengths and Needs Assessment. . The existing MCH Realignment workgroup will combine with other key groups such as the Title V/MCH Advisory Committee and the MCH data Committee. Request for financial support for the strategic planning is included in the TA section of this grant application. //2008// ***/2009/ In July, 2007, the MCH Division was created, combining the entire CSHN unit along with MCH planning, EPSDT Liaison, and WIC, under the division direction of Wendy Davis, MD. A newly awarded CSHCN State Implementation Grant will address strategic planning for the CSHN unit within the larger context of MCH and other childhood initiatives at the state AHS level //2009//***

Department of Health, the Department for Children and Families, the Department of Disabilities, Aging and Independent Living, the Department of Corrections, and the Office of Vermont Health Access: AHS has 12 field offices that coordinate closely with the VDH's twelve District Offices. In addition, there are 12 AHS Field Service Directors that oversee services in each AHS district and coordinate among the state's departmental offices in order to streamline services and support human services related initiatives. The VDH District Offices 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 VDH, 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 and Mental Health Services. All VDH Division Directors meet at least monthly to coordinate VDH activities. In addition, a close relationship exists between operations and program planning and the data and research office of the VDH. Just a few examples of this collaboration are the CSHN Measuring and Monitoring Project, the evaluation of the Healthy Babies Program, SSDI-funded activities, Childhood Injury Prevention, and the preparation of the 2005 Strengths and Needs Assessment. /2008/The VDH realignment, it is expected that the 12 district offices will be incorporated into an Office of Local Health that will answer directly to the Commissioner's Office. Previous EPSDT efforts will continue with reorganized governmental units such within the 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) continually updates the standards for preventive care titled "Health Screening Recommendations for Children and Adolescents" and the 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. //2008//

The Vermont State Team for Children, Families, and Individuals: A unique collaborative relationship exists through the AHS VT State Team for Children, Families, and Individuals. The State Team is a multidisciplinary, statewide collaborative effort comprised of representatives from the various state agencies such as 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." Each of the AHS 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. AHS and the State Team 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. 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. Recently, the Outcomes Planning by the state Team has been incorporated into the ECCS-funded planning and also the Title V Strengths and needs Assessment. /2008/State Team outcome measures have been used along with other measurement systems to advise planning for quality improvement measurement under the newly established Global Commitments.//2008// **/2009/ The MCH director has taken a much more active role in the State Team, with presentations on the new MCH structure and vision, and on collaborative MCH/AHS initiatives, most recently the "roll out" of Bright Futures and the recruitment of primary care providers as participants in their region's Building Bright**

### ***Futures planning process //2009//***

The Children's UPstream Services (CUPS) grant began in 1997 as a grant from the Federal Center for Mental Health Services to support and preserve families with young children who are at risk for experiencing severe emotional disturbance (SED) through ensuring access to behavioral and other community-based services. CUPS works to strengthen interagency coordination and expand key services for behavioral health of young children and their families. 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. /2007/ CUPS is part of the Integrated Services planning under DCF (with Healthy Babies, Kids and Families and Part C) to coordinate and streamline direct services to families.//2007// /2008/Before CUPS, in FY1996, 997 or 13% of the 7,421 children served through Children's Mental Health programs in Vermont were aged 0-6 years; ten years later, in FFY06, 1,557 or 16% of the 9,812 children served were aged 0-6 -- an increase of 56%. See SPM 9.//2008// /2009/ See **SPM9 //2009//**

***/2009/ The realignment as described above is now operational and reflected in the attached organization charts. The MCH Division is collaborating closely with key partners such as the Office of Local Health, Alcohol and Drug Abuse Programs, Health Surveillance, and Health Promotion and Disease Prevention. In addition a close working relationship exists with the Department of Mental Health. In June, 2008, Commissioner Sharon Moffat resigned and Dr. Wendy Davis, Director of the Division of MCH was appointed interim Commissioner of Health for Vermont. See also Section IV B State Priorities and Section III D. Strategic planning meetings have been held within the leadership and medical staff of Child Development Clinic to determine best practices for organizational structure and delivery of services. Input from these planning sessions was used to assist in crafting the strategies as included in the recently granted MCHB Systems Integration Grant for CSHN. See also Section III E //2009//***

***/2009/ SNA Process for CYSHCN: Strong partnership with two parent-run parent service organizations, to which we provide infrastructure support, Parent to Parent of VT (P2P) and VT Parent Information Center (VPIC); these are merging to form the Vermont Family Network (VFN) in July, 2008. VFN reaches a much broader population than the direct service programs of CSHN, and has been enabled, through the Title V support, to create a data system to track and categorize expressed needs and concerns, as well as insurance demographics, of families who contact the organization. VFN is funded as a family to family organization and undertakes surveys and projects which also gather information about needs. UVM Vermont Child Health Improvement Program (VCHIP), which began with a focus on quality improvements in primary care utilizing PDSA processes, has expanded its focus to quality improvements in the care of children with chronic diseases. In so doing, VCHIP first helps categorical clinics (such as endocrine clinic) to identify needed areas for improvement. Themes across participating clinics so far include the need for better patient management data systems and the need for more accessible information for families, through websites. MCH has forged a strong partnership with the VT chapters of the AAP and AAFP. Monthly meetings, as well as task forces, help to identify health care and systems issues affecting CYSHCN--importantly, including children who have mental health conditions. VCHIP plays a role in hosting these efforts and providing guidance in the improvement strategies resulting from identification of problem areas. Vermont has just received a three year CYSHCN State Implementation Grant whose goals include significant redesign of services to align with identified needs. The SI grant activities will focus on outcomes in Medical Home, Health Care Financing, and Integrated Community Services, and will include family partnerships throughout. In addition, the SIG will develop system complementary to other systems building initiatives at VDH, such as***

***Oral Health and the Blueprint for Health (concentrating on chronic disease in adults)  
//2009//***

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

**D. Other MCH Capacity**

Commissioner of Health

Sharon Moffatt RN, BSN, MSN, was appointed Acting Commissioner of Health in 2006, having previously served as the Deputy Commissioner of Health since 2002. Ms. Moffatt has a baccalaureate and masters degree in nursing from the University of Vermont. In 1995, Ms. Moffatt held the position of Vermont's State Director of Public Health Nursing and Assistant Director of the Division of Community Public Health. She has worked as a public health nurse for over twenty-five years in clinics, homes, schools and numerous other community settings. Since 1997, she has been an Adjunct Assistant Professor at the University of Vermont, School of Nursing. Her areas of accomplishment include curriculum development for baccalaureate and masters preparation in nursing, developing the role of the state public health nurses in emerging issues such as environmental health and emergency preparedness, refugee health, and in children's mental health, and has worked with the American Academy of Pediatrics, Vermont Chapter to create a model of care coordination for at risk families in the pediatric care provider setting. Ms. Moffatt is the Past President of the Association of State and Territorial Directors of Nursing, an affiliate of the Association of State and Territorial Health Officers ***//2009/ Ms. Moffatt is leaving the position of Acting Commissioner of Health as of June 30, 2008. A search for her replacement is under way at this writing. Dr. Wendy Davis is Interim Commissioner of Health //2009//***

Director of the Division of Maternal Child Health

Dr. Wendy Davis graduated from the University of Virginia College of Medicine, completed her pediatric residency at Case Western Reserve University and general pediatrics fellowship at Yale University. As of January, 2007, Dr. Davis began serving as Director of Maternal and Child Health at the Vermont Department of Health, where she enjoys working on initiatives related to child health promotion and disease prevention. She also has an active pediatric clinical practice in Burlington, VT.

Dr. Davis is a Professor of Pediatrics at the University of Vermont College of Medicine and serves as a senior advisor to the Vermont Child Health Improvement Program, an organization dedicated to improving the health of children in Vermont and nationally. She has served as president of the medical staff and as a member of the Board of Trustees at Fletcher Allen Health Care. Dr. Davis is past president of the Vermont Chapter of the American Academy of Pediatrics. Key accomplishments during her presidency included helping to formalize a partnership with the Vermont Department of Health and providing consultation in a number of areas related to improving pediatric preventive health service delivery. In 2002, she received the Chapter's Green Mountain Pediatrician Award. She is a member of the team that is developing a toolkit to accompany the 3rd edition of Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. ***//2009/ As of this writing, Dr. Davis is assuming the role of Commissioner of Health on an interim basis and continues in the role as Director of the Division of MCH //2009//***

Medical Director of Children with Special Health Needs Programs

Dr. Carol Hassler graduated from Radcliffe College in 1972 and earned a MD from the University of Pennsylvania in 1976. Her residency in Pediatrics took place (in 1976-1978) at the University of Virginia, and Dr. Hassler held a fellowship in Child Psychiatry at the University of Virginia (1978-1980), where she also served as Chief Resident from 1979 to 1980. She has served as the Director of the Division of Children with Special Health Needs at the Vermont Department of Health from 1990-1995, 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. Attending Physician at the Fletcher Allen Health Care Hospital ***/2009/ In the reorganization of the Division of MCH, Dr. Hassler is now the medical director of the CSHN unit and the director of the Child Development Clinic. In addition, she has become board certified in Neurodevelopmental Disabilities through the American Board of Pediatrics //2009//***

#### Director of Operations for Maternal and Child Health

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

#### Director of the Office of Dental Health

Dr. Steven Arthur graduated from West Virginia University School of Dentistry in 1968, entered the US Navy as a Navy dentist and was stationed in Iceland from 1968-70, then Memphis, TN, from 1970-71. He conducted a private practice of dentistry in Castleton and Fair Haven, Vermont from 1971-79. Dr. Arthur reentered the Navy in November 1979, being stationed in Cherry Point, NC. From 1981-84, he was on the USS Midway aircraft carrier in Yokuska, Japan. In 1984, he entered the Masters of Public Health program in Bethesda, MD, followed by a one year Dental Public Health residency at the National Institutes of Dental Research, National Institutes of Health, Bethesda, MD. In 1988, he became Board certified in Dental Public Health. From 1989-93, he was the Chairman of the Research Department at the Naval Dental Postgraduate School, Bethesda, MD. From 1993-96, he was Executive Officer of the Naval Dental Center, Pensacola, FL. From 1996-2000, Dr. Arthur was stationed in the Washington, DC area and retired from the Navy on January 1, 2000. Dr. Arthur came out of retirement to take the position of Director of Dental Health in May, 2005.

#### Nutrition and Physical Activity Chief

Susan Coburn MPH, RD was appointed the Nutrition and Physical Activity Chief for the Vermont Department of Health in 2006. She is a registered dietitian and has a Masters of Public Health in Leadership from the University of North Carolina at Chapel Hill. She came to the Department of Health in 2002 where she started in the Ladies First program to design and implement the nutrition and physical activity program to reduce cardiovascular disease among limited income women over 40. Prior to working at VDH she was employed by the Vermont Campaign to End Childhood Hunger where she coordinated Cooking for Life, a statewide cooking and nutrition program for limited income parents. She currently oversees the Fit and Healthy Vermonters initiative part of the obesity prevention grant from the Centers for Disease Control.

#### MCH Planning Specialist

Sally Kerschner holds a Masters of Science in Nursing from the University of Vermont and is a Registered Nurse. She has over 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, several of the CSHN clinical staff are parents of children with special health needs. CSHN support of P2P is best described as infrastructure support rather than direct hiring of staff. P2P has many family support and system-informing functions which are provided best by families themselves, and we benefit (as families and systems) from being able to undergird their efforts ***/2009/ P2P merges with the Vermont Parent Information Center, to form the Vermont Family Network, in July, 2008. Infrastructure support will continue //2009//***

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

## **E. State Agency Coordination**

The Vermont Agency of Human Services 2004 reorganization: See IIIC.

There are a wide variety of public health planning, coordination and program activities that have evolved over the past several years which include a range of health and health-related partners both within state government and also the community or private sectors. These collaborations deal with such public health issues such as primary health care delivery, women's health, oral health, obesity, emergency preparedness, health in the schools, injury prevention, QI in health care services, etc. Several examples are detailed below. It has become the culture at VDH and within MCH programs that, to be successful with achieving the goals of any major new public health initiative or project, key community and state partners must be involved. Public health issues are complex and require complex solutions -- which can be implemented via a multidisciplinary approach. With many of these issues, the VDH plays the key role of speaking for public health and modeling the unique role that MCH and public health can offer to the population health solution.

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. As of April, 2006, 90.2% of Vermonters have health insurance coverage, down from 91.4% from 2000. (changes not statistically significant.) 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, MCH, and the Office of Primary Health Care. In 2004-2005, a statewide advisory committee created an Oral Health Plan containing such strategies as 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.

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

Care; VT Long Term Care Coalition; and AHEC. In 2004, a main focus was 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 review 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. /2008/Current focus is the development of a new state plan for rural and primary care health services. Additional topics have been veterans health services, oral health access improvement, and the health needs of migrant farm worker and their families.//2008//

#### Coordination of Health and Public Health Components of Early Childhood Systems: 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. VDH participates in the statewide Early Childhood Workgroup, which was established to coordinate efforts between a variety of state agencies and private, not-for-profit community organizations.

/2007/VDH and DCF also coordinate closely around the creation of the Early Childhood Comprehensive Systems (ECCS) Implementation Plan.//2007// /2008/Statewide planning symposium for Building Bright futures (ECCS) was held in May, 2007. Planning continues for hiring of 12 regional directors and supporting districts in specific planning around health, early education, and early care programs and systems/2009/ **See discussion IIIA and III B //2009//**

Healthy Babies, Kids and Families (HBKF) uses a system of care approach to coordinate services for Medicaid eligible pregnant women, infants, and children up to age 6 years. The program is managed by MCH nurse coordinators 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 and prior authorization, 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, community service agencies, WIC clinics, EPSDT outreach, school nurses, the statewide toll-free Help Your Baby, Help Yourself hot line, and self referrals. Medicaid reimburses for home visits by MCH nurses and family support workers and perinatal group education for pregnant and postpartum women. 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. In 2002, funding from National Academy of State Health Policy (NASHP) enabled participation in the national Assuring Better Child Development (ABCD) Consortium and supported this expansion of HBKF to include children up to age six. In 2004, the AHS reorganization resulted in the transference of HBKF from the Health Department to the newly formed Department of Children and Families. This organizational transfer is to streamline the delivery of direct services for AHS clients /2009/ **See discussion IIIA and III B //2009//**

The Family, Infant Toddler Program (Early Interventions Service/IDEA/Part C) serves eligible infants and toddlers through an individualized family service plan. This is a cross agency program - - IDEA requirements that funds be used as payer of last resort -- includes the 62 public school districts, Dept of Ed, CIS, Child Development Division, VDH/CSHN. The CSHN collaboration includes the use of Medical Social Workers as an IFSP team member and the use of CSHN staff as advisors /2009/ **In spite of the transfer of the Part C program to the Department for**

***Children and Families (with the purpose of improving integration of the early childhood programs--see CIS), CSHN medical social workers remain members of each core team. The CSHN Child Development Clinic is a major referral to--and referral from--Part C, serving as the medical developmental diagnostic/evaluation resource for the state. We estimate that 40% of children enrolled in Part C also receive services from one or more CSHN programs //2009//***

Historically, "Healthy Child Care Vermont" (HCCVT) began via a CISS grant with the intent to build state and local capacity to provide expert public health nursing consultation and training to child care providers. In 2003, the HCCVT initiative began a transition to a new HRSA/CISS grant for infrastructure development of Early Childhood Comprehensive Systems (ECCS), which includes early care, health and education focused integration. The ECCS grant is funded by the MCHB through Title V, to support the public health presence and leadership around five key areas of a comprehensive early childhood system: access to insurance and a medical home; mental health and social-emotional development; early care and education; parent education; and parent support. Also at this time, 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. In 2004 this system began to become unified under a 'new' name - Building Bright Futures: Vermont's Alliance for Children. In 2004-2005, the BBF Health Subcommittee, co-chaired by VDH and DCF, conducted an extensive planning process under the ECCS grant.

/2007/The ECCS implementation plan has been completed and submitted to MCHB. VT continues to participate in Healthy Child Care New England Training Collaborative -- see SPM#2//2007// ***//2009/ Web based data base developed to capture Child Care Health Consultants activities. HCCVT continues to partner with Child Care Licensing, Community Resources and Referral agencies, Northern Lights Career Development Center, AAP-Vt, VDH, and ECCS Coordinator. Updating Childcare Licensing regulations and health and safety components. BBF regional councils are focusing on quality child care and consultation services. Lack of capacity in staffing capacity hinders ability to do annual on-site visits of child cares (SPM #2.) Other strategies such as phone consultations and regional inservices are used for TA and education of providers //2009//***

/2007/Children's Integrated Services: As a result of the 2004 AHS reorganization, planning began for a system of services to AHS clients that is holistic, integrated and seamless in order to support families and children. The first three programs that will be involved in this integration are Healthy Babies, Kids and Families, Children's Upstream Services, and Family, Infant, Toddler (Part C). Major partners in this planning are VDH, DCF, and the Department of Education.//2007//

/2008/Planning continues for the integration of services. CIS regional planning teams have been created and district-specific plans for service integration are being reviewed at the state level. Work plans for each region will then be created. Leaders from the VDH MCH Division and the Child Development Division of the Department for Children and Families at the Agency of Human Services are meeting regularly to assure integrated delivery of health and early education services//2008// education services//2008// ***//2009/ CIS has progressed to an early regional implementation phase in which CIS services teams have formed to provide a single entry point into the three integrated CIS care systems (Part C, HBKF, and early childhood mental health [formerly CUPS] Plans for staff training for in use of a "one plan per child/family" that will be used by all team members. Redesign of how direct services are financed by combining all three program funding streams into one and moving from fee for service reimbursement to a monthly case rate. AHS Secretary has charged the MCH director and the special assistant to the AHS secretary to co-lead the redesign of the state system of care for children with disabilities. This is a very timely goal, with the new CSHN State Implementation grant, the maturing of the CIS implementation, and several other related efforts: Act 264 (the expansion of a regional case problem-solving method for children***

***with severe emotional disturbance and special education needs, to include potentially all children who receive special education and services from an AHS program--this is a hierarchical, regional-to-centralized stepwise process to develop comprehensive care plans and assign fiscal responsibility for their implementation); Children's Medicaid Hi-tech program redesign; unified services plans (using Medicaid home and community-based services waivers to bring all fee for service and waiver services for a child into one plan under one budget); completion of a state plan for services for individuals with autism spectrum disorders; Building Bright Futures planning (regional planning for early childhood services, especially early care and education vis EECS funds); Blueprint for Health (incorporating Medical Homes); case management initiatives within Medicaid; and others //2009//***

To address quality improvement for children using Medicaid, VDH has contracted with the University of Vermont College of Medicine's Vermont Child Health Improvement Program (VCHIP) to plan and implement numerous quality improvement projects with a wide range of providers and institutions. Projects ranging from improvement of OB care in birth hospitals to improvement in adolescent health supervision and involve state agencies, providers of pediatric care, private health insurers, and consumers and has resulted in national recognition. For example, VDH and VCHIP are working closely with the child welfare agency to implement the use of a uniform health intake questionnaire for use when a child enters state custody. This document identifies immediate and chronic health needs, existing providers involved in the child's life, and needs for linkages to new providers. This tool is intended to inform the development of an action plan to address the child's physical, mental, and dental health. It is an example of collaborative work that brings together expertise and skills that may otherwise not be available in a single state agency or private institution. Another VCHIP program involving collaboration with VDH is Improving Prenatal Care in Vermont (IPCV) Sets of materials and tools are designed and tested in the IPCV Learning Collaborative. The state-wide initiative was designed to help improve pregnancy outcomes of low weight and preterm birthrates by implementing updated, evidence-based prenatal care, and developing improved office systems. VCHIP's ADHD initiative (with VDH and Dept of Education) is a multidisciplinary approach to coordinate assessment and treatment of school-aged children with this disorder ***//2009/ VCHIP has added a children's chronic disease focus, providing consultation to FAHC clinical programs for children with endocrine disorders, renal disorders, and cystic fibrosis. VCHIP is a partner in the intended SIG process, for review, redesign, and evaluation for CSHN programs within the larger system of services //2009//***

The Vermont Department of Health works closely with the tertiary care facilities that provide services to Vermonters (Fletcher Allen Health Care in VT, Dartmouth Hitchcock Medical Center in NH, and the Albany Medical Center in NY). Services are provided through the Newborn Intensive Care Units (NICU), the maternity service departments, health service providers through the Healthy Babies system of care and the CSHN programs. In addition, the Regional Perinatal Program (partially funded by Title V) provides training and data analysis to participating birth hospitals in Vermont and New York State ***//2009/ CSHN is awaiting final approval of a significant new contractual arrangement with Dartmouth to add a developmental pediatrician and a pediatric psychologist to serve VT children both at Dartmouth and in southern and western Vermont //2009//***

In other activities, the VDH has student nursing placements from the University of Vermont (Baccalaureate and Masters level), Norwich University, Vermont Technical and Castleton State College nursing programs and State University of New York Plattsburg. Student placements are also provided for the Master of Social Work program and the Nutrition program at UVM. 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.

***//2009/ VDH/CSHN continues to provide partnership support to the UVM LEND-ILEHP***

***program, to support training of in-practice professionals in neurodevelopmental disabilities. The CSHN medical director participates in the lecture series. CSHN contracts with ILEHP to provide "Community Clinic" assessments for children with especially complex, community-systems-involved, developmental concerns. ILEHP also hosts an annual week-long conference on the care of children with autism //2009//***

***//2009/ MCH/CSHN/Child Development Clinic has agreed to offer experiences for UVM Child Psychiatry fellows. UVM has been approved to offer fellowships beginning in July, 2009. These fellowships will increase the opportunities to expand the capacity of child psychiatry services in Vermont as well as to increase the expertise in caring for children who also have developmental disabilities //2009//***

The VDH is represented on Vermont's Interpreter Task Force by Office of Minority Health and Refugee Health Coordinator. This interagency collaboration 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.

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

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). In April, 2004, the Governor submitted to CMS a proposal called the Global Commitment which would pilot for five years a new approach to Vermont's Medicaid program. Under the Global Commitment, all Medicaid funding would be capped with an agreed percentage increase per year over the five year period. In exchange, Vermont would receive greater flexibility in the administration and benefit design for all Medicaid programs. If approved, the administration is planning for a July, 2005 start-up date. In par, the administration wishes to develop mental health programs with an emphasis on early prevention and screening within a pediatric setting.

*//2007/ The VDH will be involved in the planning around the implementation and client informing of the changes to Medicaid as a result of the Medicaid Global Commitment //2007// //2008/See IIIA for Global Commitment update//2008//2009/ See NPM 3, 4, 5 and HSCI 7 for updates //2009//*

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

Historically, 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.

For discussion of the Coordinated School Health grant from CDC -- See Section IIIA Overview, Current Priorities.

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 health services. In 2004, a needs assessment of the health needs of women in the correctional system, was written, with special emphasis on reproductive health needs and referral to community based clinical providers after discharge from inmate status. In districts where correctional facilities with women inmates are located, VDH district office staff work closely with Correctional personnel to assure that eligible women are enrolled in WIC and receive seamless services for themselves and their children upon return to the community **//2009/ The Incarcerated Women's Initiative has been in progress for three years. The co-case management involved in this initiative has been intense, and it has yielded results. Substance abuse (SA), mental health (MH) and co-occurring issues present in a large proportion of cases. Four years ago, the growth rate of the women's population had been 30-40% per year, with a population of 150-180 women incarcerated. Recently the population has been in the 130's, and even dropped to 128 at one point.. The growth rate for women in prison was less than the growth rate for men for the first time in ten years. Current plans to transition Northwestern State Correctional Facility (NWSCF in St. Albans) to a women's facility with the closing of the Dale (Waterbury)and Windsor facilities. Windsor would then be transitioned into a work camp for men. The Vermont Department of Labor (VDOL) has received a \$574,000 earmark for women's community re-entry projects //2009//**

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

Child Fatality Review Team: 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. Over the past two years, the Committee has focused on child deaths from all unnatural causes, not just abuse and homicide. The Title V Planner, the Injury Control Coordinator, and the Office of Research and Statistics have been planning for a system of data collection based on the uniform data set developed by the National Center for Child Death Review. Also, in response to an informal review of Vermont "SIDS" deaths, a parent education pamphlet on safe sleep environment was produced **//2009/ CFRT report released describing data from ten years of child deaths //2009//**

State Agency Coordination for CSHN: CSHN participates in a variety of interdepartmental planning and policy-making settings. Please see IIIB. (Agency Capacity--CSHCN--Pyramid Level Infrastructure), above. CSHN has a particularly close relationship with Medicaid, promoting and assisting eligibility for children, collaboration in the area of prior-authorizations, and reimbursement of CSHN program activities for Medicaid children, through fee-for-service and Medicaid Medical Case Management/EPSTD. **//2007/CSHN continues to provide the regional social work staff for the Part C early intervention system (Family, Infant and Toddler Program, FITP) within the Department for Children and**

Families, and has a seat on the ICC. CSHN is participating in several other AHS-Department of Education initiatives, Act 264 planning; Regional Autism Centers. Individual-child and system-level coordination and planning continue with the Department of Disabilities, Aging and Independent Living (including Medicaid hi-tech program; Personal Care Services; Traumatic Brain Injury project; Developmental Disabilities Services; Vocational Rehabilitation). //2007// /2008/Above efforts have been continued. See also, CSHN Pyramid Level Infrastructure, under B. Agency Capacity//2008// **/2009/ CSHN medical social workers continue to provide support for regional Part C teams, and CSHN also continues to provide all the processing of "payer of last resort" payments for the Part C program. See NPM 3, 4, 5 and HSCI 7 for updates //2009//** /2009/ **VDH/CSHN has a longstanding, strong and critically important relationship with the state's two parent-run organizations, Parent to Parent of Vermont, and the Vermont Parent Information Center. Rather than hiring individuals to serve as program staff, VT has chosen to provide infrastructure support to the organizations, to enable them to assess need and provide information and strategic support to a broader range of families than those who seek care from CSHN programs. The partnership allows CSHN, as a funding source, to have input into the priorities of the organizations, without disrupting their mission and process, and, in return, provides CSHN with immensely useful information about family strengths, preferences, and needs. The two parent organizations are merging in July 2008; the CSHN medical director is a member of the committee helping to recruit an executive director for the new organization. Interim co-leadership is being provided by the two directors of the previously separate organizations. Throughout this application/report, there are examples of the contribution of these agencies //2009//**

*An attachment is included in this section.*

## F. Health Systems Capacity Indicators

### Introduction

See discussion for each indicator.

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

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	19.9	15.6	24.0	17.8	
Numerator	66	52	79	58	
Denominator	33249	33384	32910	32496	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

### Notes - 2007

Hospital discharge data for 2007 are not available at time of submission. They should be published in early 2008.

### Notes - 2005

Observed variability between years is due in part to small numbers.

**Narrative:**

Asthma is a useful indicator of the effectiveness of preventative disease management in both children and adults. Proper access to medical care and quality clinical management of asthma within a medical home can prevent hospitalization and markedly improve the quality of life for children and adults with asthma. In 2003, 66 Vermont children less than 5 years old Vermont were discharged from a hospital for asthma treatment. 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 2005 National Survey of Children's Health reports that 7.1% of Vermont children are affected by asthma, with 10.1% of parents reporting that asthma has a great or medium impact on the family. 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 program's three year implementation phase is designed to improve services to children: 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 pediatricians and school nurses. 3) development/distribution of radio public information 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 and emergency department data. 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. Progress has been made in obtaining data from Medicaid via a report card from the PC Plus population form the Vermont Program for Quality in Health Care. The Behavioral Risk Factor Surveillance System continues to be a valuable tool for measuring asthma prevalence as well as measures of morbidity and treatment-seeking behavior in adults. For children, Vermont has included questions by proxy on the BRFSS (years 2001, 2002, 2003, 2004 and 2005) to assess childhood asthma prevalence. Unfortunately, due to the formatting of the questionnaire, there have been difficulties in weighting the data for years 2001-2004. In 2005, a "Random Child Selection module was added to the questionnaire which will help in obtaining a reliable measure of childhood asthma prevalence through the BRFSS. The Asthma Program was also able to include a question on lifetime asthma diagnosis, in addition to several questions on asthma morbidity and asthma treatment-seeking behaviors, the Youth Tobacco Survey, asked of middle and high school students in 2004.

/2007/ Partnerships with VCHIP to improve the coordination of asthma care in school aged children has resulted in an increase in the use of the Asthma Action Plans from 28% to 67% in school districts participating in the program. Forty schools have received funds from the ENVISION program to improve indoor air quality. Implementation grant submitted to CDC in June, 2006 for funds to work on such projects as programs for parents who smoke and who live with children with asthma, work with housing programs to reduce indoor environmental asthma triggers, continue work with VCHIP on Asthma Action Plans and use by school nurses. Plans for increasing asthma surveillance capacity as linked with Blueprint surveillance and evaluation systems -- increased identification of populations at risk of poorly controlled symptoms, better collection of information on childhood asthma from schools and Medicaid claims//2007//. /2008/ Milton School District has extended its pilot designation for further activities within the Envision program, such as measuring effects on school absenteeism. Coordinated school health teams implementing Asthma Action Plans in select districts. School Children's Asthma Care Forum held in collaboration with North Country Hospital in Newport. We interpret the annual rate fluctuations with caution - due to the small numbers of actual admissions. //2008// **/2009/Newly drafted Vermont Action Plan is a result of the 2007 Asthma Advisory Panel and reflects Blueprint strategies for chronic care management. State specific data indicates target populations should be lower income individuals and families and those Vermonters living in the Rutland HSA//2009//**

**Health Systems Capacity Indicator 02:** *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	94.6	84.6	85.7	86.6	85.3
Numerator	3441	3122	3148	3174	3183
Denominator	3637	3691	3674	3667	3732
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

**Notes - 2007**

In contrast to previous years, data for enrollment in Medicaid during 2004, 2005, 2006 and 2007 are split out from SCHIP - which is reported separately, below. As a consequence, results from 2003 and earlier should not be compared directly to 2004 onwards.

**Notes - 2006**

In contrast to previous years, data for enrollment in Medicaid during 2004, 2005 and 2006 are split out from SCHIP - which is reported separately, below. As a consequence, results from 2003 and earlier should not be compared directly to 2004 onwards.

**Notes - 2005**

In contrast to previous years, data for enrollment in Medicaid during 2004, 2005 and 2006 are split out from SCHIP - which is reported separately, below. As a consequence, results from 2003 and earlier should not be compared directly to 2004 onwards.

**Narrative:**

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. For example, over the past five years, data for State Performance Measure #8 show that the percent of Medicaid eligible children who use dental services (within a one year period) has yet to reach the 50% level. In partial response, VDH is creating a public media campaign encouraging lower income parents to take their children to the dentist for preventative care. (See also discussion in Section IVD State Priorities and 2005 Strengths and Needs Assessment)

VDH continues updating of the Provider's Toolkit for the dissemination of best-practice guidelines and screening tools to providers of pediatric care -- this toolkit is now "live" on the VDH website. VDH staff work with AAP and AAFP monthly to identify system, policy, clinical or reimbursement issues that might pose a barrier to Medicaid-eligible children receiving routine, high-quality preventive care. Data is guiding the development of this toolkit information -- for example,

analysis of injuries to children by age and type of injury give information as to how Vermont children are being injured and how providers and parents can be guided by age-specific information to reduce the risk to their children.

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. The Medicaid data base capacity assisted in creation of SPM#7: Increase the number of claims submitted by primary care providers to Medicaid for an annual care plan. See discussion HSCI#8.

**//2009/ VDH and grantee Vermont Child Health Improvement Program work to update Vermont's periodicity schedule to accommodate Vermont-specific guidelines with that of the newly revised national AAP Bright Futures recommendations, ie: the Vermont recommendations for pediatric lead screening levels are more rigorous than the national BF guidelines. //2009//**

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

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	NaN	85.2	89.7	90.5	87.3
Numerator	0	231	209	201	165
Denominator	0	271	233	222	189
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

**Notes - 2007**

In contrast to previous years, data for enrollment in SCHIP during 2004, 2005, 2006 and 2007 are split out from Medicaid - which is reported separately, above. As a consequence, results from 2003 and earlier should not be compared directly to 2004 onwards.

**Notes - 2006**

In contrast to previous years, data for enrollment in SCHIP during 2004, 2005 and 2006 are split out from Medicaid - which is reported separately, above. As a consequence, results from 2003 and earlier should not be compared directly to 2004 onwards.

**Notes - 2005**

In contrast to previous years, data for enrollment in SCHIP during 2004, 2005 and 2006 are split out from Medicaid - which is reported separately, above. As a consequence, results from 2003 and earlier should not be compared directly to 2004 onwards.

**Narrative:**

Vermont's SCHIP enrollees receive the same benefits as those offered by Medicaid - see discussion HSCI #2

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

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	89.3	88.6	87.7	88.1	
Numerator	5573	5585	5228	5329	
Denominator	6242	6301	5961	6047	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	

**Notes - 2007**

Vital Records birth data for 2007 were not available at time of submission. They should become available in early 2009.

**Notes - 2006**

Vital Records birth data for 2006 were preliminary at time of submission.

**Notes - 2005**

Data for 2005 were revised in June 2008 to follow new Vital Records/NCHS guidelines for estimating number of prenatal visits.

**Narrative:**

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. Efforts are ongoing to work with birth hospitals to improve accuracy in the count of prenatal visits in the last trimester. Vermont received a Pregnancy Risk Assessment Monitoring System (PRAMS) grant in 1999 and is now reviewing the first set of analyses from the state-specific weighted data files. Information 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 birth hospitals to be able to directly download birth data and increase the accuracy of the information./2008/The analysis of the PRAMS data form 2001-2004 has recently been completed. The PRAMS analyst has identified 12 preconception and 7 interconception indicators from PRAMS that will be analyzed and discussed in a report on preconception health via the SSDI-funded deliverables./2008//**2009/OBNet (included in the deliverables of the VDH grant to VCHIP for services to Medicaid eligible women and infants) continues to be expanded and refined - purpose is to gather data regarding maternal and fetal risk factors, interventions and outcomes in the FAHC web-based registry. PRAMS data also continues to inform programs and planning with regular publication of PRAMS Data Briefs. See also NPM 17,**

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

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	81.9	79.1	77.5	77.7	77.6
Numerator	57448	58119	57417	56952	55894
Denominator	70104	73502	74056	73312	71992
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

**Notes - 2007**

The estimate for the number of children aged 1-21 years who are potentially eligible for Medicaid services is based on the sum of the number of children enrolled in Medicaid at the end of FFY 2007 plus the number of children aged 1-21 with household income <300% of Federal Poverty Level who lacked Health insurance in 2005 (data source VT Banking, Insurance, Securities and Health Care Administration, 2005 Vermont Household Health Insurance Survey). Estimates of uninsured children for 2003 -2004 were based on a previous survey carried out in 2000.

**Notes - 2006**

The estimate for the number of children aged 1-21 years who are potentially eligible for Medicaid services is based on the sum of the number of children enrolled in Medicaid at the end of FFY 2006 plus the number of children aged 1-21 with household income <300% of Federal Poverty Level who lacked Health insurance in 2005 (data source VT Banking, Insurance, Securities and Health Care Administration, 2005 Vermont Household Health Insurance Survey). Estimates of uninsured children for 2003 -2004 were based on a previous survey carried out in 2000.

The numerator and denominator data for 2006 were revised slightly in 2008 to reflect updates to the Medicaid Claims database. The overall percentage was not affected.

**Notes - 2005**

The estimate for the number of children aged 1-21 years who are potentially eligible for Medicaid services is based on the sum of the number of children enrolled in Medicaid at the end of FFY 2005 plus the number of children aged 1-21 with household income <300% of Federal Poverty Level who lacked Health insurance in 2005 (data source VT Banking, Insurance, Securities and Health Care Administration, 2005 Vermont Household Health Insurance Survey). Estimates of uninsured children for 2003 -2004 were based on a previous survey carried out in 2000.

**Narrative:**

Approximately 4% of Vermont children aged 0-9 and 6% of Vermont children age 10-17 are uninsured (BISHCA report, 2005 data.) Vermont works aggressively to enroll these children as eligible into the Medicaid programs to reach an high percentage of children who have access to health insurance. Extensive outreach and informing has been a strong point for Vermont's EPSDT program. Outreach for Medicaid enrollment occurs via the VDH district offices, the programs of the Department for Children and Families, and via schools and community

organizations that serve families with young children. Age-appropriate informing letters are sent regularly to families. Other Medicaid outreach and access activities occur via a statewide central information and enrollment line, website, or via the 211 statewide information line. For a discussion of Medicaid and SCHIP, see Section IIIA and HSCI#2.

Data for tracking this measure are available via Medicaid and the EDS system. The Medicaid data, unlike many other data sources for Title V related analysis, does not reside in the Health Department. A special license is required to access the data and a required training needs to be completed before access is granted. This system of training VDH analysts has become more "user friendly" during the past few years and the VDH staff have ready access to the data bases. *//2009/ 2009/Outreach programs via school nurses. Also informing individuals and families of potential eligibility for new Catamount/Green Mountain Care state sponsored health plans. See NPM #13/2009/See NPM #13//2009//*

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

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	63.2	63.9	66.0	66.6	67.1
Numerator	4693	4782	4879	4914	4758
Denominator	7431	7488	7392	7374	7095
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

**Notes - 2005**

For FY05

**Narrative:**

The Office of Oral Health continues to promote outreach and the development of a dental home. For activities, see discussion under the 2005 Strengths and Needs Assessment, NPM#9, and SPM #8. In the fall of 2002, state monies enabled a survey of third grade children to determine the presence of sealants, showing a rate of 66% in those third grade children examined. 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 an Oral Health Robert Wood Johnson Grant, 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 have been analyzed and the findings have been 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. *//2007/*Community meetings of dental and medical professionals are being held in each VDH district statewide to begin planning for local response to the oral health plan. A pilot program placed a dental hygienist at a large pediatric office to act as a case manager for families who do not have a dental home. Legislative funding was received to place four dental hygienists in VDH district offices to act as care managers for families who do not have a dental home. Collaboration with Pediatricians to be trained to do oral health risk assessments in the pediatric setting.*//2007// //2008/* Significant progress has been made with the implementation of the Oral Health Planning as a result of the Vermont State Oral Health Plan. In 2007, the Legislature passed the "Dental Dozen," 12 targeted initiatives to improve access and

quality of oral health services. Legislative funding was obtained in partnership with Vermont Medicaid (Office of Vermont Health Access.) Initiatives include: ensure oral health exams for school-age children, increase dental reimbursement rates, reimbursement and training of primary health care providers to conduct standard oral health risk assessments on infants and young children in their practices, place dental hygienists in VDH district offices, select/assign dental home for children, enhance outreach and loan repayment for dentists willing to relocate to Vermont, and scholarships for new dentist and hygienists. Considering an initiative to assist PCP's in providing fluoride varnish treatments to young children. VDH Office of Rural Health coordinating with FQHC and Bi-States Primary Care Association to increase dental clinical service via FQHCs.//2008// **2009/ Medicaid claims data shows that 50.1% of children eligible for Medicaid services received dental services during FFY 07, similar to the 49.9% of children reported for FFY 06. Work continues to fund primary care providers to provide fluoride varnish treatments to children under age 3. VDH Office of Oral Health continues work to increase dental clinical services via FQHC's. VDH created a Vermont-specific oral health periodicity schedule that is complementary to the established Recommendations for Preventive Pediatric Oral Health Care of the American Academy of Pediatric Dentistry. This new schedule to be adopted for reimbursement guidelines by Vt Medicaid//2009//**

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

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	47.5	29.3	45.0	53.3	42.8
Numerator	649	435	691	866	687
Denominator	1365	1486	1536	1625	1607
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

**Notes - 2007**

The denominator for this indicator is derived from claims-data of SSI-eligible children under age 16 who received a Medicaid service in FFY2007. This is, of necessity, an under-count of the children who had SSI in that year, some of whom received no services, and some of whom have private insurance that paid for the services they did receive. The SSI children with Medicaid services were matched to the list of CSHN-enrolled children during the same period. In FFY07, 1,607 SSI children received a Medicaid service. 687 of these children were enrolled in CSHN programs, representing 42.8% of SSI-eligible children under 16 years.

**Notes - 2006**

The indicator begins with a claims-data review of SSI-eligible children under age 16 who received a Medicaid service in 2006. This is, of necessity, an under-count of the children who had SSI in that year, some of whom received no services, and some of whom have private insurance that paid for the services they did receive. They are matched to CSHN-enrolled children. In addition, CSHN annotates SSI status as the information becomes available. In 2006, 1,625 SSI children received a service. There were 654 children whose CSHN records show that they have SSI. 621 of the 654 were also on the SSI list (perhaps the 33 were among those who did not have a service paid in the reporting year.) In addition, 212 CSHN children, when crossmatched, were found to have SSI although the CSHN file did not indicate SSI. Therefore a total of 866 of the

1,625 SSI children, or 53.3% are dually enrolled. The annual SSA statistical report of each state's children who have SSI, reported 1415 Vermont children had SSI in December, 2006.

**Notes - 2005**

VT Medicaid reports that there were 1,536 children under the age of 16 who were SSI eligible and who received a medical service paid for by Medicaid in CY 2005. This figure compares to 1,384, the number of children under 126 who were SSI eligible as of December 2005, as reported by the SSA website ("Table 7. Number and percentage distribution of children in Vt receiving federally administered SSI payments, by selected characteristics, Dec 2005.") 691 of the 1,536 identified children (45%) also receive services through Vt CSHN, services which include, at least, care coordination. This is the figure reported (691 is 49% of 1,384, the SSA figure.)

**Narrative:**

In 2007, CSHN began to receive the complete applications of children who have just been found to be SSI eligible. The files are reviewed to see if the child is already enrolled in a CSHN program, and the program is notified. CSHN has met with the children's mental health directors (currently transferring back to a newly re-created Department of Mental Health) to discuss strategies for the non-CSHN children whose SSI-qualifying disability is based on a mental health diagnosis. Other states' CSHCN programs have been contacted for information about how they manage a similar responsibility. We are specifically looking at ways to improve the connection of the SSI child with the PCP, around the annual care plan. See also discussion for SPM 7. ***//2009//2009/This is the first year that we have been able to match the actual children who are contained within the Medicaid claims database, selected for children whose eligibility code indicated that they receive SSI, whose birthdays are within the under 16 yo range for the purposes of the performance measure, with CSHN enrolled children directly within the CSHN database. The modest differences in methods, this year, may more than account for the change in the numerator. Every child enrolled in CSHN has access to a range of supports, including a clinical contact person, often the medical social worker for their region, and, depending upon other clinic involvement, a multidisciplinary team. In addition, CSHN exists as a fiscal safety net for medically necessary services and access to respite care. The federal Social Security Administration provides each state with a December count of SSI recipients by age; however, the children birth to age 18 are combined and the number, therefore, is not able to be compared to the denominator we find through the above method.//2009//***

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

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2006	matching data files	8.5	5.7	6.8

**Narrative:**

The SSDI funding has enabled increased capacity for VDH to obtain this data from several data systems in recent years, especially Medicaid and birth certificates. However, VDH has been linking the WIC and birth certificate records and analyzing this data for over 10 years. Eligibility is the same for both WIC and Medicaid programs, and the women and children in both programs overlap. Because of the multiple years of linked WIC/birth records, VDH analyses focus on that linkage. The data show a

statistically significant higher rate for families with WIC versus those families using other insurance in the following: percent low birth weight, 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 -- the number of infant deaths in Vermont is too small for comparisons. 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. The low birthweight rate has been increasing in Vermont since the early 1990's, however the increase has been found primarily in the moderately low birthweight category. This raised questions as to whether these babies are small, but generally healthy or if these babies are experiencing increased morbidity. As part of the current SSDI grant we examined Medicaid claims data for infants who were born in 2001-2002, were eligible for Medicaid at birth and continuously enrolled in Medicaid until their 2nd birthday. We found that children who were moderately low birthweight infants were more likely to be hospitalized (49% vs. 17%), had more emergency department visits (2.3 visits vs. 1.8), had more physician office visits (26.6 visits vs. 22.2), and had more drug claims (13.4 vs. 9.9) than children born at normal birthweight. The average cost over the first two years of life for those born at moderately low birthweight was three times the cost of those born at normal birthweight (\$15,486 vs. \$5,146).

***//2009/ Both WIC and Medicaid files have been linked to the birth files. However the overlap between these matched records was much lower than expected given that the eligibility criteria for both programs are identical. Based on WIC records for 2007, 79% of women enrolled WIC reported that they had Medicaid coverage. An additional 8%, who reported that they had no insurance, were expected to enroll in Medicaid as a result of their first WIC visit. The PRAMS survey is also linked to the birth certificate, and asks mothers whether they were on WIC during their pregnancy and whether Medicaid paid for their prenatal care or delivery. We've compared the PRAMS responses to the results of our linkages. We found that the agreement between the PRAMS response and the WIC match was excellent (as measured by the kappa statistic), while the correspondence to the Medicaid linkage was considerably lower. Based on the comparison to the PRAMS data we have more confidence in the WIC match than the Medicaid match, and so reported WIC eligibility on Health Systems Capacity Indicator #5. We are currently investigating possible reasons why the Medicaid match is not as good, and once we've identified and resolved those issues we will use the results of the Medicaid match for HSCI #5. The differences between Medicaid and non-Medicaid are statistically significant for HSCI #5 for low birth weight, early prenatal care, and adequate prenatal care. The Medicaid-non Medicaid difference for HSCI 5B is not statistically significant. The data uses WIC as the surrogate population for Medicaid, because in Vermont, all women on WIC are also eligible for Medicaid. See IV E. //2009//***

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

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2006	matching data files	7.5	4.5	5.7

**Narrative:**

See discussion Section III F, HSCI 05A and discussion IV E Health Status Indicators.

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

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2006	matching data files	86.7	91.4	89.5

**Notes - 2009**

The data source for HSCI #05C is birth certificate records matched to WIC records. (Since VT State eligibility for WIC is the same as for Medicaid, WIC is used as a surrogate for the latter.) Because only 99% of records could be matched, the denominator for HSCI #05C (n = 6,046) is smaller than the denominator for NPM #18 (n = 6,084) - leading to a slight discrepancy (0.07%) in rates, after rounding to one decimal place.

**Narrative:**

See discussion Section III F, HSCI 05A and discussion IV E Health Status Indicators.

**Health Systems Capacity Indicator 05D:** *Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2006	matching data files	85.8	89.7	88.1

**Narrative:**

See discussion Section III F, HSCI 5A and discussion IV E, Health Status Indicators.

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

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1), children, Medicaid and	YEAR	PERCENT OF POVERTY LEVEL Medicaid
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<b>pregnant women.</b>		
Infants (0 to 1)	2007	300
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Infants (0 to 1)	2007	300

**Narrative:**

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

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

<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
Medicaid Children (Age range 1 to 18) (Age range to ) (Age range to )	2007	300
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Medicaid Children (Age range 1 to 18) (Age range to ) (Age range to )	2007	300

**Narrative:**

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. For a discussion of Medicaid, SCHIP and Vermont's global commitment, see Section IIIA.

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

<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
Pregnant Women	2007	200
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Pregnant Women	2007	200

**Narrative:**

Vermont's eligibility for Medicaid and SCHIP are the same at %300 FPL for infants and children up to age 18. Pregnant women under 200% FPL are also eligible. For a discussion of Medicaid, SCHIP, and Vermont's Global Commitment, see Section IIIA.

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

<b>DATABASES OR SURVEYS</b>	<b>Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)</b>	<b>Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)</b>
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	2	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

**Notes - 2009**

Vermont's CDC grant for the birth defects surveillance system is ending January 2009. The data for 2006 and 2007 will be able to be completed. Capacity for future analysis will be limited.

**Narrative:**

Infant death certificates have been matched to birth records since 1979. WIC records have been matched to birth and fetal death records annually since 1996. With support from SSDI, Vermont began linking the metabolic screening records and Medicaid birth records to the birth certificate. This has happened annually since 2003.

Hospital discharge data are available from the early 1980's for all inpatient discharges from VT hospitals and VT resident discharges from hospitals in New Hampshire, Massachusetts, and New York. Outpatient surgery performed in VT hospitals has been available since 1989. Beginning in 2001, an expanded definition of outpatient data, including emergency department visits, has been

available from VT and NH hospitals. We have developed agreements with MA and NY to obtain outpatient procedures and emergency department records of VT residents as they become available. VT began collecting data for PRAMS in January, 2001. The VDH is developing a Birth Information Network to include infants with special health conditions such as birth defects, hearing loss, metabolic and endocrine conditions and infants born at very low birthweight which is being implemented with the 2006 birth year. We expect to integrate the newborn hearing screening information into the birth certificate system in 2007. In 2005, VDH collaborated with FAHC to expand the capacity of their six hospital OBNet system to directly download birth related data into the VDH birth certificate data system to attain more accurate and timely birth data for such uses as clinical follow up, hospital-specific data, and for public health planning. CSHN is using a CDC cooperative agreement which will extend the OBNet/VDH/CSHN linkage to integrate newborn screening data with prenatal, birth certificate, and immunization data. The Newborn Screening Program receives weekly lists from the SSDI Coordinator of newly recorded births, which they then compare to their screening records to determine if every infant has been screened, or has a documented refusal. At the end of the year, after the birth files are considered to be complete, the birth records are matched to the laboratory's screening records as a final quality assurance that all infants are being screened. The VDH integrated client management system, is being expanded to link the laboratory screening records to the birth certificate records. The MCH Surveillance Report, produced quarterly, is based on preliminary vital records data from the last 12 months, and reports on entry into prenatal care, low birthweight, teen births and pregnancies, and infant mortality by district and county level. In July of 2006 the VDH implemented the revised birth certificate which will supply new data elements to inform the MCH Surveillance Report - such as weight gain and smoking. /2008//The 2005 birth records were matched to infant deaths, the WIC records, the Medicaid eligibility and claims files and the newborn screening records. PRAMS data continues to be analyzed - data briefs are created for program planners. The preliminary 2006 birth files have been linked to NBS records. Appropriate data and analysis will be made available to the MCH Strategic Planning and Title V Needs Assessment process.//2008//2009/See update Section IV E//2009//

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

<b>DATA SOURCES</b>	<b>Does your state participate in the YRBS survey? (Select 1 - 3)</b>	<b>Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)</b>
Youth Risk Behavior Survey (YRBS)	3	Yes

**Notes - 2009**

**Narrative:**

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 9A, 9B and 9C). YRBS data show a reduction from 21.8% (in 1999) to 12.7% (in 2001) to 11.1% (in 2003) to 8% (in 2005) 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. Vermont participates in the Youth Tobacco Survey. In 2002 only middle school aged children were surveyed, however in 2004 the survey was expanded to 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, asthma and youth assets. /2007/Vermont participates in both the YRBS and the Youth Tobacco Survey. In 2006, Vermont administered an enhanced YTS that includes additional questions, creating a general "Youth Health Survey." However, at least half the questions on the YHS remain tobacco-related.

Beginning in 2006, the two surveys will be administered alternately - on the odd years the YRBS will be administered, on even years the YHS will be given. Thus, every year Vermont public school students, grades 8-12, will be surveyed annually about tobacco use and other health behaviors//2007//. /2008/This system of annual surveys of Vermont youth continues to be developed and implemented. In the fall of 2007, schools will be recruited for participation in the Youth Health Survey.//2008// /2009/ /2009/ //2009//Community grants of over \$1 million are being dispensed for community based tobacco control initiatives - funds from the Master Settlement Agreement. Active work in middle and high schools with students by programs such as Vermont Kids Against Tobacco and Our Voices Exposed. VKAT is for students grades 5-8 and is now in 51 schools statewide. VKAT's 13th annual Statehouse Rally took place April 2008. Media campaigns geared to young men (linking smoking to sexual impotence) and for young women (linking smoking with premature wrinkling of the skin) Analysis of Youth Health Survey data for 2007-2008 almost complete.//2009//

## 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 access to care for both clinical health care and population based services. Along with this goal comes the responsibility to build a comprehensive system of care that is of a high quality and responsive to the needs of the population. VDH has promoted the medical home concept for both medical and dental health care needs. To this end, VDH has worked to establish strong relationships with a myriad of organizations, such as professional groups, hospitals, community-based organizations, home health agencies, schools, and so forth. The VDH's Blueprint for Health (Chronic Care Model) is a specific action plan for these long-standing goals by enhancing the quality of health care and promoting client self-management.

Evidence of success has been revealed though many of the Title V measures and similar data. Vermont has one of the lowest teen birth rates nationally (8.1/1,000 births to women aged 15-17.) VDH continues to work at providing support and prevention services to all teens and support services to pregnant and parenting teens. Groups such as the Coordinated School Health Committee and the Fit and Healthy Advisory Committee, are enabling an enhanced collaboration between prevention programs. These programs cover a variety of prevention activities, such as physical fitness, good nutrition, tobacco, drug and alcohol use, mental health and sexual activity, and are broadly aimed at supporting assets in teens and promoting healthy development. 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 rate for the measures of low birth weight and rates of prenatal care utilization for women eligible for Medicaid insurance.

The collaborative efforts addressing birth outcomes, such as HBKF, WIC, quality improvement projects and enhanced surveillance capacity address the broad measures of perinatal health. In 2006, the infant mortality rate in Vermont was 5.5/1,000 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 causes of infant mortality in Vermont continue to be congenital anomalies, SUDI, and short gestation.

Vermont was ranked the second healthiest state in the nation according to the United Health Foundation, together with the American Public Health Foundation and Partnership for Prevention, 2006 America's Health Rankings: A Call to Action for People and Their Communities. Vermont also ranked second in 2005, both years finishing behind Minnesota. Of all states, Vermont has the lowest percentage of children living in poverty and was also highly ranked for ready access to prenatal care (second best in the nation) ***/2009/ Publication of The Health Status of Vermonters compiled by VDH shows that in HP2010 measures, Vermont is doing measurably better than the rest of the nation in 19 areas but still has work to do in the areas of binge drinking and obesity (see HealthVermont.gov.)The Commonwealth's report, US Variations in Child Health Systems Performance: A State Scorecard, says that Vt ranks first for equality in children's health care and ranks second in the overall health of its youth. In addition, Vt ranked first for overall child well-being in the Every Child Matters Education Fund Report entitled Geography Matters: Child Well-Being in the States //2009//*** Vermont child death rate (18.5/100,000 ages 1-14, 2006) is low, but the activities described in the Title V application and the capacity assessment of the Strengths and Needs Assessment will contribute to preventing needless childhood deaths. 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 and non-state government groups such as the Child Fatality Review Committee are concerned about this data and are engaged in many programs to address this issue of morbidity and mortality ***/2009/ CFRT published a report with ten years of child death data and description of team activities //2009//***

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 programs such as Run Girl Run help children directly to learn about physical fitness and healthy eating. Over 1,000 girls participate in each of these programs of Girls on the Run (for 3rd-5th graders) and Run Girls Run (middle school.) Data is also describing the issue of women of childbearing age who are overweight or obese -- strategies to reach this population are in the planning phases. In examining breastfeeding, a related important health measure, NPM #7 indicates that the percent of mothers who are breastfeeding at 6 months increased from 42.9%(2005) to 56.5% (2006.) exceeding the HP 2010 goal of 50%. An emerging issue is that of women and depression -- VDH is building the connections with OB/GYN and pediatric providers to enhance systems for screening and referral of pregnant women and mothers in efforts to get vulnerable women into treatment. This project would mirror the work being done with the Blueprint systems for depression screening.

Vermont'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. Grants such as SSDI and Measuring and Monitoring have supported data capacity and planning analysis. See IV E.

***//2009/ The Office of Rural Health, in collaboration with the Vt New Hampshire Bi States Primary Care Association and the UVM College of Medicine, has convened a statewide task to examine the needs and possible actions to address the issue of farm workers safety. The goals of the broadly representative group are to gather Vermont-specific data so as to better describe the issue of farm health and safety, to improve access to health care services and medial insurance for farmers and their families, support increased farm safety programs, and increase education and outreach for those involved in a far-related occupations. This fall, faculty from the University of Iowa will be presenting a five-day symposium for health care practitioners about the health issues specific to farm workers(such as arthritis, exposure to toxins, injuries, respiratory problems, etc.) A particular focus on health risks for children will be included //2009//***

## **B. State Priorities**

Title V FFY 08 Section IVB State Priorities July 2008

Section IV B State Priorities Vt TV FFY09  
Entry for July 2008

Vermont's MCH planners and program administrators continue to work on state priorities within the framework of supporting families and community assets in addition to planning from a deficit assessment point of view. The Title V Advisory Committee has communicated regularly and met twice formally to hone the final performance measures to reflect the priority goals. The MCH planner met routinely with the SSDI data support analyst and relevant program administrators to investigate meaningful methods of measurement. The final state performance measures are described below and also in Section IVD. The themes of assets and promoting resiliency are also evidenced in planning activities in other state agencies, such as via the ECCS planning, state mental health and alcohol offices, and in the AHS state planning document Vermont Well Being. See also Section II C for a discussion of the Strengths and Needs Assessment.

The Region 1 Title V leaders continue to be invested in MCH population planning using an assets and resiliency framework. In January 2006, the leaders attended 1) a workshop by the BUSPH on periconceptual health disparities (M. Lu & J. Collins, follow up AMCHP, 2005) 2) Meetings with Milton Kotelchuck and Deborah Allen (Boston University School of Public Health) and Paula Duncan (University of Vermont) to discuss next steps in the Title V process of measuring the assets of an MCH population. /2008/ Follow up: TA request to continue meeting annually via BUSPH (See IVG) Planned Learning session at BUSPH in October, 2007 about Lifecourse model with Dr. Neal Halfon **/2009/ Another session on Lifecourse is planned for 2008-2009 //2009//**

Update on the 2005 SNA for CSHN: CSHN administrators continue to rely on the information from the family focus groups. SPM7 describes VT children under 16 years old whose special health need and family income qualifies them for SSI (the same population as HSCI 8) are covered by Medicaid. Medicaid allows billing (and payment) for an annual care plan. Thus, the percentage of this population who received an annual care plan from their PCP is available through Medicaid claims data. The CSHN Family Advisory Council focus is on the gathering of family feedback about direct CSHN clinical services. CSHN is working with Parent to Parent on general services and access issues as described in the CSHN performance measures. CSHN has expanded efforts to encourage continuous insurance coverage, particularly through Medicaid. On a monthly basis, CSHN identifies CSHN-enrolled children who have lost Medicaid coverage. This happens for several reasons, such as the burden of prospective, monthly premiums and fluctuation (especially seasonal fluctuation) in income. CSHN asks their regional CSHN staff member to offer assistance in restoring Medicaid coverage. The gradual expansion of the VDH information system "SPHINX" to include immunization registry will allow the immunization status of CSHN-enrolled children to be reviewed.

**/2009/ CSHN receives important data from Parent to Parent of Vermont (see III E.) This year, P2P reported that, of the reasons why families contacted P2P for assistance, the two major issues were health care financing (132 requests) and community based services (435 requests.) //2009//**

A discussion of the 10 Priority Goals and State Performance Measure follows (See IIIA, IIIB, IIID, and IVD)

1. Pregnant women and young children thrive. SPM: % women reporting their pregnancies are intended. According to data from the National Survey of Family Growth (NSFG), in the United States, approximately half of all pregnancies across the age spectrum are "unintended" and may be associated with social, economic, and medical costs. Although a pregnancy may be reported as unintended, most children at birth are welcomed and nurtured. In general, women who lack preparedness for pregnancy are less likely to receive timely prenatal care, and their infants are more likely to lack sufficient resources for healthy development (Healthy People 1010 Progress Review, Family Planning, December, 2004.) A wide variety of services in Vermont exist to impact this measure: home visiting programs, school health education programs, family planning clinics, etc. See NPM 8.

2. Children live in stable, supported families. SPM: % licensed child care centers serving children birth through five years that receive annual visits from a child care health consultant (Common

asset based early education indicator for Region 1) To be able to measure the link between comprehensive early childhood systems and the strengthening of assets in young children and families.. A strong system of early childhood services promotes the health and welfare of children and their families. Region 1 has committed to create a measure that captures this concept within the mission of Title V programs. The measure incorporates the philosophy of assets and also an ecological model of factors that influence child health and development. Nationally, the number of children ages birth to age six in out-of-home care has increased from 30% to over 76% since the 1970's. Thus, it has become increasingly important to be able to evaluate child care programs, to assess quality and accessibility, and to know the impact of care on children's health. Child care health consultants play a critical role in promoting healthy and safe child care environments and supporting education for children, their families, and child care providers. This support specifically includes children with special health care needs. Child care health consultants also improve access to preventive health services such as medical and dental homes, early intervention and family support. This measure is consistent with recommendations from the AAP, APHA, and MCHB/HRSA.

3. Youth choose healthy behaviors and will thrive. SPM: % youth who did not binge drink on alcohol in the last 30 days. In Vermont, 21% of students reported binge drinking during the past 30 days in 2005 (vs. 23% in 2003.) Twelfth graders were over four times as likely as 8th graders to binge drink (33% vs. 7%). The perceived acceptance of drug-using behavior among family, peers, and society influences an adolescent's decision to use or avoid alcohol, tobacco, and drugs. The perception that alcohol use is socially acceptable correlates with the fact that more than 80% of youth nationally consume alcohol before their 21st birthday, whereas the lack of social acceptance of other drugs correlates with comparatively lower rates of use. Similarly, widespread societal expectations that youth will engage in binge drinking may encourage this highly dangerous form of alcohol consumption (HP2010, CDC.) For this measure, Vermont is testing the approach of using assets-based wording to measure the absence of binge drinking in youth, so as to emphasize the social and cultural changes that must take place for youth to understand that binge drinking can become the antithesis to the social norm.

4. Women lead healthy and productive lives. SPM: % women ages 18-44 who report eating at least five or more servings of fruit and vegetables per day. The importance of improving preconceptional health in women of childbearing age has become a priority for health and public health professionals in their efforts to improve birth outcomes. Women need to be supported in certain actions, such as in eating a healthy diet, maintaining a proper weight, getting adequate exercise, avoiding smoking and substance abuse, and obtaining regular health care. One measure of these healthy habits is consumption of adequate amounts of fruits and vegetables. (MMWR - Recommendations to Improve Preconception Health and Health Care -- Unites States, April 21, 2006) In addition, Vermont BRFSS 2005 suggest that less than half (44.8%) of women 18-44 years old take a multivitamin or folic acid supplement daily. The Folic Acid Education Campaign is planning for the following: 1) Coordinate with the VDH Vermont Eat for Health collaborative to produce educational materials for women and their health care providers. 2) Work with WIC, March of Dimes, and Planned Parenthood of Northern New England to provide a train-the trainer program for health care professionals. 3) Add folic acid information the VDH Eat for Health website. 4) Place videos of folic acid messages in WIC clinic waiting rooms to be run along with other health messages. 6) Provide financial support for DCF to place Folic Acid messages in their Path to Parenthood book ***/2009/ WIC investigating ability to provide vitamin supplements to postpartum/breastfeeding participant at activities geared toward women of child bearing age. Farm to Family WIC program continues. Plans for Folic Acid media campaign //2009//***

5. Youth successfully transition to adulthood. SPM: % youth who feel like they matter to people (YRBS.) Assets research for youth shows an association between healthy youth behaviors and certain defined assets. VT added 5 asset questions to the 2001 YRBS to gather information on youth assets in relation to youth risk taking behavior. Maine also uses: "Do you feel that in your community, you feel like you matter to people." Region 1 used this approach of assessing

population assets in addition to a population needs in the 2005 Title V MCH Needs Assessment. Choosing a youth asset indicator for Priority Goal #5 is viewed as a strategy to operationalize the assessment of youth assets in addition to analyzing youth risk-taking behavior ***/2009/ The new national survey of children and youth with special health needs and their families has used a different methodology to assess the degree to which families feel that their children have the support necessary to transition to adulthood. See NPM #6 for efforts to improve the state's performance in this priority area //2009//***

6. Communities provide safety and support for families. SPM: % Vermont cities and towns (population of over 2,000) with at least 1 organized physical activity program in place that is open to all and promoted as a family activity. The Blueprint and the Obesity prevention plan, along with ongoing programs such as WIC, offer several initiatives to encourage communities to enhance residents' health by creating opportunities to be physically active.

7. All children, including CSHN, receive continuous and comprehensive health care within a medical home. SPM: % children under age 16 with SSI whose primary care provider has billed Medicaid for a comprehensive annual care plan. There are two strategies to achieving this goal, adequacy of insurance, and availability of Medical Homes. CSHN program enrollment information in 2004 shows 20% of children in CSHN programs do not have any insurance. 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. See HSCI 8 and SPM 07. ***/2008/With some reorganization within CSHN, increasing focus on child development activities and relation to the medical home, specific outreach to PCPs to increase their capacity for comprehensive care planning will include: developing/disseminating models for care plans; information about effective billing for care plans; connecting care plans to CSHN enabling services. See Attachment for results of 2005 P2P parent phone survey on the six CSHN national performance measures//2008// /2009/ Promotion of developmental screening within the medical home is a major focus of the VT-AAP chapter, VCHIP, and MCH/CSHN/CDC for the coming year, beginning with the roll-out of the new AAP Bright Futures guidelines through regional meetings to which early intervention and primary care providers are invited. The new CSHN SI grant will support activities particularly in the medical home and financial support of health care outcomes. In addition, our partnership with P2P will continue to support P2P activities in support of improved access to medical homes for CYSHCN //2009//***

8. All children receive continuous and comprehensive oral health care within dental home. SPM: % children using Medicaid who use dental services in one year time period.

The VDH Office of Oral Health works in concert with dental providers to achieve a system which encourages quality dental care as provided in a dental office where comprehensive continuous care can be achieved. Tooth Tutor dental hygienists to provide assessment and referral of students to a local dental home. VDH assists dentists with grants, loan repayments, and recruitment and retention efforts in order to ensure adequate workforce for a dental home. Planning and new initiatives have resulted from the 2005 Oral Health Plan - See Section III B, III F/HSCI 7, NPM 9. ***/2009/ P2P devoted an article in their newsletter, "The Heart of It", to dental homes and CSHCN. This newsletter has a circulation of about 6,000 //2009//***

9. Children and families are emotionally healthy. SPM: % children with emotional, developmental, or behavioral problems requiring treatment or counseling who received needed mental health services in the past year. Nationally, 58.7% of children with ongoing emotional, developmental, or behavioral problems needing treatment or counseling received mental health care as reported in the 2005 NSCH. Children with health insurance, public or private, are more likely to receive the mental health services they need. Of these children needing services who are without health

insurance, only 33.8% received any mental health care or counseling. (National rate is 58.7%, NS-CH) /2008/ Working closely with partners at the Vermont Child Health Improvement Program (VCHIP: a statewide child health quality improvement organization based at UVM College of Medicine) MCH staff have assisted in the development of several children's mental health initiatives. A multidisciplinary workgroup that included pediatricians, family physicians, psychiatrists, psychologists, and representatives from public and private mental health agencies has been meeting regularly to develop a vision and framework for addressing gaps in the delivery of mental health services for Vermont's children and families -- this group will continue to meet throughout this coming year. Specific projects include: Vermont's ADHD (Attention Deficit Hyperactivity Disorder) Initiative, through which primary care providers (PCP's) are supported in delivering high quality diagnostic and treatment services to school-age children with ADHD. Treatment plans are developed to target a child's individual strengths and weaknesses, bring together educational and medical interventions, and help eliminate gaps in the child's services or medical care. In addition, planning is developing pilot projects to place mental health professionals in pediatric offices. This collaborative model links the community mental health agency with physician practices and uses a team approach to assist primary care providers integrate new processes for mental health services into their practices; gives them the tools needed for screening, diagnosis, treatment and on-going management; and provides psychiatric consultation services to the physician. It assures that children needing services of a licensed mental health therapist receive individual therapy, case management and connection to other resources on site or through the community mental health agency. Medicaid reimbursement for services covers the costs of these interventions. This initiative has increased the number of children receiving services overall and reduced the waiting time for child psychiatry services by several months. Five different pediatric practices in Vermont now have a mental health staff person in their offices in addition to two hours a week of psychiatric consultation. In response to the needs of individuals with autism spectrum disorders (ASD) - Act 35: 2007 legislation requires the creation of an interagency proposal for a coordinated, life-long system of care designed to address the needs of individuals with ASD and their families. Development of proposal by a task force chaired by AHS and consisting of a broad array of health professionals and families. VDH is working with the Early Intervention Subcommittee of the task force to address issues of increasing access to early intervention services for children aged 0-5 years with ASD//2008// //2008// **/2009/ CSHN participated in the development of the state autism plan, which includes 20 goals and associated objectives. CSHN is focusing on the redesign of its Child Development Clinic component, with new support from the MCHB CSHN SI grant. Children with an autism spectrum disorder comprise the largest portion of all children receiving diagnostic services at CDC, a striking increase from one and two decades ago. CDC is now in the 7th year of contracting with a child psychiatrist with special expertise in the care of the children with developmental disabilities, to provide consultation and team-based direct service for children in CSHN as needed. In addition, CDC will begin providing training opportunities for UVM child psychiatry fellows beginning in July, 2009. CSHN is also exploring the possibility of collaborating with FAHC-based child psychologists. See discussion IV D SPM 9 //2009//**

10. Children and families live in healthy environments. SPM: % one year olds screened for blood lead levels. Children are most vulnerable to lead poisoning when they are under six years old, and especially at ages one and two when they normally exhibit hand-to-mouth behavior. The CDC recommends children be screened for lead poisoning at ages one and two years. VT has the second oldest housing stock in the nation - 60% built before 1978 when lead paint was banned. In 2006, the Commissioner of Health and Attorney General established a joint task force to research and evaluate the myriad of issues surrounding lead poisoning, to develop recommendations for reducing the prevalence of childhood lead poisoning, and to coordinate efforts between VDH and the state and community partners tasked with lead abatement projects. VDH's Childhood Lead Prevention Program (CLPPP) has three focus areas: primary prevention, testing and surveillance, case management of lead poisoned children. A statewide task force met in January 2006. /2008/Proposed legislation for the 2008 legislative session will strengthen several enforcement and regulatory issues such as definition of lead hazards, definition of rental

housing, increase fees for lead abatement projects, and simplify EMP requirements. The definition of an elevated blood lead level will be lowered from 10 to 5µg/dL.//2008// ***/2009/ Two new pieces of legislation passed dealing with many issues of lead poisoning prevention, screening and education such as: defining Vermont elevated blood lead level as 5µg/dL or greater, sets screening targets for 1 year olds (85% screened) and 2 year olds (75%) that must be met by health care private/public clinical systems by January 2011 otherwise the Commissioner of Health must issue rules to require screening, updates essential maintenance practices, updates requirements for real estate transactions, prohibits unsafe work practices, expands requirements for child care centers in building built pre-1978. VDH is providing training to primary care practices in lead screening so as to meet new statewide screening targets and collaborating with Medicaid about possibility of practitioner reimbursement //2009//***

## C. National Performance Measures

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

### Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	99.9	99	99.5	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	5	5	5	7	4
Denominator	5	5	5	7	4
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	100	100	100	100	100

#### a. Last Year's Accomplishments

1. Continuing to implement the expanded NBS panel.
2. Addition of CF scheduled to begin October 2007. Implemented in March 2008.
3. Continue program activities to insure that all infants are screened and none are lost to follow up.
4. Continue cross-border NBS and EHDI efforts. These continue to be person-to-person efforts.
5. Hold public hearings; implement new fee structure to reflect costs of NBS and EHDI efforts accomplished. The fee is now nearly \$100 per infant. Rather than being charged by filter paper, hospitals are billed by the in-hospital birth, because the fee represents follow-up costs (as well as FP costs), and follow-up is provided to all infants--even more for infants who miss their screens.

6. Continue active participation and leadership in NERGG. As states become more experienced with the expanded panel, VT also benefits from the shared wisdom afforded especially by participation in region-wide collaboration. The CSHN medical social worker for the Metabolic Clinic/Program and the NBS chief participate in relevant activities. A senior Special Education faculty member from the UVM UAF has agreed to participate in a special education related NERGG project.

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to implement the expanded NBS panel.			X	X
2. Continue outreach and follow-up for CF screening	X		X	X
3. Continue program activities to insure that all infants are screened and none are lost to follow up.	X		X	X
4. Continue cross-border NBS and EHDI efforts.			X	X
5. Continue active participation and leadership in NERGG			X	X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

AS ABOVE and the following:

1. Continue to implement the expanded NBS panel.
2. Addition of CF scheduled began March, 2008
3. Continue program activities to insure that all infants are screened and none are lost to follow up.
4. Continue cross-border NBS and EHDI efforts.
5. Held public hearings; implemented new fee structure to reflect costs of NBS and EHDI efforts.
6. Continue active participation and leadership in NERGG

**c. Plan for the Coming Year**

AS ABOVE and the following:

1. Continue to implement the expanded NBS panel.
2. Continue the greatly expanded follow-up effort and system adjustments needed in the new implementation of CF screening.
3. Continue program activities to insure that all infants are screened and none are lost to follow up.
4. Continue cross-border NBS and EHDI efforts.
5. Continue active participation and leadership in NERGG

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
---------------------------------------	------	------	------	------	------

Annual Performance Objective	57.4	57.4	57.4	60	60
Annual Indicator	57.4	57.4	57.4	57.4	59.8
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	65	65	65	70	70

**Notes - 2007**

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

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

**Notes - 2005**

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

**a. Last Year's Accomplishments**

1. Continued written expectation of family centered care in grants and contracts.
2. Continued regular meetings with Parent to Parent/VPIC about child/family needs and coordination of initiatives
3. Continued regular meetings with Children's Hearing Health advisory council whose membership includes significant parent representation.
4. Planned for improved/timely Title V review efforts with P2P/VPIC
5. Reinstated parent (and professional) mail-back surveys for every Child Development Clinic visit.
6. Promoted young adult involvement as a project advisor in VCHIP (contractor) quality improvement activities with FAHC clinics serving children with endocrine disorders.
7. Continued significant infrastructure support for P2P and VPIC.

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. Continue written expectations of family centered care in (direct service) grants and contracts.	X	X		X
2. 2. Continue regular meetings with Parent to Parent/VPIC about child/family needs and coordination of initiatives.				X
3. 3. Continue regular meetings with advisory councils whose membership includes significant parent representation.				X
4. 4. Continue improved/timely Title V review efforts with P2P/VPIC				X
5. 5. Reinstated parent (and professional) mail-back surveys for every Child Development Clinic visit; these will continue in a cyclical (few months "on", few months "off") sample.				X

6. 6. Continue to promote parent and young adult involvement as a project advisors in VCHIP (contractor) quality improvement activities with programs serving children with chronic illnesses. The CSHN medical director is the VDH liaison to this				X
7. 7. Continue significant infrastructure support for P2P and VPIC. P2P and VPIC are merging July 1, 2008 to form Vermont Family Network, and we will continue our grantor relationship.				X
8. 8. Parents have a core role in the implementation of the new CSHN SIG grant.				X
9.				
10.				

**b. Current Activities**

As above and also the following:

1. P2P takes a primary role in supporting parents as leaders, through the Family Faculty Program at UVM, which trains parents to teach family-centered care to medical, speech, education and physical therapy students. Each year 30 trained families teach over 200 pre-professional students. With Title V infrastructure support, P2P also supports parents in stronger advocacy and as informed consumers of health care, and provides support for parent attendance at conferences.
2. The Partners in Care conference was held in December, 2007, reaching over 250 parents and professionals in an atmosphere of true parent engagement and partnership.
3. The P2P listerv has grown by 3 new members each week, now totalling 234. P2P also supported a leadership team in Franklin and Grand Isle counties.
4. Applied successfully for a new CSHN HRSA SI grant, whose implementation will include parents at every level and phase.

**c. Plan for the Coming Year**

As above and also the following:

1. Continue written expectations of family centered care in (direct service) grants and contracts.
2. Continue regular meetings with Parent to Parent/VPIC about child/family needs and coordination of initiatives.
3. Continue regular meetings with Children's Hearing Health advisory council whose membership includes significant parent representation.
4. Continue improved/timely Title V review efforts with P2P/VPIC
5. Reinstated parent (and professional) mail-back surveys for every Child Development Clinic visit; these will continue in a cyclical (few months "on", few months "off") sample.
6. Continue to promote parent and young adult involvement as a project advisors in VCHIP (contractor) quality improvement activities with programs serving children with chronic illnesses. The CSHN medical director is the VDH liaison to this effort, and the MCH Director has a key role in the oversight of VCHIP.
7. Continue significant infrastructure support for P2P and VPIC. P2P and VPIC are merging July 1, 2008 to form Vermont Family Network, and we will continue our grantor relationship.
8. Parents have a core role in the implementation of the new CSHN SIG grant.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	56.5	56.5	56.5	60	60
Annual Indicator	56.5	56.5	56.5	56.5	51.6
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	60	62	62	65	65

**Notes - 2007**

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

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

**Notes - 2005**

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

**a. Last Year's Accomplishments**

1. The new CDC model in St. Albans continued. A retirement requires us to recruit a new medical social worker for the team. Update: With the planned position reductions in state government, we have not been able to hire a replacement MSW. However, we have rearranged current social work responsibilities to allow for continued operation of the St. Albans site.
2. The NEAT team (in Newport, involving community, CDC, and PCP) has continued on a monthly basis.
3. CSHN's role in authorizing therapy services for children in Part C early intervention has given us an opportunity to insure that the PCP is involved in the medical oversight of medical Part C services, when CSHN is asked to be a payer for services.
4. Continued our CDC based child psychiatry consultation model for children with developmental disabilities enrolled in CSHN. The child psychiatrist uses a model whereby the medication management is transitioned to the PCP, with ongoing support and consultation as needed. The need for this care continues to grow; we were able to increase clinical psychiatry hours slightly.
5. The percentage of CSHN enrolled children with an identified PCP: Our enrollment data, at the time of this report, indicates that 85.4% of enrolled children have an identified PCP.

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. Maintain the number (10, of 12) regional sites for Child Development Clinic and their opportunity for on site consultation with PCPs.	X	X		X
2. 2. Continue the NEAT team (in Newport, involving community, CDC, and PCP) monthly.		X		X
3. 3. Continue to promote the centrality of the PCP role in systems which traditionally have stepped over the PCP role: Medical authorization for Part C and Part B services; care plan writing and reimbursement (see SPM#7		X		X
4. 4. Continue our CDC based child psychiatry consultation model for children with developmental disabilities enrolled in CSHN.	X	X		X
5. 5. Track the percentage of CSHN enrolled children with an identified PCP.		X		X
6. 6. Focus on PCP collaboration in CSHN SIG implementation.		X		X
7. 7. Complete regional meetings, with the AAP/AAFP, AHS Building Bright Futures, and community providers, to roll out the new Bright Futures guidelines and to promote PCP involvement in their local BBF councils.				X
8. 8. Continue support to P2P in their dissemination of the Medical Home brochure, The Heart of It newsletter, and inclusion of topics of interest to medical homes in their annual conference.		X	X	X
9.				
10.				

**b. Current Activities**

As above and the following:

1. We included a significant collaboration with the VT chapter of the AAP and with individual PCPs (through surveys) in our successful application for the CSHN SI grant.
2. We have begun regional meetings, with the AAP/AAFP, AHS Building Bright Futures, and community providers, to roll out the new Bright Futures guidelines and to promote PCP involvement in their local BBF councils.
3. Parent to Parent has created and disseminated a Medical Home brochure (10,000, in this year and the past two years). In addition, its newsletter, with a circulation of about 6,000, provides numerous articles about how parents can help pediatricians to create a medical home. This year also included an article about dental homes for CSHCN.

**c. Plan for the Coming Year**

As above and the following:

1. Maintain the number (10, of 12) regional sites for Child Development Clinic and their opportunity for on site consultation with PCPs.
2. Continue the NEAT team (in Newport, involving community, CDC, and PCP) monthly.
3. Continue to promote the centrality of the PCP role in systems which traditionally have stepped over the PCP role: Medical authorization for Part C and Part B services; care plan writing and reimbursement (see SPM#7)
4. Continue CDC based child psychiatry consultation model for children with developmental disabilities enrolled in CSHN.
5. Track the percentage of CSHN enrolled children with an identified PCP.
6. Focus on PCP collaboration in CSHN SIG implementation.
7. Complete regional meetings, with the AAP/AAFP, AHS Building Bright Futures, and community providers, to roll out the new Bright Futures guidelines and to promote PCP involvement in their

local BBF councils.

8. Continue support to P2P in their dissemination of the Medical Home brochure, The Heart of It newsletter, and inclusion of topics of interest to medical homes in their annual conference.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	68.7	68.7	68.7	72	72
Annual Indicator	68.7	68.7	68.7	68.7	69.4
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	72	75	75	75	75

**Notes - 2007**

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

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

**Notes - 2005**

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

**a. Last Year's Accomplishments**

1. Continued to assist families with Medicaid applications and in understanding how to access their benefits.
2. Continued to review monthly which families have lost their Medicaid, and why; we identify their CSHN primary contact person to alert them that 'their' families are losing critical health insurance coverage.
3. Continued in FY07 to provide an increasing number of assessments and reassessments to help families access personal attendant care services.
4. Continued to assist some families with the purchase of private insurance.
5. Continued to advocate with Medicaid as we identify need for policy clarification or adjustment.
6. With the expansion of CSHN coverage for hearing aids (up to age 21), we continued to require families (who appear to meet medicaid income criteria) to apply for medicaid, when applying for CSHN hearing aid coverage.
7. Continued regular meetings with Parent to Parent/VPIC
8. Continued infrastructure support to P2P for its specific outreach to families about understanding and accessing their health care coverage. P2P created the monograph, "6 Ways to Access Medicaid"--a tool both for parents and professionals, including our CSHN staff. (The

monograph was rewritten and updated this year, see below.)

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to assist families with Medicaid applications esp with understanding as to how to access benefits.		X		X
2. Continue to review monthly which families have lost their Medicaid and why; Identify these families primary CSHN contact person to alert them that "their" family is losing critical health insurance coverage.		X		
3. Staff cuts will continue to reduce our ability in FY09 to provide assessments and reassessments to help families access personal attendant care services. We will work with the Medicaid PCS program to find alternative resources for this service.		X		X
4. Continue to assist selected families with the purchase of private insurance.		X		
5. Continue to advocate with Medicaid as we identify need for policy clarification or adjustment.		X		X
6. With the expansion of CSHN coverage for hearing aids (up to age 21) continue to require families (who appear to meet Medicaid income criteria) to apply for Medicaid, when applying for CSHN hearing aid coverage.		X		X
7. Continue regular meetings with P2P/VPIC and follow up to parent survey on six performance measures.			X	X
8. Our CSHN SI grant will focus on financial access to health care.				
9. Continue to stretch CSHN safety net through a combination of provider agreements/contracts, strict use of upstream payers, and negotiated discounts for services we prescribe/authorize.		X		X
10. Continue to provide infrastructure support to P2P for its many supports to parents; P2P will complete the update of the 6 Ways to Access Medicaid monograph and disseminate it. .			X	X

**b. Current Activities**

As above and the following:

1. A P2P staff member, who understands Title V and CSHN mission and programs, is the new chair of the powerful statewide Medicaid Advisory Board.
2. The new CSHN SI grant focuses, in part, on this financial CSHCN outcome and strengthening financial access.
3. Staff cuts have reduced our ability to provide PCS application and renewals.
4. Continue to seek and implement a combination of provider agreements, strict use of upstream payers, and negotiated discounts, to provide help to CSHN families.
5. P2P is updating its monograph, "6 Ways to Access Medicaid", with a distribution date of September, 2008. Expansion areas include: Medical Homes, commercial insurance, and transition to adult medicaid programs. In FY07, P2P reports that 61% of the families served had Medicaid coverage for their CSHCN. In the first 6 months of FY08, P2P provided 498 hours of one to one support to families on Medicaid information and assistance and outreach.
6. P2P assists families with Katie Beckett applications.

**c. Plan for the Coming Year**

As above and the following:

1. Staff cuts will continue to reduce our ability in FY09 to provide assessments and reassessments to help families access personal attendant care services. We will work with the Medicaid PCS program to find alternative resources for this service.
2. CSHN SI grant will focus on financial access to health care.
3. Continue to seek and implement a combination of provider agreements, strict use of upstream payers, and negotiated discounts, to provide help to CSHN families. This is an ever-shifting landscape as the rest of the health care financing picture changes around us and families.
4. P2P will complete the update of the 6 Ways to Access Medicaid monograph and disseminate it.
5. Continue to provide infrastructure support to P2P for its many supports to parents.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	72.7	72.7	72.7	75	75
Annual Indicator	72.7	72.7	72.7	72.7	89.3
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	92	92	95	95	95

**Notes - 2007**

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

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

**Notes - 2005**

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

**a. Last Year's Accomplishments**

1. Maintained CDC clinics in all 10/12 regions, despite the loss of the MSW staff in two regions.
2. As state government reduces positions through attrition, our programs have lost several nursing and social work staff and there is uncertainty which, if any, may be refilled. These positions provide direct support to families in their regions and clinics and make the "system" usable and accessible for families.
3. Continued participation in AHS interagency planning groups and also the newly forming study

group on ASD (Act 35.) in response to the legislative interest and advocacy in the creation of a better system of care for individuals with ASD.

4. Continued the CDC/CSHN child psychiatry model to build capacity to serve children with developmental disabilities who also have behavioral/mental health issues.
5. Not yet able to complete expansion, in 2007, of collaboration with Dartmouth Hitchcock Medical Center but have a contract for SFY 09
6. Continued regular meetings with P2P/VPIC to address issues identified through their contact with families.
7. Continued infrastructure support to P2P/VPIC for their uniquely valuable work in helping parents navigate the "system."

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. Continue to maintain statewide distribution of CDC clinics.	X	X		X
2. 2. Continue to redistribute CSHN clinical staff to provide direct support to families in their regions and clinics and make the "system" usable and accessible for families. families.		X		X
3. 3. Continue participation in AHS interagency planning groups and also the newly forming study group on ASD (Act 35.) in response to the legislative interest and advocacy in the creation of a better system of care for individuals with ASD.				X
4. 4. Continue the CDC/CSHN child psychiatry model to build capacity to serve children with developmental disabilities who also have behavioral/mental health issues.	X	X		X
5. 5. Implement the expansion of collaboration with Dartmouth Hitchcock Medical Center for Child Development Clinic services for the eastern part of the state.	X	X		X
6. 6. Continue infrastructure support of and regular meetings with Vermont Family Network (formerly P2P/VPIC) to address issues identified through their contacts with families.			X	X
7. 7. Collaborate with transitional and new medical directorship at Medicaid especially around case management programs affecting CYSHCN.		X		X
8. 8. Provide leadership of system design (and integration of the "integration initiatives") through the support of the CSHN SI grant.				X
9.				
10.				

**b. Current Activities**

As above and the following:

1. Vermont has been awarded a CSHN State Improvement grant; the theme of Family Professional Partnerships is infused throughout our vision. The SIG will be sued for for planning and implementation, with a focus on the outcomes of Medical Home, Health Insurance and Financing, and Community Integrated Services. As AHS takes very seriously the need for services to be organized so families can use them easily, multiple "integration" initiatives have the potential to complicate the system. The SI grant supports CSHN leadership in creating synergy among these initiatives.
2. The medical directorships of VT Medicaid and also the Medicaid case management programs is in transition, due to resignations. At this writing, there are no new hirings into these key positions.
3. P2P provides support to families to help them navigate the system, through one on one

contacts with staff, website, listserv, and matches with veteran parents. This core service of P2P, through CSHN support, reaches over 4,000 families. In the first half of FY08, P2P provided one to one support on issues related to the six core outcomes for CYSHCN. Many contacts reflect difficulties families experience in accessing services they need. For example, 152 hours were spent on Personal Attendant Care services and/or nursing issues. 799 hours were spent on helping families with referrals to needed resources.

**c. Plan for the Coming Year**

1. Continue to maintain statewide distribution of CDC clinics.
2. Continue to redistribute CSHN clinical staff to provide direct support to families in their regions and clinics and make the "system" usable and accessible for families.
3. Continue participation in AHS interagency planning groups and also the newly forming study group on ASD (Act 35.) in response to the legislative interest and advocacy in the creation of a better system of care for individuals with ASD.
4. Continue the CDC/CSHN child psychiatry model to build capacity to serve children with developmental disabilities who also have behavioral/mental health issues.
5. Implement the expansion of collaboration with Dartmouth Hitchcock Medical Center for Child Development Clinic services for the eastern part of the state.
6. Continue infrastructure support of and regular meetings with Vermont Family Network (formerly P2P/VPIC) to address issues identified through their contact with families.
7. Collaborate with transitional and new medical directorship at Medicaid especially around case management programs affecting CYSHCN.
8. Provide leadership of system design (and integration of the "integration initiatives") through the support of the CSHN SI grant.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	5.8	5.8	5.8	7.5	7.5
Annual Indicator	5.8	5.8	5.8	5.8	52
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	55	55	58	58	60

**Notes - 2007**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the

sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

The numerator for this measure was 4 - which was below the minimum (n=50) required for calculation of a statistically reliable rate.

**Notes - 2005**

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

The numerator for this measure was 4 - which was below the minimum (n=50) required for calculation of a statistically reliable rate.

**a. Last Year's Accomplishments**

1. Continued the pediatric psychiatry clinic and expanded its location to two more regional sites. This multidisciplinary clinic serves children with complex physical disabilities, especially the teen population, with a comprehensive look at activities of daily living and independence skills.
2. Continued to provide support to the Continence Project, in collaboration with the Department of Aging and Independent Living and the Department of Education, to help families and children with this important life skill.
3. Continued participation in the Hi-Tech and TBI Waiver programs' advisory groups.
4. Continued to participate in the adult CF clinic.
5. Continued to collaborate with P2P/VPIC on identifying transition system needs.
6. See SPM 9 - Achieved state wide implementation of JOBS program which links mental health services to education and employment for transition age youth who have dropped out of school and/or have been involved with juvenile justice or adult corrections.

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. Continue the pediatric psychiatry clinic at three regional sites.	X	X		X
2. 2. Continue to provide support to the Continence Project, in collaboration with the Department of Aging and Independent Living and the Department of Education, to help families and children with this important life skill.		X		X
3. 3. Continue participation in the Hi-Tech and TBI Waiver programs' advisory groups.				X
4. 4. Continue to provide fiscal and social work support to the VT adults in the adult CF clinic, and young women in the metabolic program.	X	X		X
5. 5. Continue to collaborate with P2P/VPIC on identifying transition system needs.			X	X
6. 6. The CSHN medical director will participate as a new member of the VT Developmental Disabilities Council, with a focus on the transition subcommittee and transition projects.			X	X
7.				
8.				

9.				
10.				

**b. Current Activities**

As above and also the following:

1. The CSHN metabolic program is providing support to women of childbearing age who wish to return to a PKU diet in order to prepare for a healthy pregnancy.
2. The CSHN medical director was appointed to the Developmental Disabilities Council, a group which traditionally has focused on the services of youth and adults with developmental disabilities.
3. The Partners in Care conference, 12/07, led by Parent to Parent, included transition topics, and was attended by 250 parents and providers.
4. The VPIC Transition Conference (spring, 2008) likewise included a health care transition track and was attended by 150.
5. The rewrite of "6 Ways to Access Medicaid" has a new section on transitioning to the adult health care system and its financing.

**c. Plan for the Coming Year**

1. Continue the pediatric physiatry clinic at three regional sites.
2. Continue to provide support to the Continence Project, in collaboration with the Department of Aging and Independent Living and the Department of Education, to help families and children with this important life skill.
3. Continue participation in the Hi-Tech and TBI Waiver programs' advisory groups.
4. Continue to provide fiscal and social work support to the VT adults in the adult CF clinic, and young women in the metabolic program.
5. Continue to collaborate with P2P/VPIC, as the new Vermont Family Network, on identifying transition system needs. There will be a two-day conference in 2009 which combines the Partners in Care and the Transition Conferences.
6. The CSHN medical director will participate as a new member of the VT Developmental Disabilities Council, with a focus on the transition subcommittee and transition projects.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	90	90	90	90	90
Annual Indicator	84.3	83.2	83.2	84.3	
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	90	90	90	90	

**Notes - 2007**

Reflects the 4:3:1:3 schedule for Q42006 - Q1/2007. Percentage for this same time period for the 4:3:1:3:3:1 schedule is 75.2%.

**Notes - 2006**

Reflects the 4:3:1:3 schedule for Q3/2005 - Q2/2006. Percentages for this same time period are 4:3:1:3:3 is 83.3 % and for 4:3:1:3:3:1 is 68%. NOTE: For FY09 Application, this figure is updated to reflect the full 2006 calendar year.

**Notes - 2005**

Data is from NIS for July, 2003-June, 2004. Reflects the 4:3:1:3: schedule. The percentage is entered - the acutal numerator and denominator are not available. The data for 2005 is not yet available at the time of the preparation of this report.

**a. Last Year's Accomplishments**

1. District Offices held monthly iz clinics based on demand and staffing capacity. Intervention primarily needed when there are barriers to accessing the medical home, such as not having medical insurance. Families contacted by phone/letter when due for next Iz.
2. Iz screening and follow up is conducted routinely for all children seen in WIC clinics. Follow up services include assistance in locating a regular health care provider, obtaining the child's most current immunization record from their primary care provider, in understanding Medicaid benefits related to immunization, and transportation assistance. When needed, vaccines are administered through the VDH District Office and the information is shared with the Primary Care Provider.
3. Ongoing distribution of a one page "Have Your Tots Had all their Shots" flyer, features a simplified immunization schedule and a toll free phone number to reach VDH Iz Program for more information.
4. Ongoing - via EPSDT - Post cards with the most recent immunization schedule mailed to Medicaid parents at 3 months, 8 months, and 20 months reminding them their child was due for immunizations.
5. VDH works with Refugee Resettlement to facilitate Iz and informed consent for refugees.
6. Ongoing distribution of Path to Parenthood to all pregnant mothers - includes section on Iz.
7. Ongoing distribution of Growing Up Healthy, with information on Iz, to all parents while still in hospital after birth of baby.
8. 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.
9. Using CASA software, assess 2 year olds in VDH programs - identify and inform parents if their child needs Iz.
10. VDH staff stay informed on Iz topics via a variety of methods, including distance learning (CDC and California DL Health Network)
11. 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.
12. Regular AFIX reporting from provider sites.
13. Continuing incremental increase in the number of children enrolled and practices participating in the Immunization registry.
14. Begin to set process for receipt and distribution of new vaccines, such as Rotovirus.
15. Provider manual created and distributed containing up to date clinical information regarding vaccine administration.
16. Maintenance of immunization section on VDH website and updating with crucial new information

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Ongoing immunization clinics held by VDH district offices.	X			
2. VFC program ensures universal access for Vermont children to immunizations.	X		X	

3. Continued expansion of Vermont Immunization Registry.				X
4. EPSDT/HBKF programs for outreach to families provides support for accessing immunization services.	X	X		
5. AFIX program to support clinical practices in increasing rates of fully immunized clients.		X		
6. Coordinate with child care programs to support families to fully immunize their children.	X	X		
7. Implement new legislatively updated list of vaccines required for school entry.			X	
8. Increased number of schools reporting Iz status electronically			X	
9. Enhanced outreach to physicians to improve rates of fully immunized children.			X	
10. New statewide ordering and distribution system incorporating new federal and state financing sources.			X	X

**b. Current Activities**

As listed above and including the following:

1. Implement process for adding of new vaccines required for school entry
2. Legislative rules change increasing number of vaccines required for school entry effective as of August 2008.
3. Enhanced outreach to providers in collaborative effort to increase vaccination rates for 4:3:1:3:3:1 schedule (including varicella)
4. Revision and expansion of immunization information and resources on VDH website.
5. Changes in Vaccine distribution system as of July 1, 2008. VDH Central Immunization Office takes orders directly from providers and arranges for shipments. Combined state and federal funds pay for vaccine - system is seamless to front line provider.
6. Move to a web-based school Iz reporting mechanism replacing inefficient paper system.

**c. Plan for the Coming Year**

As listed above and including the following:

1. Continued planning for universal access to vaccines for all Vermonters as legislated by Catamount statute - will benefit adults and children of all ages.
2. Continue to implement new childhood vaccine schedule and outreach to providers in collaborative effort to increase vaccination rates for 4:3:1:3:3:1 schedule (including varicella)
3. Expand school immunization reporting system to include private schools.
4. Continue implementation of new statewide immunization ordering and distribution system.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	10	10	6	6	6
Annual Indicator	6.7	8.2	8.1	8.1	
Numerator	88	109	107	106	
Denominator	13208	13274	13248	13153	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	6	6	6	5	5

**Notes - 2007**

Population estimate (denominator) for 2007 is based on estimate for 2006 and is subject to change. Vital statistics for births in 2006 and 2007 are preliminary, and are also subject to change.

**Notes - 2006**

Vital statistics for VT births in 2005 and 2006 are still preliminary. Final values for 2005 should be available in the Fall of 2008.

**a. Last Year's Accomplishments**

1. Priority is given to outreach to pregnant teens and their families including: home visits, classes and support groups, transportation to medical appointments, labor support as needed, support with educational needs.
2. 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. Similar programs are found in other Parent Child Centers statewide.
3. Teens enrolled in HBKF are strongly encouraged to finish high school or their G.E.D. and given support for prevention of second pregnancy.
4. Coordination with organizations such as Parent Child Centers, Department of Education, and Planned Parenthood to support general prevention programs and also education efforts directed at teens considered "at-risk"
5. Coordination with VCHIP, AAP, AHS, and Department of Education on broad prevention efforts using Assets-based approach to working with teens and their families.
6. Support for community and state wide activities to postpone subsequent pregnancies due to higher infant morbidity and mortality rates when pregnancies occur in younger women (15-18) and are spaced less than two years apart.
7. Continue to work with schools and the communities to provide esteem building and future directed programs for teenage girls.
8. Support physical activity initiatives such as Run Girls Run and Fit and Healthy Kids to build esteem and educate importance of personal health.
9. Coordinate with Department of Children and Families to promote pregnancy prevention theme in planning prevention programs for children and adolescents.
10. Coordination with Planned Parenthood and VDH on Male Initiative designed to impart information on relationships and sexuality to young men, ages 18-24.

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

<b>Activities</b>	<b>Pyramid Level of Service</b>
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	DHC	ES	PBS	IB
1. Services give priority to teens who are parenting and are at risk for subsequent pregnancies.	X	X		
2. Pregnancy prevention programs for at risk teens via Parent Child Centers, schools and other community organizations.	X	X		
3. Collaboration with VCHIP, AAP, AHS, and Department of Education on broad prevention programs for all teens, using asset-based approaches.		X		
4. Self-esteem and physical activity programs such as Run Girls Run and Fit and Healthy.	X	X		
5. Website for young men containing reproductive health and sexuality information.	X	X		
6. Creating system of dispensing emergency contraception via collaborative practice protocols.	X			X
7.				
8.				
9.				
10.				

**b. Current Activities**

Programs as listed above and also the following:

1. Planning for strengthened coordination with local youth serving agencies as the VDH realignment creates new structures for Local Health and MCH.
2. VDH role in operationalizing a statewide system of dispensing emergency contraception via collaborative practice - as a result of Act 101 passed in 2006. Pharmacist training held in 2007.
3. Local activities such as Rutland teen pregnancy prevention conference for school nurses and other community partners.

**c. Plan for the Coming Year**

Activities as listed above and also the following:

1. Continued coordination with community agencies via the new VDH realignment structure.
2. VDH role in operationalizing a statewide system of dispensing emergency contraception via collaborative practice - a second pharmacist training to be held to enable participation in collaborative practice system.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	67	68	69	70	71
Annual Indicator	66.3	66.3	66.3	66.3	66.3
Numerator	271	271	271	271	271
Denominator	409	409	409	409	409
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is					

fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	72	72	75	75	75

**Notes - 2007**

Data is from a one-time non invasive screening of 1,238 children in grades 1-3 in the year 2002-2003. There has not been another screening conducted since that time. Medicaid data indicates there were 1,434 children ages 6-9 years receiving sealants during FFY07. The Medicaid data is not reported as a percentage here due to inability to determine a denominator of Medicaid children of that age group who need sealants.

**Notes - 2006**

Data is from a one-time non invasive screening of 1,238 children in grades 1-3 in the year 2002-2003. There has not been another screening conducted since that time. Medicaid data indicates that there were 1,452 children receiving sealants during FFY06.

**Notes - 2005**

Data is from a one-time non invasive screening of 1,238 children in grades 1-3 in the year 2002-2003. There has not been another screening since that time. However, Medicaid data shows that there were 1,472 children receiving sealants during FFY05 (or 30% of those children ages 6-9 using Medicaid during FFY05.)

**a. Last Year's Accomplishments**

1. Ongoing collaboration with EPSDT for dental outreach and access to care activities.
2. Ongoing collaboration with Tooth Tutor and fluoride programs (school-based and community water systems). Expansion of these programs as capacity and funding allows.
3. Beginning planning for implementation of the 12 strategies from the Oral Health Plan. Legislation authorized the "Dental Dozen" initiative and associated state funding.
4. Visits to every VDH District Office to promote the State Oral Health plan and to support community planning in appropriate follow up and action steps.
5. WIC screening of children and referral to dental services.
6. Collaboration with child care providers to supply education about oral health to their families.
7. Collaboration with DCF to incorporate oral health information into Child Care Health Consultant trainings and visits to child care facilities.

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC screening and referral of families for oral health services.	X			
2. EPSDT outreach and informing letters and focus on education about benefits of sealants.	X	X		
3. District level and planning for follow up to Oral Health Plan and Dental Dozen			X	X
4. Placement of dental hygienist in large pediatric office.	X		X	X
5. Placement of dental hygienists in four district offices.	X		X	X
6. Collaboration with PCPs to perform oral health assessments	X		X	X

and varnish applications on children up to age 3 years.				
7. Medicaid reimbursement for oral health assessments and varnish applications			X	X
8. FQHC offering clinical dental services.	X	X		
9.				
10.				

**b. Current Activities**

Activities as listed above and also the following:

1. Continue development of actions to collaborate with DCF to incorporate oral health information into Child Care Health Consultant trainings and visits to child care facilities.
2. Placement of dental hygienists in four VDH district offices.
3. Begin collaboration with VDH and AAP to train pediatricians to perform oral health screening of children ages 0-3 years and perform varnish applications.
4. Work with Dept of Education, local schools, Medicaid, to inform children and families about the benefits of obtaining age-appropriate sealants for children.

**c. Plan for the Coming Year**

Activities as listed above and also the following:

1. Actively seek new sources of funding to implement strategies in the Oral Health Plan (grants and state funding)
2. Continue planning to place a dental hygienist in large pediatric clinical practice.
3. Continue collaboration with VDH and AAP to train pediatricians to perform oral health screening of children ages 0-3 years and perform varnish applications. Seeking Medicaid reimbursement for varnish applications for children under age 3.
4. Planning to place dental hygienists in all VDH district offices.
5. Distribute educational information to families about the benefits of obtaining age-appropriate sealants for children.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	3	3	2	2	2
Annual Indicator	NaN	NaN	4.7		
Numerator	0	0	5		
Denominator	0	0	106116	106110	
Check this box if you cannot report the numerator because				Yes	
1. There are fewer than 5 events over the last					

year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	2	2	2	2	2

**Notes - 2007**

Vital statistics data for VT 2007 deaths - especially deaths occurring out-of-state - are not yet available. Preliminary data should be available by the end of 2008

**Notes - 2006**

In 2006, 3 children aged 14 or younger died due to motor vehicle crashes in Vermont, a number below the threshold for which rates are to be calculated. The 3-year average is also less than 5.

**a. Last Year's Accomplishments**

1. 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.
2. Continued development of the injury surveillance plan and surveillance capacity.
3. Reexamine other opportunities for collaboration with the Governor's Highway Safety Program, such as with car crash prevention and, specifically, in education of parents as they instruct their teen children on driving techniques.
4. VDH sponsor the Young Driver symposium in July 2006 - Continue with follow up on and work with partners to establish action plan.
5. Information about car seat safety and referral programs via VDH programs such as WIC.
6. Creation and distribution of informational booklet for Parents of teens drivers.
7. Beginning data analysis of injuries and deaths to children as a result of motor vehicle crashes and other events (such as off road crashes, etc.)

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinate with VDH/state government, and community organizations on traffic safety issues.			X	X
2. Continued development of the Injury Prevention Plan and Surveillance Plan via the Vermont Injury Prevention Program.			X	
3. Follow up to Young teen Drivers symposium in July 2006.			X	
4. Special data analysis as available via CDC and SSDI funded surveillance capacity.				X
5. VDH collaborative support of traffic safety programs in schools and communities.			X	
6. Referral of parents to safety seat resources via VDH programs.	X			
7. Collaboration with partners for appropriate legislation such as for primary enforcement of seat belt use.			X	
8. VDH participation on Child Fatality Review Team.				X

9. VCHIP project to identify and implement best practices for pediatric providers for counseling teens about safe driving behaviors.		X		
10.				

**b. Current Activities**

Activities as listed above and also the following:

1. VDH grant funded activities for VCHIP to identify and recommend public health policies and also best practices for pediatric providers when counseling teens about safe driving behaviors.

**c. Plan for the Coming Year**

Activities as listed above and also the following:

1. Continued analysis of data describing motor vehicle crashes and resulting morbidity and mortality - use of data in VDH strategic planning and in planning with partners such as the Child Fatality Review Committee and the VDH Injury Prevention Program.
2. Collaborate with partners to support appropriate safety legislation, such as primary enforcement for seat belt use.
3. Continue with VDH grant funded activities for VCHIP to identify and recommend public health policies and also best practices for pediatric providers when counseling teens about safe driving behaviors. Implement teen safe driving pilot intervention. Final report due June 2010.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				45	60
Annual Indicator			42.9	55.3	55.3
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	60	60	65	65	65

**Notes - 2007**

The 2007 rate is an estimate based on the 2004 rate from the National Immunization Survey. The numerator and denominator were not reported. In July 2007, CDC revised the way that breastfeeding rates were calculated, which are now based on year of child's birth. The 2007 and 2006 rates are therefore not comparable with 2005.

**Notes - 2006**

The 2006 rate is an estimate based on the 2004 rate from the National Immunization Survey. The numerator and denominator were not reported. In July 2007, CDC revised the way that breastfeeding rates were calculated, which are now based on year of child's birth. The 2005 and 2006 rates are therefore not comparable.

**Notes - 2005**

2004 data from the National Immunization Survey, where only % are provided, without numerator or denominator.

**a. Last Year's Accomplishments**

1. Continue with Breastfeeding Friendly Employer Project - TA to businesses and Breastfeeding Friendly Employer Designation.
2. Continue with electric, manual, and pedal breast pumps statewide distribution.
4. Ongoing community based activities of Breastfeeding Coalitions, such as "Baby Showers," educational activities, infant comfort stations at public events, posters, etc.
5. Develop local resource guides.
6. Training sessions for health care professionals.
7. Annual activities for World Breastfeeding Week, including proclamation from Governor.
8. Peer Counseling - developing breastfeeding peer counselor programs for WIC participants.
9. Updating of VDH website with Breastfeeding information about resources and VDH programs.
10. WIC medical home pilot in two districts - to improve healthy early feeding practices. WIC nutritionists are present in pediatric offices to offer nutrition education to families, enroll eligible families, and establish collaborative relationship with providers and office staff.
11. Hosted Dr. Nils Bergman, public health physician and research analyst, consultant from South Africa for medical Grand Rounds and interactive sessions with key medical and public health and community based breastfeeding advocates.
12. TA to Vermont birth hospitals who are considering seeking "Baby Friendly" designation.
13. Breastfeeding goals and action steps included in "Fit and Healthy Vermonters" the state's obesity prevention plan - "Breastfeeding will be the norm for feeding infants and part of a healthy diet for a year or longer."

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. VDH and partners support of Breastfeeding Friendly Employer programs and provide TA related to new breastfeeding in the workplace legislation.			X	
2. Breastfeeding support programs via WIC such as education, pump distribution, peer counseling, and individual support.	X	X		
3. VDH support of local breastfeeding coalitions.		X		
4. VDH/DCF support of child care services that serve infants and toddlers who are being breastfed.	X	X		
5. Collaboration with University of Vermont to include science of breastfeeding in medical school collaboration.			X	
6. Collaboration within VDH and with partners to plan action steps for breastfeeding goals in the Obesity Prevention Plan.			X	X
7. VDH support of annual Vermont Lactation Consultant Association conference and other statewide conferences.			X	
8. Continued maintenance of extensive information about breastfeeding and support programs on VDH website.		X		

9.				
10.				

**b. Current Activities**

Activities as described above and the following:

1. Continue with WIC medical home pilot in two districts - to improve healthy early feeding practices. WIC nutritionists are present in pediatric offices to offer nutrition education to families, enroll eligible families, and establish collaborative relationship with providers and office staff.
2. Planning with UVM College of Medicine to include information on the science of breastfeeding in to the medical school curriculum.
3. Several statewide conferences featuring noted speakers such as Dr Kirstan Berggren, Dr. Ruth Lawrence and Nancy Mohrbacher, and Dr. Mirium Labbok.
4. Passing of H.641 requires that employers shall provide reasonable time throughout the workday for employees who are nursing mothers to express milk and shall make reasonable accommodations to provide appropriate space.
5. Vermont scored overall 81% on CDC scale of Maternity Practices in Infant Nutrition and Care Survey (Vt and New Hampshire are the highest scores nationally)

**c. Plan for the Coming Year**

Ongoing activities as described above and also the following:

1. Continue with Medical Home project as funding allows.
2. Continue implementation of breastfeeding related action steps from Fit and Healthy Vermonters/Obesity Prevention Plan.
3. TA to Vermont birth hospitals who are considering seeking "Baby Friendly" designation.
4. World Breastfeeding Week activities, featuring "Passing the Golden Bow" with the message that breastfeeding is the gold standard for infant feeding (UNICEF.) A ceremonial bow will be passed throughout Vermont such as the Olympic torch.
5. Provide TA to employers re: breastfeeding in the workplace legislation and breastfeeding friendly workplace designation.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	85	95	97	97	98
Annual Indicator	94.8	95.8	96.1	96.0	
Numerator	5619	5838	5755	5719	
Denominator	5928	6093	5986	5955	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	98	98	98	98	98

**Notes - 2007**

Hearing screening data for 2007, together with an estimate of the number of occurrent hospital births, were not available at the time of submission. They will be available in January 2009.

**Notes - 2006**

Since this performance measure relates to infants screened before discharge from hospital, only births that occurred in VT hospitals are included in the denominator. Vital statistics data for 2006 VT occurrent births remain preliminary at the time of submission.

**Notes - 2005**

Since this performance measure relates to infants screened before discharge from hospital, only births that occurred in VT hospitals are included in the denominator.

**a. Last Year's Accomplishments**

1. Performed follow up with hospitals to reduce the number of missing reports and to correct information. This is a daily activity for the EHDI program, and essential for the integrity of the data for our new database.
2. We worked on a daily basis (as needed) with the contacts at the birth hospitals to improve data quality and completeness.
3. We made significant progress on the CDC-funded database.
4. We continued to support VT birth hospitals so that no infant is missed. We also continued progress with other New England states on draft agreements for babies resident in one state but screened and/or born in a neighboring state.
5. Consistency in risk factor annotation has been improved through clearer definitions and individual follow-up with hospitals
6. We continued to meet with audiologists statewide to provide, and assess need for, continuing education, through periodic evening meetings/presentations
7. The advisory council continues to meet quarterly under strong parent/professional co-leadership. The group has focused on: the need for hearing assessment in children who are referred to early intervention; the need for guidelines for medical work-up after the diagnosis of hearing loss; and, the need to monitor hearing for children with fluctuating hearing loss. Drafts of guidelines were finalized by the council.
8. The increased newborn screening fee (\$95) was finalized and presented to the various legislative committees as a rule change. The change was approved in 2007 (and implemented in 2008).
9. We maintained the Hearing Outreach Program as the major source of outpatient rescreening for infants who do not pass or who miss their initial screen.

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. Continue follow up with hospitals to reduce the number of missing reports and to correct information.			X	X
2. 2. Continue work on a daily basis (as needed) with the contacts at the birth hospitals to improve data quality and completeness, including risk factor assessment.			X	X
3. 3. Finish database transition; close old databases.			X	X
4. 4. Continue to support VT birth hospitals so that no infant is missed. Finalize agreements with other New England states for babies resident in one state but screened and/or born in a neighboring state.			X	X
5. 5. Continue to provide, and assess need for, continuing education for audiologists				X

6. 6. Continue to support strong parent/professional co-leadership of the advisory council, and staff support of their initiatives.			X	X
7. 7. Continue to maintain the Hearing Outreach Program as the major source of outpatient rescreening for infants who do not pass or who miss their initial screen.	X	X	X	X
8. 8. Implement first year objectives of the new HRSA EHDI grant.			X	X
9.				
10.				

**b. Current Activities**

As above and the following:

1. Staff Turnover in the EHDI database project has gone very smoothly. The immunization registry module (preceding the input of the EHDI data) has expanded greatly.
2. Guidelines developed by the Advisory Council, on medical diagnosis and on fluctuating hearing loss were disseminated to medical homes statewide.
3. The increased fee was implemented in March, 2008.
4. Successful application for new HRSA funding for EHDI system improvements, particularly targeted at reducing lost-to-follow-up at all points, from screening to early intervention.

**c. Plan for the Coming Year**

As above and the following:

1. Continue follow up with hospitals to reduce the number of missing reports and to correct information.
2. Continue work on a daily basis (as needed) with the contacts at the birth hospitals to improve data quality and completeness, including risk factor assessment.
3. Finish database transition; close old databases.
4. Continue to support VT birth hospitals so that no infant is missed. Finalize agreements with other New England states for babies resident in one state but screened and/or born in a neighboring state.
5. Continue to provide, and assess need for, continuing education for audiologists
6. Continue to support strong parent/professional co-leadership of the advisory council, and staff support of their initiatives.
7. Continue to maintain the Hearing Outreach Program as the major source of outpatient rescreening for infants who do not pass or who miss their initial screen.
8. Implement first year objectives for new HRSA EHDI grant.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	3	3	3	2	2
Annual Indicator	5.5	5.3	5.7	6.9	
Numerator	8060	7770	8250	9822	

Denominator	146630	145614	143960	143384	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	2	2	2	2	2

**Notes - 2007**

Insurance data and VT population estimates currently are unavailable for 2007. They are expected to be published by March, 2009.

**Notes - 2006**

1) These data are reported from Kaiser Family Foundation State Health Facts. For consistency, the total population estimate reported by Kaiser is used for the denominator even though this number is at variance with the VT population estimate used elsewhere.

2) It should be noted that the age range reported here is 0-18 yrs, not <18 yrs as originally defined for the numerator and denominator.

**Notes - 2005**

1) These data are reported from Kaiser Family Foundation State Health Facts. For consistency, the total population estimate reported by Kaiser is used for the denominator even though this number is at variance with the VT population estimate used elsewhere.

2) It should be noted that the age range reported here is 0-18 yrs, not <18 yrs as originally defined for the numerator and denominator.

**a. Last Year's Accomplishments**

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

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

3. 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

4. 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.

5. 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)

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

7. Coordinate with state and local agencies to inform eligible clients about rules for new state health insurance programs and new federal requirements for Medicaid.

8. Examine impact of new Medicaid funding system on financing for services to MCH population.

9. Work with DCF to support child care providers to inform their families about potential eligibility for Medicaid insurance.

See also NPM #4 for CSHCN

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Outreach to potential eligible children and families via school nurses.		X		
2. Screening and referral to Medicaid services via WIC clinics and programs.	X	X		
3. Coordinate with DCF to support child care providers to refer eligible families to Medicaid.		X		
4. Coordinate with state and local organizations to inform families about the new state and federal regulations on state insurance programs and Medicaid and also on Catamount/Green Mountain Care.	X	X		
5. Use of newly revised and user-friendly informing letter.	X	X		
6. Use of data from School Nurse Health Insurance Survey to assist families with access to medical/dental home.	X	X		
7. (See also NPM #4 for CSHCN)				
8.				
9.				
10.				

**b. Current Activities**

Activities as listed above and also the following:

1. Now able to readily receive data from school nurses on numbers/percent of students receiving health insurance and who have medical/dental homes.

2. VDH informing families about new Green Mountain Catamount Health Care insurance programs and options.

See also NPM #4 for CSHCN

**c. Plan for the Coming Year**

Activities as listed above and also the following:

1. VDH planning and coordination with schools and communities to disseminate and act on newly available information about children's access to medical/dental homes. For example, use data to identify children without medical/dental home and work with those families to access care.

2. VDH continue active role in assessing impact of new health care legislation and other changes

in health insurances (such as Green Mountain Care) and works via its programs and coalitions to assist families with access to health care services.

See also NPM #4 for CSHCN

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				30	30
Annual Indicator			30.1	28.7	28.7
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	25	25	22	22	22

**Notes - 2007**

The 2006 data has been updated to reflect the value of 28.7%. The 2007 data from CDC's Pediatric Nutrition Surveillance Survey is not available at this writing.

**Notes - 2006**

Data for the past years: 2001: 28.4%, 2002: 27.7%, 2003: 29.3%, 2004: 27.8%. Data for 2006 is not available at this writing and so the value for 2005 is used as placeholder. 2006 will be updated for next year's application.

**Notes - 2005**

These values for 2004 are from the 2004 Pediatric Nutrition Survey and are for children 2-4 years of age.

**a. Last Year's Accomplishments**

1. Ongoing: Screening of every child at routine WIC visits - offering of specialized follow up for those with BMI at or above the 85%.
2. Collaboration with family's PCP for children who are overweight or obese.
3. Nutrition and activity programs such as Fit WIC
4. Myriad of breastfeeding support programs via WIC and community groups - to prevent obesity in early childhood (see NPM #11)
5. Collaborate with DCF on programs supporting good nutrition and physical activity in child care centers.
6. Community physical activity programs as supported via Blueprint and Obesity Prevention Plan (See SPM #6)

7. Development of Eat for Health nutrition information information on VDH website.
8. General nutrition education for families including special events such as nutrition-themed playgroups.
9. VDH staff placed at providers offices in certain regions to provide WIC enrollments and nutrition education services.

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

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

**b. Current Activities**

Those activities as listed above and the following:

1. Continue with collaboration with DCF - expand educational offerings for staff and parents at child care centers.
2. Continue refinement of Eat for Health nutrition information on VDH website. Include new information, such as about Folic Acid and Breasfeeding.
3. Develop display boards/videos for VDH district offices with nutrition messages.
4. Vt WIC participated in USDA Special Projects Grant entitled "Brighten My Life with Fruits and Vegetables" to increase the offerings of fruits and vegetables to WIC participants.
5. Provided WIC staff with training on childhood obesity prevention with Bettylou Sherry, Acting Team Lead for the Research and Surveillance Team in the Obesity Prevention and Control Branch at CDC.
6. Completed High Risk Counseling Guide which includes section on childhood overweight with targeted strategies for use with WIC families.
7. WIC/VDH/VCHIP coordination on development and testing of pediatric provider toolkit "Promoting Healthier Weight in Pediatrics" which is on VDH website.
8. Community grants to develop nutrition and physical activity initiatives for children and families.

**c. Plan for the Coming Year**

Those activities as listed above and including the following:

1. Continued expansion of community physical activity programs as supported via Blueprint and Obesity Prevention Plan.
2. As part of the FFY09 WIC management evaluation of WIC program administration at the local level, the state level staff will provide increased TA and oversight of the follow up activities on all high risk participants, including overweight children.
3. WIC/VDH/VCHIP coordination on implementation of pediatric provider toolkit "Promoting Healthier Weight in Pediatrics" to be printed and provider training to be implemented.
4. Provide training and TA to VDH chronic disease designees for assessment and planning for nutrition and physical activity programs directed towards families and children at the community level. Project must emphasize policy and environmental changes.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				16	14
Annual Indicator			16.8	14.8	
Numerator			1090	937	
Denominator			6497	6320	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	14	12	12	10	10

**Notes - 2007**

Vital statistics data for 2007 VT births were unavailable at the time of submission. Preliminary 2007 data should be available in January 2009.

**Notes - 2006**

Vital statistics data for 2006 VT births remain preliminary at the time of submission.

**Notes - 2005**

This is 2004 data from the Vermont birth certificate system. Data from 2005 will not be available until the end of the 2006 calendar year.

**a. Last Year's Accomplishments**

1. Pregnant women receive screening and referral to Vermont Quit line by private providers and "safety net" providers such as community health clinics and family planning clinics.

2. Vermont Quit Line - telephone counseling service - uses protocol specific for pregnant women as taken from ACOG guidelines.

2. Screening and referral for pregnant women (and for all women) in WIC clinics and via home visiting services.

3. VDH, March of Dimes, UVM and other partners produce report on the best practices for prenatal smoking cessation programs. Plans begin for implementing recommendations. Includes key elements of a research-based program such as incentives for the woman who smokes and use of the "5 A's."

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Smoking cessation services specific to pregnant women via the Vermont Quit Line and telephone counseling service.	X	X		
2. Pregnant women receive screening and referral to Quit Line by health care providers, community health clinics, and family planning clinics.	X	X		
3. VDH/March of Dimes/UVM provide TA to community groups by using the best practices recommendations of the Perinatal Smoking Cessation Plan.		X	X	
4. New educational materials for women who smoke are distributed by community providers.	X	X		
5. TV/Radio ads focus on smoking cessation for women aged 18-24 who are of lower SES.			X	
6. Giveaways for young women focus on theme of premature wrinkling of skin			X	
7.				
8.				
9.				
10.				

**b. Current Activities**

As listed above and including the following:

1. Continued collaboration with VDH, UVM, March of Dimes to work with community organizations to use recommendations from the Prenatal Smoking Cessation Plan when designing grant-funded cessation programs and projects. Recommendations include best practices such as recall systems, incentives, and breath test monitoring. Example of one such program is the Fresh Start of Baby and Me in Rutland.

2. Community coalitions and hospital partners distribute new health education materials directed to women who smoke.

3. New series of TV/radio ads target young women ages 18-28 in lower income groups highlight real Vermont women sharing their personal experiences with smoking cessation.

4. Cigarette tax increase of 20 cents to total tax of \$1.99 per pack. Average price of pack of cigarettes is over \$5.00.

5. Vermont bans sale of cigarettes over the internet.
6. Beginning plans for specific programs for pregnant women who smoke - funded by tobacco master settlement. Evaluation of existing programs (in communities and provider offices) and evaluate use of incentives to women to stop smoking.
7. "Wrinkle campaign" - describing effects of smoking on premature wrinkling of skin - targeting young women with this message - giveaways and ads in bathrooms of restaurants and bars.
8. Vermont Quit Line is now the Vermont Quit Network.

**c. Plan for the Coming Year**

As listed above and including the following:

1. Continue to develop plans for use by communities, WIC and providers' offices using the "5 A's."
2. Planning for media campaigns to complement "wrinkle campaign" and Quit Line advertising.
3. Planning for activities specifically funded by tobacco settlement for pregnant women who smoke.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	8	8	8	7	4
Annual Indicator	NaN	11.0			
Numerator	0	5			
Denominator	0	45643	45801	46163	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	4	3	3	3	3

**Notes - 2007**

Vital statistics data for 2007 VT deaths -- especially out-of-state deaths -- are currently incomplete. Preliminary data will be available in January 2009.

Population estimates for 2007 will be available in December 2008.

**Notes - 2006**

Only two deaths were reported in 2006, which is below the minimum numerator size for reporting. The 3-year average was also less than 5. Vital statistics death records for 2006 VT deaths remain preliminary at the time of submission.

**Notes - 2005**

Only two deaths were reported in 2005, which is below the minimum numerator size for reporting. The three-year average for VT was also less than 5.

**a. Last Year's Accomplishments**

1. EPSDT staff and VCHIP (via grant from VDH to VCHIP) have planned for the VCHIP Adolescent Health Initiative which is designed to improve the quality of preventive health services to adolescents.

2. Suicide deaths are routinely monitored by Child Fatality Reivew Team.

3) VDH collect and monitor data on suicide attempts and completions.

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. EPSDT/VCHIP collaboration on adolescent Health Initiative - adolescents are screened for risk and protective factors at preventative health visits.	X	X		
2. Child Fatality Review Team review of all adolescent suicide deaths.			X	
3. VDH collects and monitors data of suicide attempts and completions.				X
4. VDH follow up with Department of Education on legislation requiring that signs of suicide and prevention/intervention resources be taught in public schools.		X		
5. VDH Injury Prevention Program sponsors Poisoning Prevention symposium in Sept 2008.		X	X	X
6. Follow up if grant application for Suicide Prevention is approved	X	X	X	X
7.				
8.				
9.				
10.				

**b. Current Activities**

Activities as listed above and the following:

1. DMH and VDH work with VCHIP Adolescent Health Initiative. A major goal is to assure that adolescents are screened for risk and protective factors during preventive health visits.

2. Dept Mental Health applied for suicide prevention grant with Center for Health and Learning at Fletcher Allen Health Care. Goals 1) build infrastructure with Vt Youth Suicide Prevention Coalition 2) collaboration with United Way on statewide media campaign to de-stigmatize mental health issues and normalize help seeking behavior 3) develop statewide school and community Gatekeeper training 4) work with VCHIP to implement targeted interventions for college-age students.

3. Vt Injury Prevention program is holding a statewide Poisoning Prevention Symposium in September 2008 - including the issue of intentional poisoning as a method of suicide.

**c. Plan for the Coming Year**

Activities as listed above and the following:

1. Implement suicide prevention grant funded activities if funding received.
2. Enhance system for VDH collection and monitoring of data on suicide attempts and completions.
3. Follow up from Poisoning Prevention Symposium.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	95	95	95	95	95
Annual Indicator	76.0	93.0	86.3	79.3	
Numerator	57	53	63	69	
Denominator	75	57	73	87	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	95	95	95	95	95

**Notes - 2007**

Vital statistics data for 2007 VT births were incomplete at the time of submission. Preliminary data will be available in January 2009.

**Notes - 2006**

Vital statistics data for 2006 VT births remain preliminary at the time of submission.

Level III neonatal facilities where very low birthweight babies were born in 2006 include Fletcher Allen Health Care (VT), Bay State Medical Center (MA), Dartmouth Hitchcock Medical Center (NH), and Albany Medical Center (NY).

**Notes - 2005**

Sub specialty facilities are Fletcher Allen Health Care (VT), Boston Children's Hospital (MA), Bay State Medical Center (MA), Dartmouth Hitchcock Medical Center (NH), Albany Medical Center (NY), Brigham and Women's Hospital (MA), Maine Medical Center (ME).

**a. Last Year's Accomplishments**

1. Assessment of all pregnant women in WIC and HBKF for risk factors of VLBW and offering education and resource referral for prenatal care. Specialized referral for women who may be at high-risk.
2. Collaboration with the Regional Perinatal Training Program and the March of Dimes to facilitate the training for transport of women in PTL and the transport of infants born in community birth hospitals to regional medical centers.

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with Vermont Regional Perinatal Health Project to implement activities for training and TA to participating birth hospital staff.	X	X		
2. Assessment of all pregnant women in WIC/HBKF at risk for poor pregnancy outcomes and appropriate referral for high risk prenatal care.	X	X		
3. Collaboration with VCHIP/ICON for QI on services, policies and procedures for transfer of opioid exposed mothers and newborns.	X	X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Continue with activities as listed above and the following:

1. Vermont Regional Perinatal Program has become associated with Vermont Child Health Improvement Program and is now the Vermont Regional Perinatal Health Project. Continues with programs for training and TA to hospital perinatal staff.
2. VDH coordination with Vermont Child Health Improvement Program's Improving Care for Opioid Exposed Newborns (ICON) for care and services for opiate exposed mothers and newborns - specific communications with select birth hospitals to improve transfer policies and practices.

**c. Plan for the Coming Year**

Continue with activities as listed above and the following:

1. Continue coordination with Vermont Regional Perinatal Health Project (partially funded by Title V) on general deliverables and also on needs assessment of perinatal program activities.
2. Continue with coordination with ICON to create needs assessment and plan for improving systems for services and transport of pregnant women who are addicted to opioids.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	90	90	92	92	93
Annual Indicator	90.6	90.0	89.5	89.4	
Numerator	5696	5709	5386	5442	
Denominator	6290	6341	6015	6084	

Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	94	95	95	95	95

**Notes - 2007**

Vital statistics data for 2006 VT births were unavailable at the time the report was submitted. Preliminary data should be available in January 2009.

**Notes - 2006**

Vital statistics data for 2006 VT births remain preliminary at the time of submission.

**a. Last Year's Accomplishments**

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

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. State and community programs (WIC, HBKF) manage and facilitate a comprehensive system of care referral - priority being entry into early and adequate prenatal care.	X	X	X	X
2. VDH works with statewide partners (AHEC, UVM, ETC.) to assess and take steps to support adequate OB and pediatric health care providers for each region of the state.				X
3. Outreach with providers to facilitate referrals to the HBKF systems of care and other appropriate services.	X	X		
4. Outreach and follow up with pregnant women (via HBKF/WIC) to ensure first trimester connection with a prenatal care provider.	X	X		
5. Planning for Integrated Services with HBKF and other DCF services to promote seamless system of care for pregnant women and children.	X	X	X	X
6. Annual review of data from VDH (PRAMS, BC, etc.) and OBNet to glean information describing the system of care access for pregnant women.			X	X
7.				
8.				
9.				
10.				

**b. Current Activities**

Activities as listed above and also the following:

1. Planning for Integrated Services with HBKF and other DCF services to enhance coordination and promote a seamless system of care for families with pregnant women and young children.
2. Office of Rural and Primary Health Care activities continue activities such as surveillance and provider recruitment to ensure adequate healthcare workforce in Vermont so as to facilitate pregnant women receiving early and adequate prenatal care.

**c. Plan for the Coming Year**

Activities as listed above and also the following:

1. Progress in the planning for Integrated Services with HBKF and other DCF services to enhance coordination and promote a seamless system of care for families with pregnant women and young children.
2. VDH provide informal TA via Chronic Care model to certain safety net providers for incorporating specific strategies for scheduling newly pregnant women into care in the first trimester.
3. Annual review of data from VDH (PRAMS, BC, etc.) and OBNet to glean information describing the system of care access for pregnant women.

**D. State Performance Measures**

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				70	70
Annual Indicator	68.2	67.6	67.6	67.6	67.6
Numerator	4387	4271	4271	4271	4271
Denominator	6433	6314	6314	6314	6314
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	73	73	75	75	75

**Notes - 2007**

Estimate is based on data from PRAMS survey of women who have recently given birth to live infants. This estimate does not include pregnancies that end in abortions or fetal deaths. 2007 estimate based on 2005 PRAMS survey data. Actual data for 2007 were not available at the time of reporting. They will be available in 2010.

**Notes - 2006**

Estimate is based on data from PRAMS survey of women who have recently given birth to live infants. This estimate does not include pregnancies that end in abortions or fetal deaths. 2006 estimate based on 2005 PRAMS survey data. Actual data for 2006 were not available at the time of reporting. They will be available in mid 2009.

**Notes - 2005**

Estimate is based on data from PRAMS survey of women who have recently given birth to live infants. This estimate does not include pregnancies that end in abortions or fetal deaths. 2005 estimate based on 2004 PRAMS survey data. Actual data for 2005 were not available at the time of reporting.

**a. Last Year's Accomplishments**

1. Assessment of women's reproductive health needs and referral as needed to providers of family planning services. Assessment performed by staff in state service programs, such as WIC, Healthy Babies, Kids, and Families, and by community organizations such as Parent Child Centers and Home Health Agencies.

2. State program coordination with family planning service providers such as Planned Parenthood of Northern New England and Community Health Centers.

3. Public education about availability and use of family planning methods via brochures, websites, etc. Information available in a variety of languages.

4. Community based teen pregnancy prevention programs for pregnant and parenting teens and teens at risk of pregnancy and their male partners - via schools and Parent Child Centers.

5. VDH created and received approval for the state Rules to implement Act 101 as passed by 2006 Vermont State Legislature to allow Emergency Contraception to be available to women at pharmacies via formal Collaborative Practice agreement with Prescribers (physicians, NP's, PA's, etc.)

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assessment of women's health care referral needs and referral to providers of family planning services. Assessment performed by staff at programs such as WIC, HBKF, PCC, HHA.	X	X		
2. State program coordination with family planning service providers such as Planned Parenthood of Northern New England and FQHC.		X	X	X
3. Public education about the availability and use of family planning methods via brochures, websites, etc. (information available in a variety of languages)	X	X		
4. Community based teen pregnancy prevention programs for pregnant and parenting teens and teens at risk of becoming pregnant and their partners - via schools, Parent Child Centers, etc.	X	X		
5. PRAMS analysis of women's health experiences during pregnancy and postpartum.				X
6. Oversight of rule making and pharmacists training for enabling dispensing of emergency contraception by pharmacists via collaborative practice.	X	X	X	X
7.				
8.				
9.				
10.				

**b. Current Activities**

Activities as listed above and also the following:

1. VDH collaborated with Vermont Pharmacists Association and partners such as Planned Parenthood of Northern New England to create the processes necessary to allow Emergency Contraception to be available to women at pharmacies via formal Collaborative Practice agreement with Prescribers (physicians, NP's, PA's, etc.)
2. Statewide CEU conference for pharmacists - attendance at this conference was required for pharmacists to participate in collaborative practice for dispensing of emergency contraception medication.
3. Beginning conversations with Planned Parenthood of Northern New England to incorporate assets approach to women's well care visits.

**c. Plan for the Coming Year**

Activities as listed above and also the following:

1. A second statewide CEU conference for pharmacists is planned - attendance at this conference is required for pharmacists to participate in collaborative practice for dispensing of emergency contraception medication.
2. SSDI support for PRAMS data analysis of health behaviors of women during pregnancy and postpartum - data will be used for planning and to refine programs to better assist pregnant women during their pregnancies and in general for health programs to support women during their childbearing years.
3. Continue to investigate collaboration with PPNNE on assets approach to wellness health care.

**State Performance Measure 2:** *The percent of licensed child care centers serving children age birth to five who have on-site consultation.*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				60	60
Annual Indicator			57.3	18.4	16.2
Numerator			243	75	66
Denominator			424	408	408
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	63	63	65	65	65

**Notes - 2007**

SPM 2 is designed to measure the percent of on-site visits by child care health consultants - which is reported here as 66 visits with 10 out of 12 districts reporting. Due to staffing shortages, other methods of child care health consultation are being emphasized in addition to site visits, such as phone visits and regional inservice sessions.

**Notes - 2006**

The measure for child care health consultant visits is considered developmental. The numerator is from record reviews and surveys and the denominator is from state program data. The percentage has also changed from 2005 because of a more accurate determination of licensed child cares appropriate to include in the denominator. Also, there is still not a reliable data base to collect information on the number of visits by a child care health consultant. Planning for a web-based data base to be developed over the next year.

**Notes - 2005**

The measure for child health consultation for child care centers is considered developmental. The numerator is from record reviews and surveys. The denominator is from state program data. State planning is underway for feasibility of developing an electronic data system for data tracking for this measure and other related data. Data from previous years is not available.

**a. Last Year's Accomplishments**

1. Participate in Northern Lights Career Development Center advisory group - the Center is to offer a variety of supports to child care providers for professional education and career advancement.
2. General support planning and implementation of ECCS/Building Bright Futures grant-funded activities.
3. Continue support for Touchpoints trainings statewide for child care providers.
4. Professional development is on-going
5. Begin planning for incorporating Oral Health curriculum into education sessions for child care providers.
6. Participation in Healthy Child Care New England.

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Partnership with Healthy Child Care New England to support ongoing trainings for child care health consultants.		X	X	
2. Collaboration with ECCS/VDH on early child care systems issues and solutions.			X	X
3. Support for continued Touchpoints trainings for child care providers.		X		
4. Incorporate oral health topics into child care health consultant trainings.		X		
5. Development of web-based data base to document activities of child care health consultants.				X
6. Building of community coalitions to support quality child care and early education via ECCS grant system.			X	X
7. Support of Northern Lights Career Development Center that offers trainings and professional education for those in the child care field.			X	X
8. Revise CCHC toolkits.			X	
9. Work with DCF Child Care Licensors to coordinate training and governmental supports to child care providers.				X
10. Emergency planning and readiness for child care facilities.				X

**b. Current Activities**

Activities as listed above and also the following:

1. A web data base was developed to capture Child Care Health Consultant activities (CCHC) for reporting and monitoring state and regional consultations, trainings, etc. The site still needs some fine-tuning to be fully functional.
2. HCCVT continues to partner with Child Care Licensing, Community Resource and Referral Agencies, VT's Northern Lights Career Development Center (<http://nothernlights.vsc.org>); the AAP-VT Chapter, the Department of Health (Immunizations, Lead, WIC, EPI) and others.
3. Current health and safety resources for the CCHC's are being reviewed and updated.
4. HCCVT is working closely with Early Childhood Comprehensive Systems Initiative (ECCS) at both state and regional levels. VT's ECCS coordinator is now helping to administer HCCVT

**c. Plan for the Coming Year**

Activities as listed above and also the following:

1. Child Care Division collaboration with AAP, VAEYC, CHild Care Resource and Referral Agencies, Northern Lights Center, VDH to develop a plan for increasing the statewide CCHC capacity to meet best practices and accreditation requirements.
2. Continue to refine the CCHC web data base and link with the CCHC website with CDD's Building Bright Futures Child Care Information system ([www.brightfuturesinfo.org](http://www.brightfuturesinfo.org)), and the DCF and Department of Health websites.
3. Develop a section on the website for CCHC access to resources and toolkits.
4. VT Early Childhood Licensing Regulations are under review. Health and safety components will be updated. Health and safety training curricula for child care staff will be reviewed and revised.
5. The ECCS program is closely linked with VT's Building Bright Futures (BBF). Several BBF regional councils are focusing on quality out of home environments in their newly created regional plans. Child care consultation is an integral part of quality in child care settings.
6. Continue to develop strategies to expand VT's capacity to provide integrated child care consultation.

**State Performance Measure 3:** *The percent of youth who do not binge drink on alcoholic beverages.*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				80	82
Annual Indicator	61	77.1	78.6	78.6	77.0
Numerator		30492	31347	31347	29744
Denominator		39524	39891	39891	38641
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	82	85	85	85	85

**Notes - 2007**

Weighted data for 2007 are based on a YRBS survey carried out in the same year.

**Notes - 2006**

YRBS Survey is carried out every two years. The 2006 estimate is based on the 2005 survey. Weighted estimates are reported.

**Notes - 2005**

YRBS Survey is carried out every two years. The 2005 estimate is based on the 2005 survey. Weighted estimates are reported.

**a. Last Year's Accomplishments**

1. 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. Guidelines for discussion of assets with teens and their families.

2. Screening and education for prenatal alcohol use via the WIC/Rocking Horse collaboration.

3. VDH Office of Drug and Alcohol Abuse programs and community based New Directions grants are targeted to the prevention and reduction of underage substance abuse. In FY07, 15 coalitions received funds to support development and implementation of best and promising practices.

4. Underage drinking initiatives such as Stop Teen Alcohol Risk Teams (START), Alcohol Awareness month, public education about underage drinking and providing opportunities for dialogue (town hall meetings)

5. Vt Drug and Alcohol Information Clearing House provides information to communities, schools, service providers and the general public.

6. 10 Regional Prevention Consultants offer a variety of services to communities to address alcohol and drug prevention: presentations and trainings, program planning and consultation, community grants, information and referral.

7. Adolescent alcohol and drug treatment grant will support development of changes in state agency rules, regulations and procedures to support changes in local treatment services, enhance the capacity of the state's health and human service system to identify and refer appropriate adolescents to treatment, and enhance the capacity of the treatment system to deliver quality services to families.

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. VDH/EPSTDT work with VCHIP to design and implement screening guidelines for teens on drinking and asset/rick behavior.	X	X	X	
2. Prenatal alcohol use prevention/intervention programs.	X	X	X	
3. New Directions community grants for alcohol prevention.	X	X		
4. Strategic Prevention Framework State Incentive Grants.		X	X	X
5. Underage drinking initiative - START - and public education projects.	X	X	X	
6. Vermont Alcohol and Drug Information Clearinghouse.	X	X		

7. Regional Prevention Consultants	X	X		
8. Adolescent Alcohol and Drug Treatment Grant.	X	X	X	X
9. Explore new initiatives for asset promotion and changing culture of teens and alcohol use/abuse.		X	X	
10. FACES project implementation.		X		

**b. Current Activities**

Activities as listed above and also the following:

1. Investigate further collaborations within VDH and with VDH partners to create initiatives and access funding for programs to create the social norm for Vermont teens that binge drinking is not "cool" and to discourage this risk taking behavior.
2. The FACES (Families & Adolescents driving Care for Effective Services) Project is a collaborative effort to get parents and teens involved in helping shape teen substance use and mental health services across Vermont. The FACES Project is working towards expanding and developing regional groups of family members to help redefine Vermont's adolescent treatment system.
3. Vermont communities will have an opportunity to apply for grant funding under the Strategic Prevention Framework State Incentive Grant. Funds will support communities in a strategic planning process to address the priorities of reduction in underage drinking; reduction in high-risk drinking among persons under the age of 25, reduction of marijuana use among persons under the age of 25 and building prevention capacity and infrastructure.

**c. Plan for the Coming Year**

Activities as listed above and also the following:

1. The Division of Alcohol and Drug Abuse Programs awarded 23 Vermont communities Strategic Prevention Framework (SPF) grant funds to develop, strengthen and maintain substance abuse prevention services throughout the state. The grants will allow for a renewed focus on education, engaging and motivating action by youth, young adults, their parents, and the community about alcohol and drug issues before substance abuse becomes a life-long problem.
2. Further implementation of FACES Project.
3. The New Directions Coalition Grant is targeted to the prevention and reduction of substance abuse among 12-17 years olds. Vt community coalitions who received New Directions funding in 2007 and who are not receiving SPF grant monies were eligible to apply. Five coalitions received funding.

**State Performance Measure 4:** *The percent of women of childbearing age who consume at least two servings of fruit and three servings of vegetables daily.*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				34	35
Annual Indicator			33.5	33.5	35.0
Numerator			37726	37726	38680
Denominator			112736	112736	110600
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	35	38	38	38	38

**Notes - 2007**

Weighted data based on 2007 BRFSS survey of VT women 18-44 years. Note that BRFSS question does not differentiate between fruit and vegetable servings. Numerator reported is population estimate for women 18-44 years who reported eating 5 or more servings of fruits and vegetables, combined.

**Notes - 2006**

Data for this item are derived from a BRFSS question that is asked every other year. Estimated data for 2006 are therefore pre-populated with actual data from 2005.

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

**Notes - 2005**

Data is the weighted counts from the 2005 BRFS for 5 servings of fruit and vegetables. In addition, 39% of women (ages 18-44) reported eating 2 or more servings of fruits. 34% of women (ages 18-44) reported eating 3 or more servings of vegetables daily. This is a new performance measure and data for previous years is not available.

**a. Last Year's Accomplishments**

1. Women in WIC (and their WIC-eligible children) are offered Farm-to-Family coupons and education about fruits and vegetables to encourage consumption of in-season, locally available fruits and vegetables.
2. Women in WIC are offered a wide array of programs and individual education about nutrition and healthy food choices for themselves and thier families.
3. School health education programs offer girls and teens ongoing education about nutrition and healthy food choices - in efforts to influence healthy adult behaviors.
4. VDH support of statewide Hunger Task Force in planning for new initiatives and collaborating with exisiting state programs to assist familes in accessing adequate and healthy foods.
5. Statewide Obesity Prevention Advisory Committee for Fit and Healthy Vermonters continues to meet regularly and develop/implement action steps for Obesity Prevention Plan. This process is facilitated by VDH.
6. Eat for Health nutrition education section of VDH website launched - contains information about healthy foods, shopping tips, recipes, and locally grown foods for a healthy diet. Drive to website materials developed and distributed.
7. VDH and DCF (via ECCS) to build collaborations with child care providers on training and support to provide healthy foods in thier child care centers - mothers of these children will be educated about healthy nutrition and be able to incorporate concepts into their own daily diets.
8. VDH sponsored trainings in August 2007 for WIC staff and community health care workers on Nutrition in pregnancy with emphasis on folic acid.

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Women in WIC are offered education about fruits and vegetable consumption and supports such as Farm to Family coupons.	X	X		
2. School based programs such as health classes, food services, and other courses offer education to children and youth about the importance of fruits and vegetables.	X	X	X	
3. Collaboration with DCF/ECCS to support child care providers to promote fruits and vegetables consumption with the children and mothers who use their services.	X	X		
4. Collaboration with advisory committee for Vermont's Obesity Prevention Plan on objectives relating to improved diet and nutrition.			X	X
5. Folic acid public awareness and media campaign.		X		
6. Nutrition training for WIC and community health workers.		X		
7. Collaboration with state agencies on implementing recommendations/guidelines as detailed in 2008 legislation.			X	X
8. Maintenance of and media campaign for Eat for Health website.		X		
9. Collaboration with Governor's Task Force on hunger to create recommendations and implementation of initiatives.		X	X	X
10. Collaboration and activities around worksites, schools and communities via H.887	X	X	X	X

**b. Current Activities**

Activities as above and also the following:

1. The state Nutrition Action Plan to update the information on the Eat for Health website.
2. Updating school wellness policy guidelines for foods served and sold in schools - in conjunction with H.887.
3. The Governor's Hunger Task Force is gathering input to develop recommendations for action.
4. Emphasis on worksite wellness programs and healthy foods in communities via existing programs and support from the broad scope in activities authorized in Health Reform Legislation H.887.

**c. Plan for the Coming Year**

Activities as above and also the following:

1. Continue training and TA to schools on implementation of wellness/nutrition policies via H.887
2. Continue to develop comprehensive community programs to promote fruit and vegetable consumption via H.887.
3. Promote the Eat for Health message and logo to adults and families.
4. Work with partners to implement recommendations from Governor's Hunger Task Force.
5. Continue to develop programs and collaborations as enabled under H.887 for healthy worksites.

**State Performance Measure 5:** *The percent of youth who feel like they matter to people.*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				45	48
Annual Indicator	42	42	44.6	44.6	47.4
Numerator			17630	17630	18192
Denominator			39538	39538	38355
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	48	50	50	50	50

**Notes - 2007**

Weighted population estimate based on YRBS survey carried out in 2007.

**Notes - 2006**

Weighted data is from the 2005 YRBS which is conducted every other year.

**Notes - 2005**

Weighted Data is from the 2005 YRBS. The unweighted data is 4029/9150.

**a. Last Year's Accomplishments**

Planning for SPM 5: In preparing for the development of this measure, planners at the VDH and the MCH Advisory Committee considered that Assets research for adolescents is demonstrating an association between healthy youth behaviors and certain defined assets. In response to this research, Vermont added five asset questions to the YRBS in 2001 in order to gather information on youth assets in relation to youth risk taking behavior. The state of Maine also uses this indicator, however worded slightly differently - "Do you feel that in your community, you feel like you matter to people." Also, in response to assets research, MCHB Region One began to incorporate a philosophy that would address a population's assets in addition to a population's needs in for the 2005 Title V MCH Needs Assessment. Choosing an youth asset indicator for Priority Goal #5 is viewed as a strategy to operationalize the assessment of youth assets in addition to analyzing youth risk-taking behavior. A collaboration between Vermont and Maine allows these two states to measure the same youth asset. A region-wide collaboration has begun to support other New England states to also include similar measures into their TV planning process.

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

<b>Activities</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
1. Support of school health curricula and programs dealing with development of self esteem, such as anti-bullying and anti racism.			X	
2. Support of school and community mentoring programs.			X	
3. VCHIP development and distribution of positive youth development educational tool for providers, youth, and parents.	X	X		
4. Support of substance abuse. drug and alcohol use prevention programs.	X	X		
5. VCHIP initiatives to improve screening, referral and access to services dealing with youth and mental health needs.	X	X	X	
6.				
7.				
8.				

9.				
10.				

**b. Current Activities**

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

**c. Plan for the Coming Year**

Continue with activities as listed above and also:

1. VDH and DOe collaboration on Coordinated School Health services - a relevant goal is to support enhanced emotional health services (using assets based approach) that are implemented throughout the various school-based settings (such as health education classes, special education services, guidance services, etc.) See SPM 3.
2. Continue with VCHIP Youth Health Initiative, especially the deliverables around improving youth screening, referral and access to mental health services.

**State Performance Measure 6:** *The percent of Vermont towns (population of 2,000 or more) who have at least one organized physical activity program in place that is open to all and promoted as a family activity*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				35	40
Annual Indicator			40.7	40.7	40.7
Numerator			35	35	35
Denominator			86	86	86
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	40	45	50	50	50

**Notes - 2006**

The programs to achieve this measure are continuing, however, no new towns have begun programs to the extent that they are able to be included in the numerator.

**Notes - 2005**

2005 is the first year for this measure which is newly created for Title V. Data from previous years is not available.

**a. Last Year's Accomplishments**

1. State and local planning for implementation of school and community physical activity programs related to the Blueprint for Health and the Fit and Healthy Vermonters Obesity Prevention Program.
2. Fit WIC: Activities toolkit distributed via WIC and child care centers. Provides tools to foster children's health and development through daily physical play. The kit provides a "grab bag" of play activities that they can do any time and place, and adjust for the season of the year.
3. Girls on Track and Girls on the Run are programs designed to give girls (grades 3-8) the information, training, confidence and support to make healthy lifestyle choices while also training for a 5K race.
4. SPARK: Sports, Play, and Active Recreation for Kids - evidenced based, after school activity program for boys and girls ages 9-13.
5. Many Milers: a 7 month long youth running, activity, nutrition program for youth ages 4-14 - contracted to Burlington City Marathon.
6. Governors' Spring and Fall Daylight Savings Challenge: Bi-annually children and youth are challenged to Eat More Colors, Turn It Off and Move More (more fruits and vegetables, less television, and more activity) Schools and preschools participate in these activities and incorporate the Challenge into their programs.
7. Community Walking Programs: Supporting communities to implement community based physical activity programs using Get Moving Vermont, a best-practices program that can be adapted to meet communities' unique needs.
8. Vermont Safe Routes to School: Uses Agency of Transportation funds. 28 schools in 2006 worked with their Regional Planning Commissions to develop safe routes to schools programs which use encouragement, education, increased awareness, and enforcement to support students' safely walking and biking to school.

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. State and local planning for implementation of school and community physical activity programs related to Blueprint for Health and the Fit and Healthy Vermonters Obesity Prevention Program.	X	X	X	X
2. Support of existing programs to promote physical activity in children such as Fit WIC, SPARK, Girls on the Run, etc.	X	X		
3. Support of communities as they develop a variety of walking and physical activity programs.	X	X		
4. Funding for further community infrastructure projects via Safe Routes to School.				X
5. Participation in follow up to the Healthy Lifestyles components of H.887			X	X
6. Governor's Daylight Savings Challenge programs designed for year round activities.	X	X		

7. Launch Get Moving Vermont website to be used for physical activity team activities	X	X		
8.				
9.				
10.				

**b. Current Activities**

As listed above and also the following:

1. Vermont Safe Routes to School: Uses Agency of Transportation funds. In 2007, funds were distributed to 22 schools, totaling \$1.6 million for "infrastructure projects" such as sidewalks, improving lane markings, lighting, etc.

2. VDH participation in advising on the Healthy Lifestyles component of H.887 Health Care Reform Bill.

**c. Plan for the Coming Year**

Activities as above and also the following:

1. Participation in the policy and community support activities of H.887

2. Launch the Get Moving Vermont website that can be used to set up community teams, incorporate competitions between towns, worksites, etc. and be used for individuals to monitor and track their own progress toward physical activity goals.

**State Performance Measure 7:** *The percent of children with SSI who receive an annual care plan.*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				13	14
Annual Indicator			12.6	12.3	11.2
Numerator			193	203	177
Denominator			1537	1644	1584
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	14	15	15	15	15

**Notes - 2007**

The data for 2006 were updated to reflect more complete information.

**Notes - 2006**

Last year's provisional results were recalculated with more complete data and indicated that there were 193 care plans written in 2005, compared with 203 for 2006.

**Notes - 2005**

Data from previous years is not readily available.

**a. Last Year's Accomplishments**

1. Assist families with SSI and Katie Beckett applications to increase eligibility. This is an important effort, as families deal with rising expenses and insurance premiums. Both SSI and KB

provide medicaid eligibility for the CSHN, without premiums.

2. Annotate CSHN program enrollment database with SSI eligibility. Our CSHN database has made good progress with noting each child's SSI status, as well as their medicaid eligibility category and other insurance coverage. We use standing queries to build tables which link information from the many sub-databases within our system.

3. Efforts to promote the annual care plan as a medical home service, through partnership with AAP, especially for the child with SSI. Medicaid has clarified that only children who have the "Primary Care Plus" version of Medicaid (the state's managed care program) are eligible for annual care plan reimbursement to their PCPs. About 80% of all children who have Medicaid have PC plus, however, 94% of the children who received care plans are enrolled in PC plus; the others have low income medicaid categories.

4. Provide TA to medical homes to improve billing practices for care plans. Effective Medicaid billing (for all services) continues to be a major focus of the AAP outreach to its members.

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to assist families with SSI and Katie Beckett applications to increase eligibility.		X		X
2. Continue to annotate CSHN program enrollment database with SSI eligibility.				X
3. Expand efforts to promote the annual care plan as a medical home service, through partnership with AAP, especially for the child with SSI. We must explore with Medicaid the opportunity to expand to ALL categories of medicaid, not just PC plus.		X		X
4. 4. The new CSHCN SIG grant will also assist with supporting this key component of the Medical Home.		X		X
5. Provide TA to medical homes to improve billing practices for care plans.		X		X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

As above:

1. Continue to assist families with SSI and Katie Beckett applications to increase eligibility.
2. Continue to annotate CSHN program enrollment database with SSI eligibility.
3. Expand efforts to promote the annual care plan as a medical home service, through partnership with AAP, especially for the child with SSI.
4. Provide TA to medical homes to improve billing practices for care plans.

**c. Plan for the Coming Year**

1. Continue to assist families with SSI and Katie Beckett applications to increase eligibility. Even though the shrinking of state government positions has affected CSHN clinical positions, we will continue to make this a focus of our work in support of families.
2. Continue to annotate CSHN program enrollment database with SSI eligibility. With our new CSHN SIG, we anticipate increased attention and support to the stability and accessibility of our data system.
3. Expand efforts to promote the annual care plan as a medical home service, through

partnership with AAP, especially for the child with SSI. We must explore with Medicaid the opportunity to expand to ALL categories of medicaid, not just PC plus.

4. The new CSHCN SIG grant will also assist with supporting this key component of the Medical Home.

5. Provide TA to medical homes to improve billing practices for care plans--continue, through the AAP.

**State Performance Measure 8:** *The percent of low income children (with Medicaid) who utilize dental services in a year.*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	51%	51	52	52	54
Annual Indicator	48.0	47.7	49.1	49.2	50.2
Numerator	35733	35845	36413	36376	35912
Denominator	74501	75144	74140	73886	71551
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	54	55	55	55	55

**a. Last Year's Accomplishments**

1. WIC screen and referral for Dental Health Services.
2. Close coordination with VDH Office of Oral Health to improve educational materials for both parents and dentist.
3. VDH Oral Health distributes a dental health newsletter to pediatric and general dentists and updates to VDH website.
4. WIC: Coordinate parent education and family referral systems with child care providers.
5. Continue to administer and expand Tooth Tutor programs as capacity allows.
6. Continue to monitor, via the school health emergency card, the number of children reporting they do not have a dental home.
7. Beginning followup to the statewide Oral Health Plan and Dental Dozen - information and planning meetings held at all twelve VDH District for community and clinical service providers about oral health service delivery issues.
8. Planning for including oral health into educational sessions for child care providers - educate providers about the importance of oral health and how to refer children to dental services.
9. Collaboration between FQHC and VDH Rural Health to create dental clinic in the Community Health Center in Rutland.
10. Loan/scholarships for dental health professionals administered via Office of Rural Health.

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

<b>Activities</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
1. Coordinate with Dental community and Medicaid to implement	X	X	X	X

new pediatric periodicity schedule				
2. Incorporate oral health information into trainings for health consultants and child care providers.	X	X		
3. Expand tooth tutor as capacity allows.		X		
4. Continue VDH district communications statewide to follow up on oral health plan and Dental Dozen			X	X
5. Pilot to place dental hygienists in four district offices.		X	X	
6. Pilot to place dental hygienists in large pediatric offices.		X		
7. Train pediatricians and family practice physicians to perform oral health assessments on infants and toddlers.			X	X
8. EPSDT and school nurses monitoring/follow up with children who report not having access to dental home.	X	X		
9. FQHC offering clinical dental services.	X	X		
10. Loans and scholarships for dental health professionals			X	X

**b. Current Activities**

Activities as listed above and also the following:

1. Planning for including oral health into educational sessions for child care providers - educate providers about the importance of oral health and how to refer children to dental services.
2. Planning to place a dental hygienist in one of the state's largest pediatric practices to evaluate the oral health needs of children, ages 0-3 who use Medicaid insurance - assess and referral to participating area dentists.
3. Development of 12 strategies from the Oral Health Plan and building capacity through staffing and funding.
4. Continue planning for dental hygienists to be placed in four VDH district offices - pilot project to do case management of children needing a medical home.
5. Data on dental home from school health emergency card is able to be organized and retrieved electronically.
6. Vt Dental Periodicity Schedule created in conjunction with recommendations of American Academy of Pediatric Dentistry.

**c. Plan for the Coming Year**

Activities as listed above and also the following:

1. Intense planning and implementation of Dental Dozen initiative.
2. Work with Medicaid/AAP partners for reimbursement to PCPs to apply varnish for children under age 3.
3. Planning continues to expand program to placement of Dental Hygienist in pediatric practices, also planning a pilot program to place a dental hygienist in an OB clinical practice.
4. Coordinate with Medicaid and dental providers to implement new dental periodicity schedule.

**State Performance Measure 9:** *The percent of children with emotional, developmental, or behavioral problems that require treatment or counseling who received needed mental health services in the past year.*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				72	72
Annual Indicator			70.0	70.0	70.0
Numerator			7956	7956	7956
Denominator			11371	11371	11371
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	73	74	75	75	75

**Notes - 2007**

These data are derived from a NSCH survey that was last carried out in 2003-04. The estimate for 2007 is therefore carried over from the previous years.

**Notes - 2006**

These data are derived from a NSCH survey that was last carried out in 2003-04. The estimate for 2006 is therefore carried over from the previous year.

**Notes - 2005**

2005 data is from NSCH survey carried out in 2003-04. US rate is 58.7%. This is a new measure created for the FY07 Title V application.

**a. Last Year's Accomplishments**

1. Fostering Healthy Families public health nurse coordinates with local child welfare office staff to complete the Health Intake Questionnaire on all children who enter state custody - assists the state child custody system to ensure that the child receives needed medical and behavioral health care.
2. Continued support to the integration of early childhood childhood services (Family Infant, Toddler, Children's UPstream Services, Healthy Babies, Kids and Families)
3. Medicaid waiver to enable children to receive treatment in home or community to avoid psychiatric hospitalization.
4. VDH Division of Mental Health providing support and oversight of children admitted to psychiatric hospitalization and ensuring that discharge planning takes place.
5. DMH is part of the interagency Case Review Committee for children being considered for residential treatment placement for mental health needs. The committee ensures that each child's needs are met in the least restrictive environment appropriate, the proposed placement offers the needed care, and the child's treatment team actively prepares for the child's return.
6. VDH, Dept of Mental Health, Fletcher Allen Health Care, the Office of Vermont Health Access, and the state's network of community mental health centers (CMHCs) worked together to identify the variety of models available and to assure coordination between the different entities to ensure mental health services are reaching communities effectively.
7. CMHCs provided core capacity services to 9,600 children and adolescents. Services fall into 4 categories: (1) prevention, early intervention, and community consultation; (2) supports; (3) clinical treatment in outreach and clinic settings; and (4) immediate response, acute care, and access to intensive residential treatment.
8. Achieved state-wide implementation of the JOBS program which links mental health services to education and employment for transition age youth who have dropped out of school and/or have been involved with juvenile justice or adult corrections.
9. Department of Mental Health is re-created from being folded into the Department of Health in Agency of Human Services Reorganization of 2005.
10. Begin planning for integrated system of care for mental health services for children and

families. This may include such initiatives as: 1) system of contractual relationships for school-based services using potential new reimbursement systems available under Global Commitment. 2) Co-location of mental health/substance abuse professionals placed in primary care offices 3) Consultation and education to primary care offices

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

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Health intake questionnaire on all children entering state custody.	X	X		
2. Community care coordination via CUPS.		X		
3. VDH/VCHIP create depression screening tool for use by PCP for screening youth for depression.	X	X		
4. VDH role in oversight to systems of community mental health organizations to assure capacity, quality, and discharge planning.		X	X	X
5. Child tele-psychiatry pilots in community health centers			X	
6. UVM child psychiatry fellowship	X			
7. Medical home for adolescents transitioning to adult life	X	X	X	X
8. Co location of mental health services	X			
9. Increased access to psychiatric consultation services	X	X		
10.				

**b. Current Activities**

Activities as listed above and the following:

1. Psychiatric Consultation [University Pediatrics, UVM Child Psychiatry faculty, Berlin Family Health, Essex Pediatrics] provides child psychiatric consultations to PCP's in several forms: a) 6-7 hours per month of on-site consultation to medical providers on psycho-pharmacological treatment of their patients and on deepening their knowledge of psychiatric conditions, b) In the ADHD project, consultation is provided via fax/e-mail correspondence. c) Limited telephone and/or face-to-face consultation by full-time faculty in the Dept of Psychiatry at UVM's College of Medicine.

2. Psychiatric Consultation [DMH and Otter Creek] provides training and TA to primary care providers to improve ability to screen, diagnose, refer, and assist Medicaid eligible children to access mental health services. Consultation available on specific conditions, psychotropic medications, and interaction with other patient meds.

3. Co-location of CMHC clinical staff at family/pediatric medical practice and at a small rural medical center - providing ready access to information for practitioners and to services for children and families in a non-stigmatizing environment.

4. DMH leading two workgroups for AHS/DOE to assure sustainability and desired outcomes for Success Beyond 6 Programs that provide mental health services in educational settings. (47% of all children who receive public mental health services are in education settings)

**c. Plan for the Coming Year**

Activities as listed above and the following:

1. The Vermont legislature appropriated \$100,000 in the spring of 2008 to VDH for the child psychiatry division in the Vermont Center for Children, Youth, and Families (VCCYF) to support

child tele-psychiatry pilots in community health centers that will: a) Pair VT health centers' medical, nursing, social work, and psychology staff with the UVM VCCYF child psychiatric consultative team; b) Provide monthly training and education resources for health center staff by UVM faculty; c) Help strengthen and expand the newly established UVM child psychiatry fellowship program; and d) Provide critical child psychiatry assessment and consulting services across the state that will establish relationships to help recruit and retain new child psychiatrist for Vermont.

2. VDH, DMH, and SA will work to develop a medical home for adolescents transitioning to adult life.

3. VDH and DMH will participate in an agency-wide initiative to improve supports, services, and outcomes for adolescents transitioning to adult life.

**State Performance Measure 10:** *The percent of one year old children who are screened for blood lead poisoning.*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				80	82
Annual Indicator	66.9	73.4	75.1	77.5	80.0
Numerator	4329	5007	5119	5209	5249
Denominator	6467	6818	6818	6721	6560
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	82	83	84	85	90

**a. Last Year's Accomplishments**

1. Ongoing program to assess and offer lead screening in WIC clinics and support to providers to incorporate into their practices.

2. Instruction and logistical support for performing lead screening available to primary care practices and clinics.

3. Collaborations with housing authorities to perform lead abatement at identified homes.

4. Postcards routinely mailed to parents of 10 and 20 month old children reminding them of need for lead screening at their medical home.

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

<b>Activities</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
1. Assess and offer Lead screening services at WIC clinics.	X			
2. VDH to offer instruction and logistical support for lead screening to primary care providers and community health centers.		X	X	

3. Collaboration with housing authorities to perform lead abatement at identified buildings.			X	
4. Increase surveillance system capacity so as to capture all lead screening and testing results into one data system.				X
5. Geocoding system to identify high risk communities.			X	X
6. Postcard mailing to parents of 10 and 20 month olds reminding of need for lead screening.		X		
7. Postcard mailings to rental property owners about compliance with Vermont's lead screenings laws.		X		X
8. Community grants			X	
9. Public media and awareness activities		X		
10. Implementation of VDH-related aspects of recently passed lead legislation	X	X	X	X

**b. Current Activities**

Activities from last year in addition to the following resulting from a strategic planning process:

1. Public media campaign on the dangers of childhood lead poisoning: health fairs, Welcome Baby bags, poster, attendance at home shows, etc.
2. Additional staff capacity for CLPPP.
3. Collaboration with specific communities of Burlington and Bellows Falls for activities.
4. Postcard reminders to 9,000 rental property owners about compliance with Vermont's lead law.
5. Geocoding system to identify high risk communities.
6. Provide education to Legislators for crafting of Lead legislation dealing with essential maintenance practices, safe housing, lead in consumer products, child screening requirements, etc.

**c. Plan for the Coming Year**

Activities from last year in addition to the following:

1. Continue with aggressive approach to implementation of Lead Strategic Plan.
2. Support enactment of recently passed legislation and implement activities related to its regulations.
3. Provide support to provider community with trainings and TA to achieve goal of screening 85% of 1 year olds and 75% of 2 years olds by January 2011. Overall goal is to move routine lead screening into the medical home.

**E. Health Status Indicators**

The Title V program has been moving aggressively to become a more data-driven system. As the data requirements of this program have increased, the need for data support has also increased. This discussion will provide an overview of the available MCH data, the VDH capacity for analysis, use of the data for planning and evaluation, and plans for future analysis and reports. The SSDI funds provide significant support for the MCH data analysis in Vermont. In addition, this data support and analyses will be a major support for the planned MCH strategic planning in

2007-2008 and the 2010 Strengths and Needs Assessment. /2008/ See also related discussions and updates in Section IIIA State Overview, Section IIIF Health System Capacity Indicators, and the 2005 Strengths and Needs Assessment.//2008// **/2009/ Realignment of Division of MCH has been the main focus this past year. Strategic planning to be performed in concert with 2010 Strengths and Needs Assessment. SSDI support will be invaluable for both initiatives. Information that the SSDI program is now compiling and producing, such as the MCH Indicators Reports, will help to direct the Title V strengths and needs assessment and resulting VDH prioritizing and program planning //2009//**

The MCH Surveillance Quarterly Report was developed in the late 1980's when obstetricians were closing their practices or limiting the number of patients they were accepting. The report was designed for early identification of problems or changes in key OB/MCH indicators. The report is based on preliminary vital records data from the twelve months previous to the publication date. In addition to entry into prenatal care the report includes tables and graphs of low birthweight, teen births and pregnancies, and infant mortality.

These quarterly updates are also used by program planners for VDH, especially in the Divisions of Health Improvement and Community Public Health and by the local MCH Coalitions in each VDH district. Other state agencies, such as the AHS planning office and Department of Children and Families in addition to non-state organizations such as Vermont Child Health Improvement Project, the Vermont Regional Perinatal Program, and the Vermont Program for Quality in Health Care use this data for planning and monitoring and program evaluation. In July of 2006 the VDH implemented the revised birth certificate. This provides an opportunity to review and modify the MCH Quarterly Report. There are many new data elements on the revised certificate, and there has been interest expressed by program staff in adding some of these items, such as weight gain and smoking.

The low birthweight rate in Vermont has been relatively stable for the past several years, however this current rate is significantly higher than it was in the late 1980's and early 1990's. It is essential that policymakers have a longer-term perspective of changes in key indicators. Thus, in addition to the on-going quarterly reports, VDH is planning (with SSDI support) to produce an annual report to monitor trends in key MCH indicators. This new report system is envisioned to include various measures, including Title V national and state performance measures, health outcome measures, health status indicators and health systems capacity indicators.

The low birthweight rate has been increasing in Vermont since the early 1990's, however the increase has been found primarily in the moderately low birthweight category. This raised questions as to whether these babies are small, but generally healthy or if these babies are experiencing increased morbidity. As part of the current SSDI grant, a report examined Medicaid claims data for infants who were born in 2001-2002, were eligible for Medicaid at birth and continuously enrolled in Medicaid until their 2nd birthday. It was found that children who were moderately low birthweight infants were more likely to be hospitalized (49% vs. 17%), had more emergency department visits (2.3 visits vs. 1.8), had more physician office visits (26.6 visits vs. 22.2), and had more drug claims (13.4 vs. 9.9) than children born at normal birthweight. The average cost over the first two years of life for those born at moderately low birthweight was three times the cost of those born at normal birthweight (\$15,486 vs. \$5,146). As capacity allows, it is planned to extend the analysis to the child's 5th birthday to determine if the differences in health care utilization continue as the child gets older.

A significant analysis was performed using the data from the 2004 WIC and Birth Certificate records. Selected measures by WIC client status were used, comparing the prenatal WIC client. Also included was a comparison of the WIC participation level of various demographic groups. The data show that the WIC population has worse outcomes than the non-WIC population as measured in the rates of: early start of prenatal care, adequacy of prenatal care, smoking during pregnancy, adequate weight gain, preterm delivery, low birthweight, singleton low birthweight, and small for gestational age **/2009/ HSCI #5 indicates that women who use Medicaid have**

**statistically significant higher rates for percent low birth weight babies, early prenatal care, and adequate prenatal care. There is no significant difference for the rate of low birth weight babies by Medicaid use. The WIC enrolled mothers are used as the surrogate population for Medicaid, because in Vermont the women who are eligible for WIC are also eligible for Medicaid. Information such as this and other analyses describing disparities reflecting social economic status will inform MCH planning and 2010 Strengths and Needs Assessment //2009//**

The analysis showed that WIC participation (prenatally) as a portion of all VT resident births held steady at about 39% in 2004. WIC participation within various demographic groups shows the same pattern reported for 2002 and 2003. Most young mothers are in WIC (70% of those under the age of 25), most older mothers are not (20% of those over 30). Most single mothers are in WIC (71%), relatively few (24%) of the married mothers. Most smoking mothers are in WIC (73%), but only a minority (31%) of the nonsmoking mothers. Most mothers with HS education or less are in WIC (64%), while the more educated mothers generally are not (19%). Again, there is no significant difference between first pregnancies (38% in WIC) and subsequent pregnancies (40% in WIC). The demographics, smoking rates, inadequate weight gain, and breastfeeding of the post-partum-WIC-only group are intermediate between the prenatal-WIC and the non-WIC groups, but the rates of obesity, short interpregnancy interval, low-birthweight, and preterm delivery are similar to that of the prenatal WIC clients.

There are plans to combine the information from both PRAMS and the traditional MCH status indicators (from vital statistics) data to prepare new reports for planning. VDH MCH planners and program administrators will benefit from the fresh approach now enabled by the many various combinations of data elements from both sources of data. Using SSDI support, a report is possible examining various elements of the prenatal counseling topics that are included in the PRAMS survey -- the first of these PRAMS Data Briefs has been produced in July, 2007. Also, these new data opportunities allow the creation of a report to monitor preconceptual health. Using the recommendations of the CDC/ATSDR Preconception Care Work Group as guidelines, it is planned for the SSDI Coordinator to draft a set of indicators and data sources, such as from the PRAMS and the Behavioral Risk Factor Surveillance System, for this report. These reports will be of great value to Title V planning and the MCH Advisory committee **//2009/ The SSDI Coordinator has identified a wide range of potential indicators available from the Behavioral Risk Factor Surveillance System, the Youth Risk Survey, PRAMS, and WIC that could be included in this report. Next steps are to further categorize these indicators, determine the best data source when more than one is available, and present them to MCH program directors and staff for their review //2009//**

**//2008/ New data analyses from PRAMS is proving invaluable for both strategic planning and program planning. For example, the 2003 data show that 50% of women using WIC reported their pregnancies were unintended, versus 20% of non-WIC women. In addition, 30% of women using WIC were at or above 30% BMI or as compared to 20% of non-WIC women. Over 40% of women using WIC smoked in the three months before they became pregnant, as compared to 15% of non-WIC women. These and other data describing women's health behaviors and needs will be further analyzed and incorporated into major planning efforts.//2008//** **//2009/ Continued routine PRAMS Data Reports are being issued -- topic include breastfeeding, co-sleeping, housing, intendedness, drug/alcohol/substance use, psychosocial stressors, etc //2009//** In addition, pending SSDI support, an analysis of Vermont-specific data from the 2007 National Survey of Children's Health is planned. Using the national report as a model, the analyses will be replicated with the VT-specific data. Preliminary results will be reviewed with the MCH Director, the MCH Advisory Committee, and others as appropriate for comments and suggestions. A report of the findings will be completed. Depending on the findings, further analyses may be conducted.

WIC and non-WIC analyses as planned are as follows: (1) an evaluation of the match; (2) a comparison of WIC and non-WIC clients on demographics, risk factors and birth outcomes; (3) a

trend analysis of those same measures for WIC clients; and (4) a VDH district-level report which combines the most recent three years of data.

An SSDI-supported analysis of hospital data was conducted during 2005 and 2006. Data was analyzed by 5-year age groups examining changes in utilization rates and reasons for inpatient hospitalizations over 10 years. Emergency Department data is more recently available and we are examining reasons for ED visits in 2003. For this next grant period we plan to update the inpatient analysis, and examine several years of ED data. VT is also beginning to collect additional outpatient procedure data, and we will explore what information may be available from this data source.

***/2009/ General updates on SSDI funded activities are as follows: The 2006 birth records were matched to infant deaths, the WIC records, the Medicaid eligibility and claims files, and the 2006 and 2007 birth records have been matched to the newborn metabolic screening records. A report based on the WIC/Birth record match was completed and distributed to the MCH team. The report presents data on demographics, risk factors and birth outcomes and consists of three parts -- a comparison of WIC and non-WIC clients, a trend analysis for WIC clients from 1996--2006, and a Vermont Department of Health (VDH) District Office level report. MCH Surveillance Reports based on birth certificate data have been produced and distributed quarterly. The 2005-2006 National Survey of Children with Special Health Care Needs has been analyzed with a focus on comparisons to the National and Region I data, assessment of Vermont's ranking on key indicators, and where possible, comparisons to Vermont's 2001 data. We have completed the compilation and reporting of data for this year's Title V grant submission. The 2006 newborn bloodspot screening records were linked to the 2006 birth certificate records in July, 2007 and the 2007 records were linked in May 2008. IN both years, all records were accounted for -- that is all births that occurred in Vermont were either matched to a screening record, or were documented as an out of state transfer, a refusal or an early infant death. Vermont participates in the Pregnancy Risk Assessment Monitoring System (PRAMS), and this survey of new mothers includes questions on whether the mother was on WIC and whether Medicaid paid for her prenatal care and delivery. The PRAMS sample is drawn from the birth certificate, which allowed us to compare the results of our linkages to the responses from the PRAMS survey. We found excellent correspondence between our WIC linkage and the PRAMS responses //2009//***

***/2009/ Regarding the Six CSHN performance measures, an analysis showed that the changes between the 2001 data and the 2005/06 data for NPM 2 and NPM 4 are not statistically significant and cannot be considered to reflect a true difference in survey responses. For NPM 3 and NPM 4, the differences between the years of 2001 and 2005 cannot be compared because of different wording and other additions to the questions used in the survey. In addition, for NPM 6, the data from the two different surveys also cannot be compared. Compared to the 2001 survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the indicator. There were also issues around the reliability of the NPM 6 2001 data because of the sample size. Thus, the data for NPM 6 cannot be compared, however, the data for NPM 6 for 2005 can be considered baseline data //2009//***

Many VDH staff and statewide partners are involved in monitoring data and trends for infant and child unintentional deaths. The Child Fatality Review Committee performs a thorough review of all child deaths from unnatural causes, especially those due to child abuse, drug overdose, injuries, motor vehicles, and SUDI. The VDH's Injury Prevention Program's Advisory Committee is also a key partner in monitoring trends and responding to the unique issues that affect Vermont's child death rates. For example, a state wide symposium was held in July, 2006 to assess the issue of death and injury associated with young teen drivers. /2008/ VDH providing data support to the Child Fatality Review Committee for the Committee's preparation of a status

report on child deaths for the years 1995-2005.//2008// **/2009/ Report released Spring 2008**  
**//2009//**

The recent SSDI-supported partial analysis of the 2005 National Survey of Children's Health has been helpful to MCH injury prevention staff. For example, although VT compares favorably to national data on most measures, the percent of children ages 6-11 that stay home alone is significantly higher in Vermont. This finding is particularly salient following the March, 2006 drowning of three young children who were playing unsupervised after school. More detailed analysis in this area would provide valuable information for policymakers.

The Vermont Injury Prevention Program's infrastructure is based on the State and Territorial Injury Prevention Directors Association's (STIPDA) Safe States five component public health approach to injury prevention. The first component is directed at determining the burden of injury and developing a plan of action -- planning for this component is happening at present. The draft list of categories of injuries that have been identified in the Vermont Injury Surveillance Plan (in congruence with CDC grant requirements) are as follows: suicides, falls, motor vehicle injuries, poisoning, firearm-related injuries, homicides, TBI, drowning, and fire-related injuries. Injury Surveillance Data Sets utilized in Vermont are as follows: Vital records, Hospital discharge data, Hospital emergency department discharge data, Fatality Analysis Reporting System (FARS), Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Surveillance System (YRBS), Medical Examiner (ME), National Occupant Protection Use Survey (NOPUS) and Uniform Crime Reports (UCR.) **/2009/ Beginning support from Children's Safety Network to analyze Vermont farm-related injuries and fatalities. Continue this effort with MCH statistics and research staff and also CSN as appropriate for 2010 Strengths and Needs Assessment and also as support to the newly formed Farm Health Task Force //2009//**

SSDI support enabled the analysis of the 2003 Emergency Department data, the first complete year of ED data. The 2004-2008 ED data will be available for future analysis, enabling the monitoring of changes over time in the number and rate of visits and reasons for the visits. Preliminary results will be reviewed with the MCH Director, the Injury Prevention Coordinator, the Emergency Medical Services for Children Coordinator and the MCH Advisory Committee, and a final report will be completed. Depending on the findings, further analyses may be conducted.

Vermont injury data demonstrate that motor vehicle crashes among teens and young drivers are the number one injury for this age group. An SSDI-supported analysis also reported that between 1994 and 2003, 105 children aged 0-14 were injured in nontraffic motor vehicle accidents in Vermont, averaging almost 47% of those injured in traffic accidents. In 2003, as many children were injured in nontraffic crashes as those injured in traffic crashes. More than half of these injuries occurred to the driver, and almost two thirds involved off-road vehicles. Among youths 15-24, there were 156 nontraffic crash injuries, which averaged almost 12% of the traffic crash injuries. In this ten year period, there were 41 deaths among children from motor vehicle crashes, and 213 deaths among youths 15-24. Few of these deaths occurred in nontraffic crashes, three among children and one among youths driving off road. Traffic crashes killed 38 children and 212 youths in that same time period.

In addition, it was found that a total of 16 children were injured in snowmobile crashes between 1994-2003, which represented 6.2% of the total snowmobile accidents. There were crash injuries to 60 youths aged 15-24, which was almost one quarter of all snowmobile crash injuries.

/2008/ Regarding the analyses for HSI 4, the data for all nonfatal injuries for children ages 14 and younger reflect a rate of 176/100,000 as taken from the hospital discharge data from inpatient stays. This data reflects the number of injury events, not the actual number of children injured. However, because this number reflects only inpatient stays, it accounts for less than 2% of all unintentional injuries in this age group of 0-14 years. In 2005, a total of 14,791 injuries to children aged 0-14 years were seen in hospital related clinical systems (emergency rooms, outpatient clinics, and inpatient admission) for treatment of unintentional injuries. Of these injuries, 441 were

related to motor vehicle crashes and 244 were due to non-traffic motor vehicle events. Considering inpatient stays for the age group of 15-24 years, the rate is 166/100,000. In 2005, a total of 18,198 youths aged 15-24 were seen in hospital-related clinical systems for treatment of unintentional injuries. Of these injuries, 2,181 were related to motor vehicle crashes and 412 were due to non traffic motor vehicle crashes. Thus, a rate for all unintentional injuries for the 0-14 age group is 13,938/100,000 and for the 15-24 age group is 19,997/100/000. //2008//

Data on Chlamydia and other sexually transmitted diseases are collected and analyzed from laboratory reports to the VDH. The Sexually Transmitted Disease Program within the Division of Health Surveillance monitors prevalence of these diseases and collaborates with state and community organizations such as Planned Parenthood, American Red Cross, Department of Education and many local groups to direct efforts at prevention and treatment.

A VDH grant for obesity prevention was been received from the CDC in July, 2004. The grant supports 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 beyond the traditional WIC and YRBS data bases. Ongoing data-related activities from the CDC Nutrition Grant include: 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. In 2006, the Obesity Burden Report has been published using data sources of BRFSS, YRBS, PNSS, PedNSS, Vital Statistics, and the National Immunization Survey. See discussion of obesity prevention and Fit and Healthy Vermonters activities in Section IIIA.

//2007//The VDH, via the Office of Minority Health, is beginning a new approach to overall analysis of health disparities in relation to race and ethnicity, such as assessing the needs of migrant farm workers and Vermonters who are of Native American heritage. The minority health assessments will also focus on health disparities as related to poverty and the unique issues of special populations living in rural areas. In addition, these analyses will use approaches using GIS techniques//2007//

Data on the social and economic status of Vermont families is available from numerous state agencies in addition to the Vermont Department of Health, such as Department of Employment and Training, Department of Education, Department for Children and Families, and the Department of Public Safety (Vermont Criminal Information Center.) Also, the Center on Rural Studies at the University of Vermont provides a wealth in information for planning and evaluation on aspects of Vermont rural life such as health, education, social status, and economic well-being. The Vermont Agency of Human Services Planning Office produces a comprehensive annual report entitled Vermont Well Being. The report compiles a variety of indicators that describes health and social well-being from a broad definition using health, education, social, and community indicators. The report is used by state administrators in all departments for program planning, management and also offers measurements for broad evaluation outcomes. Vermont Well Being also contains data and techniques using the asset measurement approach -- an approach which was used by the MCH Advisory Committee in preparing the Title V 2005 Strengths and Needs Assessment. Many of the measures and goals from the Vermont Well Being were adapted for use by VDH MCH planning.

For FFY 2006, the Title V Strengths and Needs Assessment was performed and the report is submitted with the Title V FFY06 application. New sources of qualitative and quantitative data

that have been developed over the years (via SSDI and other initiatives) have informed the assessment. An approach of assessing both the strengths and needs of Vermont's MCH population has been used. Region 1 has collaborated on this overall approach of assessing strengths and needs of a population and on choosing appropriate common measures./2008/Newly analyzed data such as for PRAMS, childhood injury, and also parent surveys from Parent to Parent will be used in Title V strategic planning which is to begin in the Fall of 2007 and linked to the 2010 SNA.//2008// **/2009/ Parent to Parent is merging with the VT Parent Information Center, to form the Vermont Family Network (VFN) in July, 2008. The new organization will enable more comprehensive family input into the SNA. Parent to Parent became one of the Family to Family Health Information Centers in 2002. The P2P director writes, "This federal grant, now a part of the Family Opportunity Act, interacts seamlessly with the support we receive from Title V. The effect of this investment in family services means families are better informed about their child's diagnosis, available supports, connected to other families and therefore less isolated, and more families are accessing health insurance to pay for their child's care." P2P (VFN) continues to collect and report to CSHN data about what families say they need from their child's health care system //2009//**

## **F. Other Program Activities**

Refugee Program: Health evaluation for newly arriving refugee families takes place within 30 days of arrival and is conducted by medical homes located in the county where the refugee is resettled. VDH maintains relationships with medical home to ensure they are prepared to meet the health needs of refugees that are seen in their practices. The Refugee Health Coordinator, the State Coordinator, and the District Office staff work closely with the Vermont Refugee Resettlement Program and other community-based organizations to assure that critical health services are both available and culturally appropriate. Since 1980, Vermont has received approximately 5,000 refugees. The goals of the refugee health program continue to focus on health outreach for refugees, technical support for providers, and surveillance of infectious diseases.

Office of Minority Health (OMH) supports and initiates VDH program strategies that address disease prevention, health service delivery and applied research for minority and health disparate populations. The OMH also promotes cultural competency support within the VDH and with state and local partners. 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/2007/ Newly hired OMH Director to develop methods of defining minority health issues around quantifiable disparities that arise from differences due to SES and also those from living in rural areas.//2007// /2008/Draft Minority Health Plan completed. OMH coordinated with local health coalitions on health issues affecting the families of migrant Mexican farm workers. Position of Director of OMH is presently vacant, but an interim special assistant to the Commissioner will focus on minority health affairs//2008// **/2009/ Interim special assistant continues to work on key goals of OMH strategic plan 1) Building infrastructure 2)Data quality, collection, reporting 3) Cultural competency training 4) Community development and leadership //2009//**

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) through a network of community based

activities. See Section IIIB and SPM 3.

The Office of Rural and Primary Care receives funds from the HRSA Bureau of Health Professions and the Office of Rural Health Policy to improve access to health services for underserved populations. This is done through planning, technical assistance, grants, coordination and advocacy. Activities are: 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 and program grants to the statewide AHEC and Free Clinics. The Steering Committee is composed of a broad range of provider groups concerned with access to care: 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. 2002: Nursing loan repayment enacted by state legislature. Primary Care Loan Repayment Program updated in 2002. 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. In 2004, the Office began working with the Medicaid Office, Dept of Mental Health and the Office of Alcohol and Drug Abuse programs to examine policy, programming and funding to support the integration of behavioral health and primary care. In 2003, the Office received a grant from the RWJ Foundation to increase access to oral health services for Medicaid eligibles: 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. The Office has been very active with development of the Vermont State Oral Health Plan/2007/Nurse faculty loan repayment program, FQHC Look Alike development, migrant farm worker health and health access assessment, statewide healthcare workforce development planning//2007// /2008/Nurse faculty loan repayment has been refunded. Planning for integration of children's mental health and primary care services, web based referral network for behavioral health services, planning for child telepsychiatry in FQHC sites. FQHC Look Alike planning, assessment of farmer and migrant farm worker health needs, statewide healthcare workforce development. Promotion of dental service access (dental clinics located within FQHC) and dental workforce//2008//**2009/ Planning continues as in 2008. Child Telepsychiatry pilot is being implemented in FAHC sites. Training by University of Iowa faculty in Fall 2008 for clinicians on serving agricultural workers and families //2009//**

AHS Domestic Violence Initiative begun 2002. Domestic Violence Advisory Groups (DVAG) begun 2006: VDH, Dept of Corrections, Dept for Children and Families, Department of Disabilities, Aging and Independent Living, Injury Prevention, and Medicaid. VDH DVAG goals: VDH programs responsive to domestic violence victims, increase awareness among VDH staff of domestic violence as a public health issue, and to develop an agenda within VDH for the primary prevention of domestic violence **/2009/ AHS Secretary approves new policy "AHS Responds to Domestic Violence." Each DVAG is responsible for policy implementation within own department. June, 2008: several states, federal and private entities collaborated to sponsor a well attended conference "Before It's Too Late: Taking Action to Prevent Domestic Violence Homicides in Vermont Communities," focusing on role of bystanders in domestic violence situations. S.112 and S.357 passes, strengthening penalties for domestic violence and assistance for victims //2009//**

Comprehensive Obstetrical Services Program: Administered by OB/GYN, Fletcher Allen Health Care, Burlington, provides comprehensive, team based, maternity care to women who are

socially/economically at-risk. The care coordination team includes an obstetrician, a social worker, a nurse and a nutritionist. Services include comprehensive prenatal care, lab and genetic testing, birth and postpartum services, enrollment in WIC, breastfeeding support, and contraception counseling. Service coordination also happens with the NICU and the intensive services for women who have chemical addictions.

## **G. Technical Assistance**

Title V FFY09 Section IV G Technical Assistance Request for July 2008

I: Vermont Department of Health MCH Strategic Planning

IA: Description of Technical Assistance Requested: Financial support to contract with professional facilitators to guide a strategic planning process for the staff and leaders involved in MCH public health services the Vermont Department of Health.

IB: Reason why assistance is needed: In December, 2006, the Acting Commissioner of Health, Sharon Moffat, called on VDH staff and leaders to engage in planning for a comprehensive realignment of all programs and services in order to better serve Vermont's public in achieving the mission of enabling Vermonters to lead healthy lives in health communities. During 2007, intense planning by staff at all levels of the organization resulted in a variety of creative ideas and structures for the realignment. The resultant organization changes created a new Department of Maternal and Child Health within the Vermont Department of Health. The MCH leaders plan to use this realignment as an opportunity to create a strategic plan for MCH public health services as provided by the Vermont Department of Health. In addition, the strategic planning will be linked to the planning needed for the Title V 2010 Strengths and Needs Assessment. An independent professional facilitator is desired to guide this process. The final deliverable will be a written MCH strategic plan.

IC: What entity would provide the Technical Assistance: A professional facilitator with experience in public health processes will be selected via a search process.

II: Vermont Department of Health MCH Strategic Planning for CSHN

IIA: Description of Technical Assistance Requested: Financial support to contract with professional facilitators to guide a strategic planning process for the staff and leaders involved in the Children with Special Health Needs services the Vermont Department of Health.

IIB: Reason why assistance is needed: In Fall, 2007, the Director of the Division of MCH and the Medical Director of CSHN began a series of discussions with key CSHN staff (such as medical staff of the Child Development Clinic) to examine the possibilities for re-designing the overall system of care for CSHN in the state of Vermont. In Spring, 2008, CSHN applied for and received an MCHB State Implementation Grant for Integrated Community Systems for CSHN grant from MCHB. Both events create an opportunity for analysis and creation of new approaches to health and associated community services for the population of CSHN. A formal strategic planning process will be instrumental in linking these two processes and optimize the opportunities presented by both the grant and other systems changes in Vermont (such as Children's Integrated Services, Blueprint, Medicaid service coordination services, etc.) In addition, the strategic planning will be linked to the planning needed for the Title V 2010 Strengths and Needs Assessment. An independent professional facilitator is needed to guide this process. The final deliverable will be a written comprehensive CSHN strategic plan that reflects both the CSHN planning and the objectives of the Integrated Community Systems grant.

IIC: What entity would provide the Technical Assistance: A contracted professional facilitator with experience in CSHN populations would be selected via a search process.

### III: Vermont Department of Health MCH Strengths and Needs Assessment (SNA)

IIIA: Description of Technical Assistance Requested: Financial support to contract with professional public health consultant to perform the necessary research, compilation of information, and writing to create a comprehensive SNA that meets the requirements of the Title V MCH Block Grant.

IIIB: Reason why assistance is needed: Every five years the MCHB requires states to create a comprehensive strengths and needs assessment of their Title V organizations and of their MCH population which they serve. The SNA is then used for guiding public health planning, service provision, and financing to best enhance the processes for meeting the goals and measures of the Title V Block Grant systems. In order to create an accurate, thorough, and comprehensive SNA, Vermont plans to augment its existing staff capacity by contracting the essentials of the development and writing of a SNA to a public health professional or organization. This entity would work closely under the supervision of the Title V Planner and the Director of the Division of MCH.

IIIC: What entity would provide the Technical Assistance: A contracted professional public health consultant with experience in population health needs assessment and systems analysis will be selected via a search process.

## V. Budget Narrative

### A. Expenditures

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

- **Reorganization.** The Vermont Agency of Human Services reorganized beginning July, 2004. This reorganization transferred Vermont's Mental Health programs into the Health Department. The impact of this change on the Health Department's finances was enormous, since mental health costs essentially doubled the size of the Health Department. However, effective July 1, 2007, the Mental Health programs are removed from the Health Department and a new Department of Mental Health has been created. This new department will continue to share business office functions, IT support and physical space within the Health Department, but it will be programmatically and organizationally separate. None of the Mental Health expenditures are included in this report for FY05 or FY07. "Other federal funds" does not include Mental Health funding, although a large share of these expenditures are for children. Additionally, several programs that had been closely related to Title V have been moved to the new Department for Children and Families, including the payments to community providers for the Healthy Babies program serving pregnant women and infants, and the Family, Infant and Toddler Program funded by the U.S. Dept of Education and formerly part of Vermont's CSHN.
- **Medicaid payments for MCH services.** Medicaid payments for CSHN clinics have increased remarkably in recent years. This is the largest change in the expenditure pattern related to MCH services, and it leads to a reduction in our charges to Title V. 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 therefore is apparent in our FY2006 expenditure report and in budgets for future years.

**Expenditure documentation.** Vermont began using its current accounting system in FY'02. The system is named "VISION," which is an acronym for "Vermont Integrated Solution for Information and Organizational Needs". The accounting package includes the Financial and Distribution modules contained within PeopleSoft's software suite for Education and Government (E&G) version 7.5. It is designed to be an integrated financial and management tool. While most transactions are entered into VISION directly, payroll information is currently run on a separate system and summary payroll data are extracted from the Human Resource Management System (HRMS) and uploaded into VISION. The HRMS software is also a PeopleSoft product and is compatible with VISION. Upgrades to both VISION and HRMS will be implemented in tandem. The VISION system was implemented with as few Vermont-specific characteristics as possible so that future upgrades could be accepted with relatively minimal retrofitting work. VISION contains a number of modules that allow for a variety of functions, such as asset management, as well as expenditure tracking.

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

**Cost Allocation.** The Vermont Health Department operates under a Cost Allocation Plan approved by the DHHS Division of Cost Allocation. Our Plan has been revised due to the AHS reorganization and other changes. This Plan determines how we will collect certain overhead costs into cost pools and how those overhead cost pools will be allocated to the various programs and funding sources, including the Maternal and Child Health Block Grant. Because we have an approved Cost Allocation Plan, Vermont does not have an indirect rate agreement, which would be the alternate method for charging overhead costs to programs. Cost Allocation Plans--instead

of indirect rate agreements--are relatively rare among Health Departments. Basically, the approved methods collect general overhead costs on a quarterly basis into cost pools at the division level and also at the Department-wide level. Allowable charges from the Statewide cost pool are also determined. These three overhead cost pools (division, department and statewide) are then allocated to all of the programs in the department (including state funded programs as well as federally funded programs). The allocation process is based on the relative direct salary costs of each program in the quarter.

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

The current Plan was approved by DHHS Division of Cost Allocation on February 28, 2006. The Vermont Agency of Human Services continues to work with Public Consulting Group, Inc., of Boston on these on-going revisions.

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. Although the Maternal and Child Health Block Grant does not qualify as a "major" program for audit purposes, transactions may be tested as part of a general review of management control. There were no findings related to expenditures funded by the Maternal and Child Health Block Grant in FY 2007.

## **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 requirement. The quarterly calculations of the allowable claim by AHS, like the calculations of the Health Department, deducts one quarter's share of the maintenance of effort amount from our allowable charges prior to determining the cash draw for the quarter. AHS also determines that the needed non-federal share is available for each quarter. Once each quarter, AHS and the Health Department formally review the allowable federal claim after making adjustment for these factors. In this way, AHS assures that the Health Department has an independent review of our claims for federal funds.

30%-30% Requirement. The Health Department calculates the amount expended on each category. For FFY 2006, 42% of expenditures was made in Component B and 49% was made

for Children with Special Health Care Needs.

Administration costs. Administrative costs are defined in the same terms that they were defined in 1989: administrative costs are the extra-departmental costs that are allocated to the Health Department and to the programs within the Health Department. These costs are that component of the allocated costs that are attributable to the support services of payroll, buildings, etc. The definition of "administration" costs does not include costs such as the policy direction activities of the Health Commissioner, etc. The administrative costs of the Maternal and Child Health Block Grant can be readily determined by analysis of the allocated costs, and these costs are tracked on a quarterly basis to ensure that there is no increase in the costs that would exceed the allowable maximum. Administrative costs for FFY2006 were 2.4% of total costs.

Maintenance of effort. [Sec. 505(a)(4)] The maintenance of effort amount for Vermont, based on the amount of unmatched State expenditures reported in 1989, is \$167,093. We deduct one quarter of the maintenance of effort amount from our allowable claims each quarter. 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. As noted above, this has not been changed to include Mental Health expenditures.

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.