Maternal and Child Health Services Title V Block Grant

Vermont

FY 2023 Application/ FY 2021 Annual Report

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Table of Contents

I. General Requirements

I.A. Letter of Transmittal

VERMONT

State of Vermont
Department of Health
Division of Maternal and Child Health
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HealthVermont.gov

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Agency of Human Services

August 12, 2022

HRSA Grants Application Center
Attention: MCH Block Grant
910 Clopper Road, Suite 155 South
Gaithersburg, MD 20878

The Vermont Department of Health has submitted the State of Vermont Maternal and Child Health Services Block Grant program application for FY2023 and annual report for FY2020 (CFDA# 93-994) via the HRSA Electronic Handbook.

If you have any questions, please feel free to contact me at ilisa.stalberg@vermont.gov or 802-951-4026.

Thank you,

Ilisa Stalberg, MSS, MLSP
MCH Director
Division of Maternal and Child Health

I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2021 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: January 31, 2024.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Program Overview

Title V is VT's backbone structure for MCH. Title V allows VT both to align with national priorities, as well as seek emerging priorities within state and local context. VT has used the Title V framework and funding to support staff and programming towards meaningful integration. Title V is the connective tissue to promote and enhance systems integration and partnership for all children and families across the state.

The Vision of our Division of MCH is: Strong, healthy families power our world.
Our mission is: We invest in people, relationships, communities, and policies to build a healthier VT for future generations.

MCH works across the life course to encourage optimal health and positive outcomes for all Ver. We support programs that provide direct services to pregnant people, children and families and build healthy communities. We provide leadership and guidance to professionals who work with children and families in a variety of settings including health care, early care and learning, schools and human service organizations. We respond to the needs of families by helping them connect to resources, improving access to quality health care and services, and ensuring policies and systems are developed to allow all residents to achieve optimal health. Collaboration with local, state and national partners encourages a collective impact resulting in long-term positive outcomes.

Examples of key programs administered by MCH include CSHN, reproductive health, WIC, school health, EPSDT and preventive services, adolescent health, home visiting, child injury prevention, quality improvement in clinical care and community programs, and early childhood services and programming.

We align our Strategic Plan with the Title V framework. (Our Strategic Plan will be extended for another year, due to the impact of the COVID pandemic on our work. We will develop a new Strategic Plan during 2023.)

Priorities

Data analyses from the 2020 Title V Needs Assessment resulted in the identification of MCH population needs and areas where data indicate areas of strength. Despite this, VT continues with longstanding significant disparities.

Women's/Maternal

1. PM: % of women who smoke during pregnancy
   [State] % of women advised by a HCW to abstain from alcohol during pregnancy
   Priority: Ensure optimal health prior to pregnancy

VT has one of the highest rates of smoking during pregnancy in the country: 13.5% in VT (NVSS 2020) compared to the U.S. at 5.5%. This data is more striking when stratified by WIC participation. Yet, VT has good cessation benefits for pregnant individuals through Medicaid and the 802Quits Network, including a moderate financial incentive. Through improved partnerships between MCH and the Tobacco Control Program, Title V has renewed action on this. Ongoing strategies include the promotion of 802Quits Network (ESM), as well as evidence-based training for professionals and a pilot contingency management project with financial incentive.

Like smoking, VT has a very high rate of alcohol use in pregnancy. 11.5% of women drank during the 3rd trimester of

pregnancy compared to 7.5% in the US (PRAMS, 2020). Sixteen percent of women age 35+ drank alcohol during the last 3 months of pregnancy, compared to 9.8% of women nationally (2020 PRAMS). Moreover, 14% of women who drank before pregnancy reported that their providers did not advise them to abstain from alcohol during pregnancy. VT data demonstrate higher rates of alcohol use in pregnancy among older women, yet providers are least likely to advise this population to abstain. Despite VT's former campaign: 049 (zero alcohol during nine months of pregnancy) to message to providers to provide this essential advice, VT's numbers did not improve significantly. Consequently, we have chosen this new PM to reinvigorate coordinated work in this area and have launched a significant evaluation and messaging project: *One More Conversation* to improve these rates, discussed in more detail in the Women/Maternal narrative sections.

Perinatal/Infant

2. PM: % of infants breastfed exclusively through 6 months
   Priority: Promote optimal infant health and development

VT has a strong breastfeeding support system. WIC is respected for its strong clinical and peer counseling services, and MCH works with clinical and community providers to increase awareness and knowledge as to how to support breastfeeding. While VT has high rates of initiation (90.4% in 2018, compared to 83.9% for the U.S. population), there is substantial room for improvement in sustained breastfeeding (36.5% in Vermont vs. 25.8% for the U.S.). Significant disparities regarding education, marital status, age, and WIC participation persist. Prior to the pandemic, VT launched a stakeholder-engaged breastfeeding strategic planning process to identify strategies for the next three years (on hold due to COVID-19 efforts). These included: promotion of Baby-Friendly hospital initiative, coordinated training efforts, as well as efforts aimed at early care and learning and workplaces.

Child

3. PM: % of children, ages 9 through 35 months, receiving a developmental screening
   Priority: Achieve a comprehensive, coordinated, and integrated state and community system of services for children

Data from the 2018-19 NSCH indicate that 51.8% of VT children have been screened for development.

MCH, with key partners, continues work on our system of universal developmental screening through Help Me Grow (HMG). HMG aligns screening efforts across settings to improve early identification by offering free access to a statewide Ages and Stages (ASQ) Online system, which will be integrated with Vermont's Universal Developmental Screening (UDS) Registry, to improve communication and coordination among providers and reduce screening duplication. With the need for telehealth, tele-home visiting, and virtual classrooms during the pandemic, use of HMG's ASQ Online system increased exponentially. By the end of 2020, 2,325 developmental screenings had been completed online. By the end of 2021, this number had grown to 6,418 with over 660 screenings focused on social-emotional development. Developmental screening is a Blueprint for Health and Accountable Care Organization (ACO) quality measure that child health care providers can fulfill by using the UDS Registry. Developmental screening is a standard for all home visiting programs and Children's Integrated Services programs, bringing synergy across multiple initiatives. Between 2020 to 2021, HMG trained 423 health care and human service providers, early childhood educators, and others to conduct developmental and social/emotional screening and to refer families for further evaluation and services.

4. PM: % of children, ages 6 - 11, who are physically active at least 60 min/day
   % of children, ages 1 - 17, who had a preventive dental visit in the past year
   Priority: Reduce the risk of chronic disease across the lifespan

While VT has comparably higher rates of physical activity among 6 to 11-year-olds (33.5% in VT compared to 26.2% in the U.S.- NSCH 2019-20), this rate is shockingly low. VT has long-been engaged in strategies to improve this and is using the opportunity of Title V to enhance coordination with our chronic disease division and other partners. This work includes

strategies such as: promoting VT's 3-4-50 initiative to early care and learning settings and schools; offering bonuses in our early care and learning quality rating system; working with VT's early care professional development system; promoting the use of FitWIC: materials for parents and preschoolers; and promoting school wellness policies. The AHS Secretary has signed increasing interest in this topic so our MCH and chronic disease teams have just begun some internal strategic planning to further joint efforts.

More than 84% of VT children ages 1-17 had a preventive dental visit in the past year, compared to 78% for the U.S. population (NSCH 2019-20)). While VT has fairly good dental coverage rates, access to dental providers is limited, particularly for the Medicaid population. There are significant gaps in knowledge among medical and dental providers regarding oral health guidance. VT has a strong oral health program, coalition, and key strategies are increasing WIC participation in our public health dental hygienist program, increasing student/school participation in the 802Smiles Network of school dental health programs (ESM), and promoting midlevel dental therapists.

5. PM: [State] % of children 6 months to 5 years who are flourishing
   Priority: Promote protective factors and resiliency among VT's families

According to the 2019-20 NSCH, 82.3% of children ages 6 months to 5 years are flourishing, suggesting that about one-sixth of VT's children are not thriving in at least one of four areas: curiosity, resilience, attachment to caregivers, and positive affect. To this end, VT has incorporated *Strengthening Families Framework* into all relevant work, with an emphasis on preventing and mitigating the impact of toxic stress. We are continuing to promote and expand Help Me Grow VT to promote optimal child development by enhancing protective factors, as well as home visiting. We will continue our systemic work to prevent domestic and sexual violence. The state is also investing in Building Flourishing Communities framework with MCH as an essential partner to make a broader connection for our work to increase resiliency in young children and are partnering with the Agency of Human Services Trauma Prevention and Resilience Director to help set priorities and identify and plan activities to promote resilience, as well as developing statewide resiliency messaging and toolkit.

Children with Special Health Needs

6. PM: % of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care
   Priority: Achieve a comprehensive, coordinated, and integrated state and community system of services for children

VT has an already very high percentage of children with medical homes, so we have turned our attention to transitions. According to the 2019-20 NSCH, only 30.8% of adolescents with a special health care need received transition services. VT's CSHN program continues work on establishing strong relationships between its medical social workers and primary care practices with a focus on care coordination activities statewide. CSHN and UVM's Center for Disability Community Inclusion are working together to inventory statewide activities and identify opportunities through a statewide summit. CSHN has worked to build relationships with the statewide network of HireAbility (formerly VocRehab) Transition Counselors.

Data from the 2019-20 NSCH shows that youth without special health needs receiving transition services (24.7%) is similar with to those with special health needs (30.8%) and slightly higher when compared to the nation (17.6%). Clearly, there is much work to do here.

Adolescent

7. PM: % of adolescents, ages 12 - 17, with a preventive medical visit in the past year
   [State] % of adolescents that feel they matter to people in their community
   Priority: Youth choose healthy behaviors and thrive

While VT appears to do well on this measure on national surveys exceeding the HP2030 target and national average (VT

84.8%, US 75.6% in 2019-20, NSCH), state specific data from practice improvement chart audits and all-payor claims data suggest this is still an area of concern. MCH plans to identify and develop communication materials and social marketing strategies for providers, parents/caretakers, and adolescents, to be used in tandem with EPSDT outreach and informing letters, school nurse materials, and patient handouts. Specifically, MCH is working with schools to promote Bright Futures recommendations of an annual well-exam. We are creating opportunities to assess and convene school-based health centers and plan to promote the PATCH for Teens.

Although it is difficult to move the needle on adolescents who feel they matter (58.2% in 2019, down from 60.5% in 2017, but up from 50.5% in 2015; source: YRBS), VT aims to promote healthy behaviors among youth through an empowerment model. VT has joined with other organizations in highly innovative and effective programming: Getting to 'Y' is an opportunity for students to take steps to strengthen their school and community by addressing risks and promoting strengths. Additionally, VT has formalized a Youth Advisory Council. New strategies include participation in the VT9to26 (afterschool) coalition; leadership to the Youth Systems Enhancement Council, and promotion of Youth Thrive as a key framework to support positive youth development. A key concern is the impact of COVID on school attendance and mental health and how this measure will be impacted. MCH will keep close monitor of this, as well as implement COVID recovery programming and systems improvements to address emerging concerns.

8. PM: % HS students who made a plan to attempt suicide in the past 12 months
   Priority: Children live in safe and supported communities

VT has a high rate of high school students who made a plan to attempt suicide in the past year -- 13.4% in 2019, above the Healthy Vermonter's 2020 target rate of 8% and the Title V target of 7%. Significant differences exist in this indicator when looking at health equity. 21.1% of Latinx students, 17.8% of multiracial, and 13.7 of Native American students compared to 14.8% of black students made a suicide plan, compared to 12.7 of white students. Disparities exist by sexual orientation, as well (35.6% of LGB compared to 9.6% of heterosexual students).

VT's MCH program has long been committed to addressing injury prevention in the MCH population; however, several years ago, VT lost dedicated injury funding and it has been challenging to prioritize this work. New efforts around suicide prevention, farm health, child maltreatment, and infant safe sleep have enabled a renewed commitment to this work. VT's primary strategies include: collecting and report on QI data from pediatric practices on depression screening in partnership with VCHIP; participation in AYA CoIIN for systems improvement in screening youth for depression and other factors that may lead to suicidality; promoting suicide screening in primary care using the nationally recognized Zero Suicide approach; assessing ED protocols and coding for response to patients who have attempted suicide; and supporting UMatter Youth and Young Adults Mental Health Wellness Promotion and community Action in schools. Vermont is digging even deeper into these topics, in the context of COVID and its impact on mental health and substance use.

9. PM: % of MCH programs that partner with family members, youth, and/or community members

In 2021 eight out of nine (88.9%) MCH programs that partner with family members, youth, and/or community members. VT has a long tradition of promoting family-centered care and involving families in all levels of decision making. Our MCH Division values family input across programming and planning and works to do this in an authentic and meaningful manner. VT is advancing a new state performance measure on family partnership which aims to ensure that MCH programming partners with families across all levels of engagement.

Partnerships

Vermont's Title V is actively engaged in ensuring a statewide system of services, which reflect principles of comprehensive, community-based, coordinated, family-centered care.

The MCH Division works very closely with other divisions within VDH to carryout activities under and connected to Title V. VT

does not have county level health departments, but local offices at the district level. MCH Coordinators and School Liaisons in each of these district offices carry out Title V and other MCH-related work within communities. The Division of Health Promotion and Disease Prevention houses programmatic activities related to tobacco control and prevention, oral health, physical activity and nutrition, and chronic disease. MCH works with the Division of Emergency Preparedness, Response and Injury Prevention to address childhood injury, Environmental Health around toxic exposure, and the Division of Substance Use Programs on shared planning around substance use in pregnancy and youth substance use. MCH epidemiology, data analysis, surveillance and immunization is conducted by staff within the Divisions of Health Statistics and Informatics and Laboratory Science and Infections Disease.

VT is a small rural state with a population of slightly more than 600,000, with proportionally small state government agencies. Committed staff across children and family-serving state agencies and nonprofit organizations work closely with each other and family organizations to address the needs of VT children and families. VT has many strengths and is at the leading edge of significant innovation and advancement in health care delivery and financing for VT's children, including those with special health care needs.

III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts

How Title V Funds Support MCH Efforts

VT MCH's strategic plan is aligned with our Title V framework. This allows us to be more strategic in our work & engagement with partners. Title V has & continues to be VT's backbone structure, allowing us to align with national priorities, as well as respond to state and local emerging priorities.

Federal funds have helped align efforts across funding sources, that have the potential to be disjointed. VT uses the Title V framework & funding to support staff & programming towards meaningful integration. For example, we have used national and state PMs, such as substance use in pregnancy, physical activity and nutrition, and youth engagement and empowerment to further integrate across the health department, Agencies of Human Services and Education and community partners, ensuring we are all pulling in the same direction. Likewise, we frequently use Title V funding to test innovative strategies that can be replicated & sustained with other funding sources.

Title V is the guidepost to align strategies statewide. Vermont's MCH's integration with clinical medicine, as well as our deep roots in EPSDT and school health positioned us perfectly to advance the needs of children and families during COVID. As described elsewhere, we quickly established a school and child care branch within the Health Operations Center and worked intimately with primary care, schools, and child care throughout the response.

Throughout and across MCH programing and activities, we focus on our identified crosscutting measure: family engagement. VT has a long tradition of promoting family-centered care and involving families in all levels of decision making. Our MCH Division values family input across programming and planning and works to do this in an authentic and meaningful manner.

Over the last several years we have been increasing our emphasis on health equity in all the work we do, but COVID-19 has challenged us to rethink business as usual and find creative solutions to addressing health disparities in our small, rural state. Title V allows us to weave strategies that support and elevate health equity into our programs and services. We plan to update our strategic plan next year, and at that time we will assess how to bring added attention to health equity. It was our intention to include health equity as a crosscutting measure in this application, but due to COVID-19 priorities in Vermont, we will address it next year when we have additional capacity focused on our MCH priorities and the ability to align with our strategic planning process. We have also recently hired an MCH-focused Health Equity Team Lead who will lead us through this important work.

Although VT's allocation is among the smallest in the nation, we have successfully braided Title V funding with other sources: WIC, MIECHV, Preschool Development Grant, Medicaid, and competitive cooperative agreements such as HRSA's MDRBD and ECCS funding to provide a comprehensive system of care for children & families.

III.A.3. MCH Success Story

MCH Success Story – Youth Engagement

Challenge

Individual human services providers and youth workers use strengths-based methodologies and the Circle of Courage model to meet youth “where they are”, and to ensure that all Vermont youth have the opportunities to belong, gain proficiency in a skill, make decisions, and give back. Although individual direct services are strong and contain varied approaches, opportunities for adults to center youth and encourage thoughtful and authentic youth voice in program planning, implementation, and evaluation is a place for growth.

MCH’s Title V program is committed to ensuring that all children and youth thrive as they move through school and into their adult lives. Priority areas of this work include using the principles of healthy youth development to advance authentic youth engagement, encourage the development of social and emotional competencies, and build protective factors that can mitigate against risk behaviors. Programs that stress authentic youth engagement and promote youth voice reduce risk behaviors through the development of protective factors such as school connectedness, self-control, self-confidence, and quality peer relationships. Key to all these areas of work and learned skill sets is the principle of “nothing about us without us.” It is time for VT practitioners to practice power-sharing with young people.

Solution

VT Title V funds support the work of Vermont Afterschool, a public-private statewide partnership dedicated to providing quality expanded learning experiences for all Vermont youth, and to contributing toward positive outcomes for all youth in Vermont. Funding from our Division supports several strategies for the promotion of youth leadership and voice.

A Youth Voice Community of Practice meets monthly with a group of 8 youth work professionals. The focus in recent months has been on empowering youth to engage in school-based and outside-of-school program planning that is responsive to the COVID-19 pandemic.

During this reporting period, Vermont Afterschool led 34 individual program consultation sessions on fostering youth voice. Youth voice consultation sessions are about assessing how prepared an organization is to receive and implement youth driven activities and ideas, and then supporting them in planning for implementation. This is considered at three different tiers: the individual interactions of staff with youth; interactions with youth in groups or classes; and in the overall operation of the organization itself. Vermont Afterschool’s youth empowerment framework starts with learning about the youth's interests and skills, then supporting them to envision and plan for change to be made using their voice, and eventually supporting youth in enacting that plan. Much of this work involves supporting adults to make tangible changes in their programming to establish more of a power and decision sharing model with youth.

Additionally, Vermont Afterschool has begun implementing Youth Voice Coaching Sessions with 5 sites during this reporting period, offering more focused youth voice consultation support and exploration of how to better integrate youth leadership in their program planning. Recent coaching topics have focused on supporting the development of regional youth councils. There is a general model to follow, but where youth workers often struggle is with the details of enabling youth empowerment. Small but important strategies like supporting youth in the development of meeting agendas, prompts for peer conversation, and the mechanics of participatory budgeting help the coaching groups enhance their skill in supporting youth engagement.

III.B. Overview of the State

Overview of the State

VT is a scenic and mountainous state bordered on the north by Quebec, Canada, on the east by NH, on the west by Lake Champlain and New York State and on the south by western Massachusetts. Vermont's overall population is 645,570 (Census population estimate, 2021). VT is designated as a rural state, estimating that nearly two-thirds of its residents live in rural areas; there are no towns with more than 50,000 residents. Vermont's land mass is small – 9,216 square miles – and averages 68 people per square mile. Composed of 14 counties with 255 municipalities (towns, cities, unincorporated areas and gores), Vermonters are governed at the state and local (but not county) level. More than one-quarter of all Vermonters live in Chittenden County. Rutland County, the next most populous, has less than one-tenth of the state's population, and Washington County, where the state capital Montpelier is located, is the third largest. The counties that make up the Northeast Kingdom – Caledonia, Essex and Orleans – are the least populated and most rural.

These demographics strongly influence the way in which MCH services are delivered and how Title V planners address statewide policy and programming to improve health outcomes. Residents of rural areas tend to have lower incomes, fewer years of education, use public health insurance or have no insurance, and live farther from health care resources than their urban counterparts. Income is the most common measure of socioeconomic status, and a strong predictor of the health of an individual or community. The lower the income, the less likely it is that a person will have a healthy diet or regular physical activity, and the more likely they will smoke. This leads to a greater likelihood of adult conditions such as depression, obesity, asthma, diabetes, heart disease, stroke, and premature death and is also a risk for poor birth outcomes such as prematurity and infant mortality.

VT is aging faster than other states. In 2019, the median age of Vermonters was 42.8 years, compared to the national median of 38.2 years (ACS 2016-2020 5-year estimates). And the state/national age gap is widening, from about two years in 2000 to over four years in recent years.

Vermonters come from a wide range of racial, ethnic and cultural backgrounds, including African Americans and American Indians, many of whom are descendants of the original Abenakis. Many more recent residents come from Africa, the Middle East, Asia and Eastern Europe – and a Hispanic/Latino population from Mexico, Cuba and the Americas. While Vermont's racial and ethnic minorities, at 7.8% of the total population (2021 Census population estimates), are proportionately small compared to the rest of the U.S., the percentage of people of color has doubled over the past 15 years. Some of the growing diversity across the state is due to immigration from other countries, from a variety of regions around the world, including Africa, the Middle East, Asia, and Eastern Europe. This includes approximately 8,700 who identify as Black/African American, 2,100 as American Indian/ Alaskan Native, 12,300 as Asian/Pacific Islander, 14,400 as Hispanic, and 12,300 people of two or more racial groups.

Since the start of the state's refugee resettlement program in 1980, between 7,500 and 8,000 refugees have arrived in the state, some of whom are people of color. Over the past year, Vermont has welcomed around 200 Afghan humanitarian parolees, many of whom have arrived as family units with multiple children. Vermont anticipates welcoming 50-100 Ukrainian humanitarian parolees this year. A second refugee resettlement agency was established in Vermont this past year, significantly expanding resettlement efforts and capacity in the state. The addition of a second agency now provides Vermont with access to resettlement services in both northern and southern Vermont. Other refugees currently arriving to Vermont are resettling from Democratic Republic of Congo, Egypt, Sudan, and Iraq. There are fewer than 5,000 undocumented individuals, mostly Mexican and Central American farm workers, according to the Pew Research Center.

In VT in 2019, the average per capita income was $35,854 and the median household income was $63,477 (2020 ACS 5-year estimates), approximately the national average. Ten percent of Vermonters earned incomes below the Federal Poverty Level (2020 ACS 5-year estimates). Low-income Vermonters are more likely to be female, young (age 18 to 34), less

educated, unemployed or unable to work, or a member of a racial or ethnic minority. The state's workforce numbers just over 334,697 (June 2022), according to the U.S. Bureau of Labor Statistics. The state unemployment rate in June 2022 was 2.2% compared to 3.6% nationally. (During the COVID pandemic, as of July 2020 Vermont's unemployment rate was 8.3%, compared to 10.2% nationally).

Education is closely linked with occupation and income. Assessed together, these can provide another measure of socioeconomic status. Vermonters tend to have more years of formal education than people in the rest of the U.S. 94.6% of adults age 25 and older had a high school education or more, compared to 88.5% for the U.S. (2020 ACS 5-year estimates), and 39.7% had earned a bachelor's degree or higher, compared to 32.9% for the U.S. Educational attainment varies across the state: adults in Chittenden and Washington counties have higher levels of educational attainment, while those in the Canadian border counties have lower levels.

While the total population has grown, the population of children (0-17) has fallen since the 2000 Census count of 147,523 to an estimated 116,976 in 2021, which is a slight increase in recent years (114,005 in 2019). Vermont Medicaid covers pregnancy care up to 200% FPL and we have highest first trimester prenatal care rates in the country: in 2020, 84.4 percent of the babies were born to mothers who began prenatal care in the first three months of pregnancy. In general, the percentage of women receiving first trimester prenatal care has steadily increased since 1987. In 2020, 7.0% of Vermont resident births were low birth weight (less than 2,500 grams or 5 pounds, 8 ounces) and 0.8% were very low birth weight (less than 1,500 grams or 3 pounds 5 ounces). The U.S. low birth weight rate for 2019 was 8.2%. Vermont has very high rates of children enrolled in health insurance (98%--ACS 2020 5-year estimates).

Medical and Community Health Service Systems

VT is a rural state and relies on an extensive system of distinct center and home-based services throughout the state that are offered by a variety of community organizations. These organizations consist of agencies such as mental health agencies ("publicly funded Designated Agencies"), Parent Child Centers, home health agencies, and community action partnerships. The Department of Health ensures statewide coverage through 12 local health district offices. There are no county Health Departments in VT. For clinical services, there is comprehensive statewide coverage by private providers (the large majority of whom accept Medicaid patients) Federally Qualified Health Centers, and family planning services (Title X) offered by a statewide system of Planned Parenthood clinics. Of note, Vermont just recently reentered the Title X program after the state withdrew from the program under the prior Administration's rules; yet we continued to fund services with state funding.

Vermont has a strong primary health care system for the pediatric population which makes us uniquely positioned to leverage high quality pediatric medical home efforts to support Title V efforts. Vermont families have high rates of health care access and a high level of trust in their health care providers. For decades, public health (Vermont MCH) has actively been integrating with clinical medicine as well as conducting dozens of CQI projects to improve evidence-based practice.

Vermont children have some of the best access to health care in the U.S., with 96% percent of children under age nine having some type of health insurance, according to the National Survey of Children's Health. 81% of families report that insurance for their children is adequate, with reasonable out-of-pocket costs, benefits that meet their children's needs, and the ability to seek medical care when necessary. 91% of children under age six have seen a healthcare provider at least once during the last year for any kind of medical care (2019-2020 NSCH). Vermont is a Medicaid-expansion state with generous Medicaid benefits and a global commitment waiver that allows a high degree of flexibility and innovation. Medicaid covers children up to 312% of FPL (birth to age 18); this includes children enrolled in CHIP. Nearly two-thirds (61%) of children 0-5 are enrolled in Dr. Dynasaur (Medicaid and CHIP, combined). All pediatricians accept Medicaid. Vermont's rate of preventive visits by insurance type is consistent across payors: 89.8% of privately and 85.4% of publicly insured Vermont children had a preventive visit within the last 12 months.

Despite a high rate of Medicaid eligibility and access to pediatric health care for this population, Vermont has significant

disparities in health, family and community indicators whereby publicly insured (Medicaid) children experience poorer outcomes than privately insured children, as demonstrated below.
Child Health Measures by Insurance Type (Source: NSCH)

	% Publicly	% Privately
Premature birth	11.9	9.3
Medical home	50.0	63.3
Ever breastfed	73.3	94.1
Behavior or conduct problems	15.8	3.4
Developmental delay	7.7	3.2
Child with a special health care need	28.4	16.0
Did not receive needed care coordination	20.4	15.5
Fair/poor mental/emotional health status of mother/primary caregiver	14.3	3.4
Two or more ACES	36.0	11.2
Does not live in a supportive neighborhood	40.0	30.2

Of note, a large majority of families with children under the age of 11 (63% of publicly insured and 61% of privately insured) in the NSCH noted that they did not receive care in a well-functioning system.

Existing qualitative data, and what can be deduced from quantitative data, suggest that equitable access to high quality care, services, resources, and support is variable, particularly for BIPOC families and children who experience adversities such as poverty, homelessness, or immigrant/ refugee status. The role of rurality in maternal and child health also creates challenges in equitable access to services and care.

According to the 2020 BRFSS, more than nine in ten (92%) Vermont adults under the age of 65 said they have a health plan. This is significantly higher than the 87% reported for the U.S. Health care coverage rates among Vermont adults 18-64 were similar in 2017 and 2018 but have increased significantly since 2011 (89% to 93%). Eighty-five percent of Vermont adults reported having a personal health care provider in 2020, significantly higher than the 77% reported by U.S. adults. Less than one in ten (8%) of Vermont adults said there was a time in the last year they did not go to the doctor because of cost. This is significantly lower than the 10% among U.S. adults.

Vermont's 14 counties are served by eight Critical Access Hospitals (CAHs), one additional Small Hospital Improvement Program (SHIP)-eligible hospital, four regional PPS hospitals (three in rural counties), one VA hospital, and two academic medical centers. These two large hospitals are both Level 1 Trauma facilities, serving most of Vermont, much of western New Hampshire and part of northeastern New York. VT is also well-served by a network of 12 FQHC organizations, operating ~50 primary and ~17 dental care sites in all 14 counties. Mental and behavioral health care is also available on site or through local partners. VT also has 10 Rural Health Clinics (9 attached to CAHs), 8 Planned Parenthood of Northern New England health centers (reduction of 4 centers in the last 6 months), and a network of 9 free clinics through Vermont's Free & Referral Clinics (VFRC). Population to provider ratios can be found on the Health Department website at: http://www.healthvermont.gov/systems/health-professionals/shortages-and-designations. Most Vermont hospitals, FQHCs, RHCs, MH designated agencies and many long-term care facilities and other providers are participating in OneCare Vermont, the single statewide Accountable Care Organization (ACO) and Vermont's All-Payer Model (APM) health care reform agreement with the Centers for Medicare and Medicaid Services (CMS).

In 2020, there were 5,127 babies born to Vermont residents. The crude birth rate in 2020 was 8.2 per 1,000 residents, a slight decrease from the 2018 rate. The teen pregnancy rate for ages 15-19 was 10.6 per 1,000, lower than the 2019 rate of 11.7 and the 2018 rate of 12.8. In general, the teen pregnancy rate has been decreasing since 1991. Teen pregnancies vary significantly among communities. The 2020 rates show that while Burlington/Chittenden County (Vermont's only MSA) has a

teen pregnancy rate of 6.4 per 1,000 female 15-19 population, rural communities such as Newport (22.4) and Springfield (19.) have significantly higher rates. New families at risk, defined as first births to single mothers aged less than 20 years with less than a high school education, accounted for 2.6% of first births for 2020.

Social Determinants of Health (SDOH)

Despite high rates of coverage and health care utilization, Vermont children experience concerns related to SDOH that impact their growth and development. Chronic poverty can lead to a wide range of challenges, which negatively affects physical and social emotional health and development and the ability to learn and be successful in school and beyond. More than one in eight Vermont children birth to 5 live in poverty (13.1%). This is further exacerbated by race, whereby 24.2% of Vermonters who identify as black live in poverty compared to 10.3% of white Vermonters.

In 2019 in Vermont, 14%, or approximately 15,730 children under age 18, live in households that are food insecure. Of the 14% of children living in food insecure households, 42% are likely ineligible for federal nutrition programs compared to 23% for the nation. The cost and availability of housing is another significant challenge: 54.5% of Vermont households who rent and 26% of households who own report paying more than 30% of their income toward rent or a mortgage. The average Vermont renter makes $13.83 an hour and can afford to spend $719 per month on rent, but the average two-bedroom apartment costs $1,231 per month.

Exacerbating the challenges related to food and housing, 70% of Vermont's children live in rural areas, making access to reliable transportation a necessity. However, low-income families often rely on older vehicles and spend a higher proportion of income on transportation fuels (which is only increasing); 10% for drivers making less than $25,000 per year compared to 5% for drivers making more than $75,000 per year. For those who need or want to get around without a car, existing fixed-route public transit does not exist in many rural areas of the state or when available, it is not flexible enough to consistently get rural residents to work, childcare, and other services.

Children and families are grappling with unemployment, access to adequate food, housing, affordable childcare (particularly for infants), and other necessities, all of which have been exacerbated during the COVID-19 pandemic, indicating a need to address SDOH. For example, a 600% increase was noted in 2020 in calls to Vermont's 2-1-1 for families reaching out for support, largely in the areas of food resources, basic needs, and need for problem solving/listening support.

Toxic Stress, Child Safety, and Resilience and Early Childhood and Family Mental Health

Living in strong families within supportive communities provides the foundation for long-term child health and well-being and the ability to overcome adversity. In Vermont, 13.5% of children under age nine have had two or more adverse childhood experiences. The four most common ACEs in Vermont are: experiencing the divorce of a parent or guardian (16%), living in a home where it is hard to cover basic needs (14%), living with someone with substance use disorder (9%), and living with someone who has a serious mental health challenge (7%). Another indicator of child safety is the number of Vermont children exposed to domestic violence. According to the Vermont Network Against Domestic and Sexual Violence, in 2020 there were 1,389 children and youth connected with an advocate for help related to abuse toward a family member or toward themselves.

Vermont's child protection system has struggled in the past few years—with rising caseloads and increasingly complex cases, including substance use. In 2021, there were 18,507 reports were made to the Child Protection Line—2 ,785 more than in 2020. Of these reports, DCF conducted nearly 2,000 investigations and substantiated 609 reports, representing 722 unique child victims. During the last quarter of 2021, there were: 1,061 children in DCF custody, 469 children in the conditional custody of a parent, relative or other person known to the child and family, and 296 families getting ongoing services after an investigation or assessment determined there was a high to very high-risk of future maltreatment https://dcf.vermont.gov/sites/dcf/files/Protection/docs/2021-CP-Report.pdf).

There has been an increasing trend over time in the percent of behavioral, emotional, mental health, and developmental conditions for Vermont's young children. For example, the percentage of children ages three to five with a behavioral, emotional, mental health, or developmental condition has increased from 8.3% in 2016-2018 to 10.4% in 2017-2019 to 12.2% in 2018-2020. However, the availability of early childhood and family mental health services, publicly and privately cannot keep pace. There has been a substantial and growing number of vacancies in the community mental health system from 500 vacancies in June 2020 to 862 in August of 2021. This sector of the workforce makes possible the critical mental health resources, services, and supports for Vermont's young children and their families.

Substance Use

Supporting the reduction of women's use of harmful substances during pregnancy has been one of Vermont's key public health initiatives in recent years due to some of the highest rates of substance use in pregnancy across the nation. This includes tobacco, alcohol, marijuana, and other substances. One fifth (19.3%) of women smoked cigarettes in the three months prior to pregnancy; yet a significant number (15%) received no guidance from their health care provider to quit smoking. 11.5% of women drank alcohol during pregnancy—with much higher rates of alcohol use in the three months prior to pregnancy (71%). More than one in 10 (11.4%) women report using marijuana during pregnancy (PRAMS 2020).

In 2014, Vermont's rate of infants born with a diagnosis of drug withdrawal syndrome hit a peak rate of 35.0 per 1,000 live births but has since dropped down below the 2009 rates to 20.4 per 1,000 live births, one of the highest rates in the nation. Vermont has built a strong system for pregnant and parenting families with SUD, and specifically Opioid Use Disorder, however, we are concerned with trends we are seeing in data such as Plan of Safe Care notifications which indicate that many families are being missed.

Youth Risk Factors

Data from the 2019 YRBS demonstrates concerning risk factors for Vermont's high school students.

13%	students drank alcohol before age 13; 15% reported binge drinking in the past 30 days
7%	students smoked tobacco in the past 30 days; during the last 30 days, 26% of student reported using electronic vapor products (EVP)
40%	students have ever used marijuana (27% used it in the past 30 days)
12%	Students ever used a prescription stimulant or pain reliever that was not prescribed to them or used one in a manner different from how it was prescribed
6%	students have ever been physically forced to have sexual intercourse; 1 in 15 experienced physical violence
11%	students made a suicide plan; 5% of students attempted suicide
31%	students reported having sex in the past 3 months; 9% reported 4+ sexual partners in their lifetime and 3% had sex by age 13; among sexually active students: 56% used most or moderately effective contraception; 20% used drugs or alcohol at last sex

State health agency current priorities/initiatives

VT is a small state, with a culture of collaboration among state government, community agencies, coalitions, hospitals, health centers and health care providers. The Health Department is the single public health agency that serves all Vermonters, with its central offices and lab in Burlington, and 12 district offices located around the state. State health reform efforts have included a focus on promoting health and preventing chronic illness. Public Health is written into the state's health reform law.

Vermont finalized our State Health Assessment and State Health Improvement Plan, which helps us prioritize goals and objectives for health, monitor trends, identify gaps and track progress. The SHA/SHIP use a health equity framework, evaluating MCH (and other health) data by key populations that have experienced historical injustice. The Department of Health used a collaborative process to develop the SHA/SHIP; key department and external stakeholders reviewed health status indicators of Vermonters with the goal of identifying three to five statewide strategic health priorities. The SHIP presents the priorities and improvement strategies agreed upon by multiple public health partners and provides the framework for creating healthier communities over the next five years. Several the outcomes identified for the five-year SHIP are MCH focused, including: Optimal Child Development and Resilience. Title V/MCH is perfectly positioned to take a leadership role in the development and implementation of strategies to achieve this outcome.

VT public health planning relies on the framework of the Prevention Model, as based on a five-level Social-Ecological Model. This model recognizes that, although individuals are ultimately responsible for making healthy choices, behavior change is more likely and more sustainable when the environment supports individual efforts. Comprehensive prevention and health promotion programs, to be most effective for the long term, and to reach the largest number of people, should address multiple levels of the model. VT public health assessment and actions are also rooted in the concepts of the social determinants of health. The Health Department leadership recognizes that public health efforts need to influence not only health care and health systems, but also areas such as education, early care and education, housing, law, economic opportunity, community planning, transportation and agriculture.

The Health Department emphasizes that public health actions are based in researched strategies and in measurement and accountability. Use of resources from national agencies, such as the Centers for Disease Control & Prevention, Substance Abuse and Mental Health Services Administration, and the Maternal and Child Health Bureau (MCHB) offer resources to programs and policymakers that guide the selection of successful evidence-based interventions. For example, VT Title V has benefited from the technical assistance available from the MCHB Collaborative Improvement & Innovation Network, the AMCHP resource center, and the MIECHV evaluation resources.

The Department of Health has a comprehensive performance management framework in place to improve the health status of Vermonters by ensuring the efficacy and evidence base of services delivered. Performance management establishes and manages systems at the Health Department to identify and regularly report on population objectives and performance measures, perform quality improvement activities, and assess and emphasize the need to fund and implement evidence-based practices to change population outcomes. These measures are designed to be evidence-based and describe how the department holds itself accountable to making population-level change. Performance measures are displayed on the Performance Dashboard at: http://www.healthvermont.gov/hv2020. Note that due to the COVID pandemic, this dashboard has not been kept fully up-to-date—but this is part of the plan in the coming year.

The Public Health Accreditation Board (PHAB) Accreditation Committee awarded five-year accreditation status to the VT Department of Health in June 2014 and reaccredited us in March 2022. With accreditation, the Health Department is demonstrating its commitment to improving and protecting the health of Vermonters and advancing the quality of public health services nationally. The process has allowed our department to assess our strengths and identify areas for improvement to continue to improve the quality of our services and performance. We are in the final phases of submitting our application for reaccreditation.

Vermont's Department of Health, and especially MCH, has an ongoing commitment to health equity and family engagement. CDC Health Disparities funding, has enabled us to start an Office of Health Equity Integration which is comprised of a Director and community engagement liaisons who play integral roles in addressing systemic barriers both within and outside of state government and building sustaining relationships with community partners based on new models of power sharing. Additionally, many of the divisions, including MCH, were able to hire Health Equity Team Leads to ensure health equity integration throughout our programming and systems improvement. MCH's longstanding commitment to family engagement is described throughout this application.

As Vermont continues to work through and emerge from the COVID pandemic, there is a mountain of work to do. MCH will continue to work in partnership with the Health Department's COVID leadership, as well as the Agency of Education, Child Development Division, and other partners to provide policy recommendations, guidance, and supports to Vermont's families and children.

State Statutes and Legislation

Bill #	Title	Summary
H.462	An act relating to miscellaneous Department of Health programs	Child Fatality Review Team Proposal on data sharing across the country Drug Disposal Kiosk Program Expansion to chain pharmacies
H.628	An act relating to amending a birth certificate to reflect gender identity	Authorizes the State Registrar to amend or issue a new birth certificate to reflect an individual's gender identity. Also authorizes the Department of Health to adopt rules that add new gender pronouns to the list of markers that be used on birth records
H. 293	An act relating to creating the State Youth Council	This bill proposes to create within the Agency of Administration the State Youth Council to advise the Governor and the General Assembly on policies that impact young persons in Vermont
H.711	An act relating to the creation of the Opioid Settlement Advisory Committee and the Opioid Abatement Special Fund	Create the Opioid Settlement Advisory Committee to provide advice and recommendations regarding remediation spending from the Opioid Abatement Special Fund with Commissioner of Health as chair.

III.C. Needs Assessment
FY 2023 Application/FY 2021 Annual Report Update

Needs Assessment Update

Vermont continually reviews MCH data and gaps in services. Vermont's COVID-19 has impacted MCH efforts over the two and a half years, as the majority of MCH staff were deployed for a large percentage of the response to the Department's Health Operations Center (HOC). MCH is proud of this work including contact tracing and index patient interviews, quality improvement and data review to support contact tracing efforts, standing up the School and Childcare branch of the COVID-19 response, leading the effort to create a case manager program for Vermonters in need, and taking on leadership roles in the state response. Our needs assessment update includes the following:

- VT MCH's Strategic Plan, aligns with our Title V framework, and we plan to update our Strategic Plan and process for Title V reporting in 2023.
- Annual review of MCH outcomes at the district, county & state level for key MCH topics: infant mortality, LBW, preterm delivery, pre-pregnancy BMI & weight gain during pregnancy, prenatal care entry, adequacy of prenatal care utilization, smoking around pregnancy, teen birth/pregnancy rates & new families at risk. A Vital Statistics bulletin is posted annually.
- Our Division of Health Surveillance publishes regular data briefs on key MCH topics & special populations including PRAMS, BRFSS, YRBS, & School Health Profiles. While some of this work has been delayed as staff worked on the COVID-19 response, with additional COVID-19-specific capacity being added at the Health Department, we anticipate we will soon be able to dedicate additional time to this work.
- VT finalized the State Health Assessment and State Health Improvement Plan in 2018, which continues to guide our work. The SHA and SHIP help the state prioritize goals & objectives for health, monitor trends, identify gaps & track progress. The SHA/SHIP use a health equity framework, evaluating data by key populations that have experienced historical injustice. The SHIP priorities include outcomes that specifically relate to MCH topics: optimal child development, substance abuse & mental health.
- Many of our programs solicit ongoing consumer feedback through satisfaction surveys. We convene regular advisory councils that include representation from professionals & direct consumers.
- Needs assessments are regularly conducted by programs at MCH (including, home visiting and family planning) and partners such as: The Office of Head Start, Department for Children and Families and Substance Use Programs. This information is shared and incorporated into our program planning.

Overall direction for VT's Title V needs assessment & ongoing planning is provided by the MCH Leadership Team with representation from all programmatic areas. Our 2020 needs assessment findings are helping to develop & refine materials & methods to best meet the needs of these communities.

MCH Population Needs

Women/Maternal Health

The landscape in women's health services continues to improve. Through the VT Blueprint for Health, women's health providers provide enhanced health & psychosocial screening along with comprehensive family planning counseling & timely access to LARC. These screening efforts align with perinatal mood and anxiety disorder screening through the Screening, Treatment, and Access for Mothers & Perinatal Partners (STAMPP) cooperative agreement with HRSA. The Blueprint for Health provides staff capacity, training, & payments to support effective follow-up to provider screenings. New laws codify the ACA's contraceptive coverage rules into state law. Currently, there is a constitutional amendment on the ballot to codify the right to abortion services.

Nurse home visitors, parent educators, & WIC staff regularly screen pregnant women for tobacco use & refer to the Quit Line resources & medical follow up. MCH and it's partner division: Substance Use Programs is gearing up to lead a strategic planning process around substance use in pregnancy and early parenting to identify gaps and improve systems and coordination, as well as inform programmatic efforts for Opioid Abatement funds. Vermont's Perinatal Quality Collaborative is gaining more momentum and deeply engaged in multiple quality improvement efforts in both hospital and community settings. We have applied for the CDC PQC opportunity, which will help us to improve birth certificate quality, as well as improve clinical-community linkages to provide care and supports across fields.

Perinatal/Infant Health

VT continues to be a leader in US perinatal & infant health outcomes, including low rates of elective caesarians; perinatal regionalization; services, supports, & treatment for infants exposed to opioids; & breastfeeding initiation & duration. In recent years, Vermont passed legislation to require paid sick leave for employees, which is of major significance in supporting perinatal, infant & family health. Legislators have (unsuccessfully) attempted to pass paid family leave, which may be brought before the legislature again in the coming session. Vermont is moving forward with the expansion of postpartum Medicaid until 1 year postpartum, which is expected to launch in early 2023. Additionally, MCH is working to expand nurse and family support home visiting through Medicaid and we have a legislative proposal pending to expand the DULCE model (described elsewhere). VT is stepping up efforts around safe sleep & SUID prevention, including working with birth hospitals to implement safe sleep policies & a comprehensive messaging campaign for parents & providers. VT launched a breastfeeding strategic planning process informed by stakeholder input just before the pandemic, which we have recently begun to revisit.

Children's Health

VT continues to expand its services & supports for early childhood. VT's Help Me Grow system is about to celebrate its sixth birthday, demonstrating considerable successes. We have rolled out the statewide developmental screening registry with health care providers, early care & learning providers & other partners. Help Me Grow now offers online developmental screening removing barriers for families and providers. Vermont is also the lead on the HRSA ECCS opportunity and is actively engaged in statewide discussions around early childhood systems and potential restructuring.

While VT is ranked among the healthiest states for many public health indicators, we are concerned about the growing number of children who do not engage in the recommended amount of physical activity. In partnership with WIC & our chronic disease division, we are promoting physical activity recommendations in ECE environments, schools & communities.

VT is committed to strengths-based approaches to supporting children, families, & communities. In partnership with VCHIP, VT has recently reinvigorated the state's commitment to implementing the Touchpoints approach.

Adolescent Health

VT has relatively high rates of adolescent well-visits on the National Survey but claims data & survey data with providers suggest that these are not comprehensive or quality well-visits. VT has high rates of adolescent substance use & other risk behaviors. To this end, VT was one of the first five states chosen to participate in the initial AYAH CollN, & we have continued our commitment to quality improvement focused on behavioral health. VT has formalized a VT Youth Advisory Council, with the goal to actively engage adolescents & young adults in strategies to create youth friendly services. In addition to improving AWVs, VT aims to promote healthy behaviors among youth through an empowerment model and coordinated linkages to after school programs.

VT has worked closely & in partnership with pediatric and family medicine providers to provide up-to-date information on COVID-19, including vaccination for adolescents as well as provide anticipatory guidance to families of babies, children, & adolescents regarding COVID-19.

CSHN

VT MCH continues to leverage substantial federal grants for systems & programs to complement the significant existing CSHN work accomplished by Title V funds for the past many years. CSHN programs have been able to move towards systems-building, population-based & enabling services to support families, a model that more thoroughly supports children & families by supporting comprehensive, coordinated, clinical service delivery, while utilizing traditional payment models. VT continues to work to improve coordination among family service entities and improve overall systems health, which we plan to do through further refinement of the role of CSHN Care Coordinators. Ongoing efforts to refine data analysis help identify gaps in & barriers to the system, to achieve a comprehensive, coordinated system of state & community services & supports.

VT Title V is in the very final phases of transitioning a large part of our Child Development Clinic to the UVM Medical Center. With Title V funding, UVMMC hired a Developmental Behavioral Pediatrician, and we've established an integrated clinic with child psychiatry & CDC to diagnose & treat children with concerns of developmental delay & autism. This has been years in the making & is a major success for children & families. VT continues to work closely with our partners at the Department of Mental Health, Department of Aging and Independent Living, Department for Children and Families/Child Development Division, and Department of Vermont Health Access (Medicaid). We established a working group to address barriers in accessing timely developmental assessment and evaluation, and support families in accessing resources and services even during times of long waits.

Title V Program Capacity

There have been no changes in the Title V organizational structure; although, VT also seeks to expand capacity through existing staff, new staff, & partnerships. In 2020, Breena Holmes, MD, MCH's previous Division Director, transitioned out of her position. Dr. Holmes is now faculty at the University of Vermont Medical Center and Vermont Child Health Improvement Program and continues to work closely in collaboration with MCH. Ilisa Stalberg, MSS, MLSP, the Deputy Director of MCH, was promoted into the role of Division Director providing strong leadership, continuity of vision & mission implementation, & support for staff and partners during this challenging time in public health.

Title V/MCH sits within the Department of Health (VDH), the state's health agency & is overseen by Commissioner of Health, Dr. Mark Levine. VDH is one of 6 departments within the Agency of Human Services, therefore enjoying joint leadership & close partnerships with: Departments of Mental Health, Health Access (Medicaid & health reform), Disabilities, Aging, & Independent Living, Children & Families, & Corrections. The AHS Secretary reports directly to the Governor. The Governor has identified increasing early childhood & higher education funding, as a continuum, as one of the top priorities of his administration.

The AHS Secretary & Governor have a strong interest in prevention & are focusing efforts on home visiting as a key strategy to ensure the healthy future of Vermonters. In fact, he allocated funds in the SFY20 budget for sustained home visiting which unfortunately was put on hold due to COVID, but work has restarted with a launch date of Jan 1, 2023.

The MCH Division, led by Ilisa Stalberg, has primary oversight for all Title V programming. Several other federal initiatives are housed within the MCH Division: WIC administration, MIECHV, Help Me Grow, Title X, PREP, EPSDT/school health. VT's CSHN program is under the MCH Division.

Partnerships, collaboration, & coordination – public, private, family

VT is a small rural state with proportionally small state government agencies. Committed staff across children & family-serving state agencies work closely with each other & family organizations to address the needs of children & families. VT has many strengths & is at the leading edge of significant innovation & advancement in health care delivery & financing. Title V is actively engaged in ensuring a statewide system of services, which reflect principles of comprehensive, community-based, coordinated, family-centered care. Examples of key partnerships:

Vermont Department for Children and Families. MCH works in close partnership with the Division of Family Services to ensure public health is at the core of child welfare programming, including ensuring that all children newly entering state's custody have up-to-date medical and dental health services. We also work very close with the Child Development Division (CDD) to align our early childhood efforts, including Children's Integrated Services (CIS). These efforts provide a continuum of prevention & early intervention services for eligible prenatal/postpartum women, infants & children 0-6 & their families. During the pandemic, MCH worked very closely with the child care team and CIS at CDD to ensure for guidance for child care providers and timely response to emerging topics.

VT Child Health Improvement Program (VCHIP). VCHIP is a population-based child & adolescent health services research & QI program of the UVM. Since 2000, the partnership between the MCH & VCHIP has resulted in measurable improvements in child health outcomes across the pediatric age spectrum & a variety of health service areas.

American Academy of Pediatrics VT Chapter (AAPVT). VDH collaborates with AAPVT to assist VDH in the development of more efficient & effective health care services for children & families through consultation with the health care professional community & to identify & improve systems of care for children at risk. A monthly Primary Care & Public Health Integration meeting convenes the leadership of MCH, VCHIP, AAP, AAFP, Planned Parenthood, ObGyns, & internal medicine providers, to coordinate various projects.

University of VT Medical Center/University of VT Children's Hospital: VT works very closely with UVMMC to improve the system of care for children & families.

Agency of Education. MCH collaborates with the health education consultant at Agency of Education to align skills and content in our state's approach to health education in public schools. We also work closely with AOE around essential school health services through our state school nurse consultant. AOE and MCH worked in tight partnership during the pandemic to develop policy and implement guidance for schools throughout the pandemic, including the 2022-2023 upcoming school year.

VT Family Network: VFN is committed to a mission that promotes better health, education & well-being for all children & families, with a focus on children & young adults with special needs. VFN regularly participates in our annual Title V submission, needs assessment, & attends the block grant review yearly.

Vermont Afterschool is a public-private statewide partnership dedicated to supporting and sustaining innovative learning opportunities that extend beyond the school day for all VT's children and youth. Activities are directed toward increasing the quality and availability of education programs during non-school hours.

Emerging Issues

Maternal and Child Health works to align our approaches to our Governor's platform which is:

- Growing the Economy through Expanding and Strengthening VT's Workforce
- Making VT More Affordable:
- Protecting the Vulnerable and Natural Resources
- Addressing the Opioid Epidemic
- Preserving the Environment
- Supporting Safe and Healthy Communities

Vermont's MCH program is a leader in the state's COVID-19 response including a focus on health equity, health & vaccine education for families and providers, and standing up the state's School and Childcare Branch. VT is committed to continued engagement and learning around the social determinants of health & heath equity. While VT is consistently ranked as one of the healthiest states in the nation, data shows not everyone has an equal opportunity to be healthy. To further promote the understanding & recognition of SDOH, VT has engaged in several strategies, including: *Bright Futures*

Guidelines Roadshow, and implementation of the Developmental Understanding and Legal Considerations for Everyone (DULCE) model (both described elsewhere). Additionally, through participation in the CHHS Aligning Early Childhood and Medicaid (AECM) initiative and in partnership with the ACO, VT is advancing strategies to modify how we stratify risk for children in health care payment reform.

As in all states, VT continues to work to address the opioid crisis. VT is the recipient of the HRSA funded initiative: Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program. VT recently participated in ASTHO's Opioid Use, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative Learning Community and is developing an action plan to address postnatal support for families with SUD. VT is also advancing a coordinated message around the prevention for & treatment of all substance use, including alcohol, tobacco, cannabis, opioids & other drugs: One More Conversation.

VT works closely with colleagues in the Family Services (FS) Division (child welfare) at DCF. Efforts are underway to ensure the medical and dental needs of children in custody are known to FS Caseworkers and foster parents, as well as the clear identification of children with special health needs, as these cases are often overlooked with serious consequences. Additionally, Vermont (including MCH) is participating in a CMS Affinity Group to improve coordination and care for children in foster care.

VT continues to work to align its suicide prevention & response efforts but is challenged by siloed strategies & competing priorities. We are engaging state level leadership to help coordinate suicide prevention efforts across our agency including Department of Mental Health & Medicaid.

On August 15, 2019, Vermont relinquished our Title X funding and has only just rejoined the program (April 2022). The Vermont Department of Health has partnered for over 40 years with U.S. Department of Health and Human Services (HHS) and our family planning network, Planned Parenthood of Northern New England (PPNNE), to provide critical family planning services to thousands of Vermonters through the Title X program. During the hiatus from Title X, the Health Department moved forward to use state funds to preserve the access to services provided by PPNNE. This means that from a patient perspective, the type and range of care received should have been the same as it was funded under Title X. Funding for the administration of this new state-funded program (staff time) was supported directly through Title V.

Click on the links below to view the previous years' needs assessment narrative content:

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2019		2020	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,583,663	$1,077,815	$1,627,812	$708,834
State Funds	$1,354,840	$808,361	$1,387,652	$522,685
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$1,000,000	$943,702	$1,276,000	$379,730
SubTotal	$3,938,503	$2,829,878	$4,291,464	$1,611,249
Other Federal Funds	$25,713,114	$18,466,433	$19,123,790	$20,397,465
Total	$29,651,617	$21,296,311	$23,415,254	$22,008,714

	2021		2022	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,633,060	$1,085,287	$1,633,060	
State Funds	$1,224,795	$786,612	$1,224,795	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$900,000	$312,605	$0	
SubTotal	$3,757,855	$2,184,504	$2,857,855	
Other Federal Funds	$23,183,762	$19,297,132	$22,925,928	
Total	$26,941,617	$21,481,636	$25,783,783	

	2023	
	Budgeted	Expended
Federal Allocation	$1,656,553	
State Funds	$1,242,415	
Local Funds	$0	
Other Funds	$0	
Program Funds	$0	
SubTotal	$2,898,968	
Other Federal Funds	$23,615,428	
Total	$26,514,396	

III.D.1. Expenditures

Vermont uses our Title V funding as a complement to our other federal and state funding. To ensure maximal integration among statewide programming and services, we braid and blend Title V funding with these other sources. Vermont actively strives to ensure that Title V funding reflects national and state priorities and performance measures. We also use funding to test pilot projects with the plan to identify alternate sustainable funding down the line. In some cases, we use Title V funding to bridge gaps in funding of existing programs. We also routinely use Title V funding to support professional development of staff and sponsor key MCH initiatives by other organizations. Some examples include:

- Child Development Clinic expenditures
- Grant to UVM Medical Center in support of Developmental Behavioral Pediatrics
- Grant to UVM Medical Center in support of Genetics
- Grant to UVM Medical Center in support of the Child Abuse Physician
- Grant to UVM Medical Center to provide training and technical assistance to community-based sexuality health educators
- Grant to UVM Medical Center in support of the Vermont Center for Children, Youth and Families Autism Assessment Clinic
- Grant to Vermont Family Network in support of peer-to-peer network and family leadership
- Grant to Up for Learning in support of Getting to “Y” youth empowerment activities
- Grant to Center for Health and Learning in support of UMatter suicide prevention activities
- Grant to Vermont Afterschool in support of a statewide Youth Voice Coordinator, the creation of a Youth Council, and a Participatory Budgeting fund for youth
- Grant to United Way 2-1-1 to support a coordinated information and referral system to align the efforts of early childhood partners
- Family Engagement contract
- CHAMP Project with VCHIP
- Parents as Teachers (PAT) affiliation fees and curriculum subscriptions
- Staffing support for home visiting, MCH injury, and sexual and reproductive health
- Staffing support for Help Me Grow Vermont (HMG) outreach and training activities
- Staffing support for MCH leadership and operations

Expenditure documentation: Vermont began using its current accounting system in FY02. The system is named "VISION," which is an acronym for "Vermont Integrated Solution for Information and Organizational Needs". The accounting package includes the Financial and Distribution modules contained within PeopleSoft's software suite for Education and Government (E&G) version 9.2. It is designed to be an integrated financial and management tool. While most transactions are entered into VISION directly, 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 as approved by the DHHS Division of Cost Allocation. This Plan determines how we will collect certain overhead costs into cost pools and how those overhead cost pools will be allocated to the various programs and funding sources, including the Maternal and Child Health Block Grant. Because we have an approved Cost Allocation Plan, Vermont does not have an indirect rate agreement, which would be the alternate method for charging overhead costs to programs. Cost Allocation Plans—instead of indirect rate

agreements—are relatively rare among Health Departments. Basically, the approved methods collect general overhead costs on a quarterly basis into cost pools at the division level and 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 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.

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

Single State Audit. The State Auditor of Accounts arranges for an annual audit in compliance with the Single Audit Act, as well as in conformity with Section 506(a)(1) of the Maternal and Child Health Block Grant. The audit was performed by CliftonLarsonAllen (CLA) under contract with the Vermont Auditor of Accounts. Although the Maternal and Child Health Block Grant does not qualify as a "major" program for audit purposes, transactions may be tested as part of a general review of management control. There were no findings related to expenditures funded by the Maternal and Child Health Block Grant in FY21 or prior years. The audit report can be found on the State Auditor's website at http://auditor.vermont.gov.

III.D.2. Budget

In general, financial resources for Vermont's FY23 MCH program remain stable. The MCH program relies heavily on the Block Grant to support its core functions. We continue to supplement the Block Grant with the availability of Medicaid and WIC funds and successful applications for selected categorical grant funding.

30%-30% Requirement: The Health Department calculates the amount of federal funds expended on each category. ForFY21, Vermont anticipates 51.3% of expenditures will be made in Component B and 30.1% for Children with Special Health Care Needs. Our FY23 application assumes that this balance will remain at approximately this same level.

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 components 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 FY21 are anticipated to be 3.4% of total costs. The FY21 Administrative costs remained lower this year due to the continuing public health emergency starting in February 2020 that resulted in reassignment of many health department staff to the emergency response. Administrative costs are allocated on the basis of a program's direct salary costs. Our FY23 budget assumes the resumption of direct and administrative costs to the pre-emergency levels.

Maintenance of effort: [Sec. 505(a)(4)] The maintenance of effort amount for Vermont, based on the amount of unmatched State expenditures reported in 1989, is $167,093. We deduct one quarter of the maintenance of effort amount from our allowable claims each quarter rather than annually. Quarterly reductions of our allowable costs are more consistent with federal cash management directives than an end-of-year adjustment. This practice will continue in FY23.

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 Clinical Genetics Group, 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 Clinical Genetics Group grant is $208,211. State General Funds (not Block Grant or other federal funds) are used to support the adolescent pregnancy program at the Addison County Parent Child Center, which was initiated under a Title VI grant prior to 1981, and is referred to as a consolidated health program in Sec. 501(b)(1)(D). The Addison County Parent Child Center grant is $32,820.

Other Federal funds: The other Federal funds used to support MCH-related goals are listed in Form 2. This list includes only those Federal funds under the direct control of Vermont's Title V Director; other divisions of the Vermont Health Department receive funding from the Federal grant sources listed.
Vermont once again is the recipient of FY22 funding from the DHHS Title X Family Planning grant to fund statewide activities.

We do not currently anticipate FY23 funding from dedicated Federal COVID-19 response funds.

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). 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.

Programmatically, we anticipate many of the same expenditures in FY23 as in recent years. Title V will continue with support for the costs of Help Me Grow Vermont, until other anticipated funding is secured. The major programmatic change that will impact Vermont's Title V budget will be the completed movement of the Child Development Clinic from the health

department to the UVM Medical Center. The State will no longer receive program income from Medicaid reimbursement for clinical services that were historically provided directly by the Health Department and the Autism Assessment Clinic at the Vermont Center for Children, Youth & Families. Home visiting services, MESCH Nurse Home Visiting and Parents as Teachers Family Support, will benefit from Title V support as VDH continues work with Medicaid to finalize a funding model.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Vermont

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

Program Purpose and Design

The vision and mission of Vermont's MCH Division are:

- **Vision:** Strong healthy families power our world.
- **Mission:** We invest in people, relationships, communities and policies to build a healthier Vermont for future generations.

We believe in a:

- **Strength-based approach** that promotes protective factors and recognizes that families have many strengths and the capacity to learn, grow and change
- **Two-generation framework** that creates opportunities for, and addresses the needs of, both children and the adults in their lives
- **Fundamental need to partner** with state agencies, health care providers, human service organizations, and families to succeed at our vision

As you will see in this application, we seek to achieve these by providing leadership in important ways:

- Serving as a convener, collaborator and partner in addressing MCH issues
- Supporting coordinated, comprehensive and family-centered systems of care at state and local level
- Developing and utilizing innovative and evidence-based or -informed approaches to address crosscutting issues that impact the health status of specific MCH populations and sub-populations, such as social determinants of health
- Implementing the core public health functions of assessment, assurance and policy development through program efforts that are supported by the MCH Block Grant

The MCH Division has primary oversight for all Title V programming. Key MCH programming includes:

- Women, Infant and Children (WIC)
- Early childhood programs including evidenced-based home visiting programs, Help Me Grow, and DULCE
- School health and early periodic screening, diagnosis and treatment (EPSDT)
- Children with Special Health Needs (CSHN)
- Sexual and reproductive health (family planning, sexual and domestic violence prevention, and adolescent sexuality education)
- Child injury prevention (focus on suicide, infant safe sleep, agricultural safety, child abuse and neglect)
- Quality improvement in clinical care and community programs
- Crosscutting programming, such as tobacco, oral health, and substance abuse, perinatal mood and anxiety disorders, and strengthening families

The MCH Division works very closely with other divisions (chronic disease, substance use programs, immunization, environmental health, emergency preparedness) within the health department to carryout activities under and connected to Title V. Vermont does not have county-government but does have district offices at the local health (coordinated at the central state-office level). MCH Coordinators and School Liaisons in each of these district offices carry out Title V and other MCH-related work within communities, in partnership with MCH. Vermont's MCH Division works in close partnership with the Agency of Human Services and its departments: Mental Health, Children and Families, Medicaid, Corrections, and Disabilities, as well as the Agency of Education and other community partners. These partnerships are described elsewhere.

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

III.E.2.b.i. MCH Workforce Development

Workforce Development

VT's Title V workforce is extremely robust, representing a diverse background of training and expertise, and spanning several generations. Title V staff hold degrees in medicine, nursing, public health, social work, and more. Staff routinely demonstrate initiative, innovation, and adaptability to the ever-changing landscape of health and human services.

During FFY21, 12.04 FTEs, representing 40 staff worked directly on behalf of Title V programming. These staff are located at the central office in Burlington, as well as staff in the local health offices, the division of Health Statistics and Informatics (health research and statistics), and division of Health Promotion and Disease Prevention (physical activity and nutrition and oral health.) There are 53 (classified, non-temp) staff in the MCH Division (including CSHN). The MCH Division is led by a team of public health/MCH professionals who contribute to MCH planning, evaluation, data analysis, financial, and administrative capabilities.

VT's MCH Division includes the following, not all funded by Title V:

- Reproductive health and family planning
- Breastfeeding
- WIC
- Early childhood including *Maternal Infant and Early Childhood Home Visiting, Help Me Grow, Early Childhood Comprehensive Systems, and* HRSA-funded *Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program*
- EPSDT, school and adolescent health
- Children with special health needs
- Injury and violence prevention, including safe sleep, agricultural safety, youth suicide, and domestic and sexual violence

In September 2020, MCH Director, Dr. Breena Holmes transitioned from her position and acted as a Physician consultant to the division and department until June 2021 when Dr. Holmes moved to a new position at the Vermont Child Health Improvement Program. Ilisa Stalberg, former MCH Deputy Director, took on the new role of MCH Director. Dr. Holmes continues to work with MCH in her role at VCHIP in the areas of perinatal quality and children's mental health, as well as ongoing clinical expertise.

The overwhelming majority of MCH staff were deployed to state's COVID-19 response, in a variety of positions. The Division stood up the School and Childcare Branch of the Health Operations Center as early as March 2020 and did so through the duration of the response. The School and Childcare Branch has been primarily responsible for the development of health and safety guidance for the reopening of childcare, schools, camp, and out of school care. MCH public health nurses and social workers staffed a technical assistance line for administrators and program directors to answer complex questions in this ever-changing time. We developed strong communication materials and provided dozens of webinars and learning opportunities for thousands of school, childcare, and camp staff to acclimate them to the guidance and answer questions. Branch staff also consult on policy issues and additional guidance by state partners including mental health, agency of education and Dept for Children and Families. Branch staff demonstrate commitment, passion, and nimbleness in an extremely complex and challenging time. The majority of branch staff were demobilized in summer 2021, but MCH continues to provide technical assistance and policy guidance to the COVID response and will play a pivotal role in supporting recovery efforts for children and youth.

As discussed elsewhere, MCH staff also played a critical role in Vermont's contact tracing efforts. Public health nurses and social workers in CSHN were identified early as expert contact tracers. MCH staff in these positions quickly rose into leadership roles. Several of our CSHN Medical Social Workers were the architects of Vermont's Contact Tracing Care

Coordination program ensuring that individuals in quarantine and isolation had access to supports and services to address barriers to care. They were also a key connection to the health equity team.

MCH Coordinators (MCHCs), are public health nurses at the local level, who lead the way on local issues. Similarly, School Liaisons work directly with schools to promote the MCH mission and further EPSDT mandates. MCHCs and School Liaisons are within the organizational structure of the Office of Local Health and are not managed by MCH. However, the work plan and content expertise are directed by MCH. Local level staff are responsible for activities such as: local MCH and breastfeeding coalitions; routine information sharing and outreach around best practice and public health initiatives with women's health and pediatric providers, as well as other professionals serving MCH populations; members of local community and planning teams; and more.

The MCH Division has continued to be incredibly successful in bringing in interns to support programming and to train a variety of students on their paths as new emerging public health professionals. We have had several rounds of interns from the MCH Workforce Development program who completed a summer-long internships, including two this year working with our WIC program. We have also had students from the University of Vermont working on projects related to key MCH areas of work: maternal depression, substance use and pregnancy, WIC, and adolescent health. A former intern who worked on follow up efforts related to the initial maternal depression grant needs assessment transitioned into a state temp position and worked on a statewide resilience messaging project. Another student who was an Equity Studies major led the development of a health equity toolkit for the health department, a very useful resource that is supporting the advancement of healthy equity efforts across our department and with community and other state partners. We routinely have Pediatric Residents shadow MCH staff, as well as MSW students completing their year-long placements. We are looking forward to developing a partnership with Saint Michael's College as they recently launched an undergraduate public health program as well as a graduate certificate in health equity. MCH has spent the past several months working to formalize our internship processes and opportunities to expand the statewide MCH workforce. As we emerge from the COVID pandemic, we look forward to bringing more interns and structure to MCH.

MCH promotes the use of the MCH Navigator to all staff, and addresses training needs through the annual performance evaluation and voluntary Individual Development Plans. VDH has highlighted workforce development as one of only six strategic plan goals. Public health core competencies are promoted and every three years, a self-assessment is performed to analyze strengths and measure gaps in competencies. Training is tailored to meet identified needs. Prior to the pandemic, staff engaged in trainings across the spectrum: evidence-based public health, evaluation, and project management. All VDH staff are required to complete training in HIPAA, public health 101, sexual harassment, trauma/resiliency and emergency preparedness training; supervisors are required to take supervisory training. Vermont MCH recently received the Vermont Workforce Snapshot from MCH Navigator. Although we haven't yet had the opportunity to dig into the findings, we look forward to exploring opportunities to increase the knowledge area and skills in such areas as: critical thinking, negotiation and conflict resolution, policy.

MCHs employee engagement committee is a direct result of the MCH Strategic Plan, in order to promote overall employee engagement and connection to vision, mission, and team. As staff exit the COVID response, and enter back into their MCH roles, the Department and Division are committed to support staff's emotional health and well-being through organized listening sessions, trauma-informed trainings, and additional opportunities to reflect and release. The MCH Employee Engagement group has reinitiated the division wide newsletter, monthly small group conversations with the MCH Director, and are working to identify priority areas for MCH staff training. This group also helps to identify critical issues emerging with staff and reports back to the leadership team for problem solving. MCH employee engagement also assists with planning regular all staff meetings to ensure that the focus and content are meaningful and support staff connections to each other and division priorities and programs.

Prior to COVID, the Health Department was engaged in cross-Divisional work to stand up and sustain targeted health equity work as part of all of our programming. Through the Health Equity Advisory Team (HEAT), staff were offered training and self-learning opportunities about systems of oppression, social determinants of health, and health disparities. The HEAT

helped to outline actions that VDH can take to further and deepen health equity work by addressing both internal systems and processes as well as health equity leaders within divisions.

During COVID, our work with community partners was dramatically transformed to respond to significant inequities which were uncovered across the country, including in Vermont. A new Health Equity and Community Engagement (HECE) Team was developed and installed within the Command staff of the Health Operations Center (HOC). The Health Equity Technical Advisor and team lead was an MCH staff person throughout the majority of the response. The HECE Team engaged partners across the state and enhanced the HOC educational, prevention, and outbreak response strategies.

Through new CDC Health Disparities funding, the Health Department has expanded upon the HECE teams' work to address health equity across public health areas, not limited to the COVID-response. As part of this expansion, the Division of MCH hired a full-time Health Equity lead. As a member of the MCH Leadership Team, this position supports MCH and the Health Department to: supply workforce development and health equity training; participate in departmental and division-level planning (including development of the MCH Strategic Plan and selection of Title V measures); work with managers to assess MCH programming, identify gaps, develop recommendations and implement health equity plans; and advise on funding decisions, grantmaking processes, and business processes.

Through additional COVID funding, MCH is planning to expand our workforce to support COVID response, recovery and ongoing MCH work. In October 2021, we hired two public health nurses to support the ongoing COVID work with schools, child care, and out-of-school time programming. Through the COVID response, we have deepened our relationships with the Agency of Education, Child Development Division (child care licensing), and community organizations that provide training and supports to these fields, as well as directly with programs across the state. We see a major opportunity to continue this work in the years to come and to leverage these relationships to help pivot to our other MCH priorities in working with these organizations and programs such as school nurse leadership and health and safety in child care. We also recently hired an MCH Evaluator (start date Sept 2022) to assess the COVID experience in schools and identify lessons learned and opportunities moving forward.

The development of VT's health care workforce, including the workforce serving MCH populations, is overseen by the State Office of Rural Health and Primary Care (SORH/PC). One of the key functions of the SORH/PC is the bi-annual FTE surveys of more than 40 health professions including physicians, physician assistants, dentists, nurse practitioners, nurses and mental health providers. This data is reported in full statistical reports, summaries or data briefs. The SORH/PC staff participates in a statewide Health Care Workforce planning committee appointed by the Governor under the State Innovation Model (SIM) grants from CMS.

Within MCH, we engage in many activities aimed at improving the current MCH workforce, to promote evidence-based best practice services that are culturally relevant and family-centered.

Our MCH program has strong partnerships with the professional organizations that serve Vermonters of childbearing age, pregnant people, children, and families. Through ties to the VT chapters of the AAP, AAFP, ACOG, AMA and the VT NP Association, MCH ensures that public health content, messaging, and skill building are imparted to these workforces.

This work is bolstered by our partnership with VCHIP. Together, MCH and VCHIP have lead dozens of QI initiatives aimed at improving the skill and capacity of providers and early care and education. Projects such as those focused on developmental screening, perinatal healthcare, adolescent well-visits, family well-being and food security, among others provide essential training to providers to improve practice.

MCH convenes the School Nurse Advisory Committee, charged with advising and supporting the development of school nurse workforce clinical practice and leadership skills, including the promotion of the School Nurse Leader model and development/revision of the new school nurse orientation program. MCH's State School Nurse Consultant leads two courses Leadership Skills for Nurses 101 (communication, delegation, mentorship, performance measurement) and 201

(ongoing learning community).

VT MCH is a major sponsor of the VT Family Network's annual conference to educate health, human service, and educational providers, as well as the annual suicide prevention symposium. Likewise, MCH staff are frequent speakers at local, statewide, and national conferences.

III.E.2.b.ii. Family Partnership

Family Partnership

During this reporting period, and continuing past, we in VT are learning lots about best practices in family and community engagement, and how to authentically elevate the voices of Vermonters who are impacted by Health Department programming and action/inaction. The COVID-19 pandemic, and the mobilization of the Health Operations Center (which assigned most of our Division to temporary emergency response roles) brought with it many lessons learned about responsiveness to community needs and feedback.

VT has a long tradition of promoting family-centered care and involving families in all levels of decision making. Our MCH Division values family input across programming and planning and works to do this in an authentic and meaningful manner.

Many of our Division's program and administrative staff worked within the Health Operations Center's (HOC) School and Childcare Branch during the reporting period. Several were also deployed to the Health Equity and Community Engagement Team, Contact Tracing, and other sections of the emergency response. Through these venues, Maternal and Child Health staff had unique opportunities to respond directly to the concerns of priority populations. These include families, individuals, and programs most likely to experience disparate health outcomes due to inequitable health systems and systems of oppression. English Language Learning families, folks living in multi-generational housing, migrant worker families, front line workers who parent kids in the public school system; the intersections for the populations we serve are vast. We are grateful for the mutually beneficial gains of our partnerships.

The Family Partnership Coordinator position is currently vacant, and discussions are underway about how to sustain the valuable work of the outgoing Coordinator. Excerpts from our Family Partnership Toolkit demonstrate what our Division has learned about authentic engagement of a State Department and the communities they serve:

"A Family Partner is *an individual who has received or taken part in any services or programs offered or directly supported by MCH. A Family Partner will work in collaboration with MCH staff at all levels to help make services and programs more responsive to the needs of community members and families.*

The role of Family Partner is to bring the individual, youth, and/or family voice and perspective to policies, programs, operations, and education throughout MCH to improve program design, delivery of services, and staff satisfaction. Family Partners also serve as champions in promoting a culture of collaboration among administration, staff, community providers, consumers, and families.

What does a Family Partner actually *do*?
(May include one or more of the following):

- Participate in Advisory Council meetings
- Share perspectives, experiences, and advice in a variety of settings and situations
- Help create, implement, and evaluate policies, programs, and services
- Respect and protect the confidentiality of individuals, family members, and employees at all times and in all circumstances
- Support the mission, vision, and values of MCH

What are best practices for including Family Partners?

- Assign a 'point person' for the Family Partner(s). The point person will:
    - Introduce the Family Partner to the team
    - Ensure they receive all pertinent communication, including meeting times, location, and relevant project updates.
- Actively incorporate Family Partners, especially during the first few meetings:

    - Provide the Family Partner with the contact information for their project- specific point person.
    - Include Family Partners in introductions, and be sure to incorporate names, roles, and pronouns
    - Avoid using jargon or technical terms; consider assigning someone the role of 'jargon buster'
    - Address some questions specifically to the Family Partner throughout the meeting/discussion to emphasize interest in their participation. New Family Partners may find it difficult to know when to speak up and share their vital perspective.
- Provide clear information about the purpose/goal of the project or committee.
- Send the Family Partner(s) meeting agendas, minutes, and other project notes ahead of time for their review.
- If the project or committee is put on hold or discontinued, provide the Family Partner with updated meeting frequency.
- When the project is complete, inform the Family Partner and thank them for their contribution

MCH continues to partner closely with the VT Family Network (VFN). VFN is the national Family Voices VT chapter and Parent-to-Parent Program. VFN empowers and supports all families of children with special needs. VT's CSHN program has a history of supporting the ongoing work of VFN. Through a subrecipient grant, CSHN collaborates with VFN to continue their mission.

Parents or parent representatives from family support organizations are regular members of many state committees and advisory boards. To promote the involvement of people who utilize state services, the state has a policy of providing stipends and mileage reimbursement to participate on state advisory committees and boards.

Some Title V funds continue to support the work of Vermont Afterschool in convening youth councils statewide. Shortly after this reporting period ended, Vermont's General Assembly passed Act 109, which creates a Statewide Youth Council who will report to the Legislature and the Governor. We in MCH have will lead some aspects of this work, and Vermont Afterschool and the Youth Services Advisory Council will support the rest. Our new grant to Vermont Afterschool will have a required activity of collaboration with the VT Child Health Improvement Program (VCHIP)) and the youth health advisory council called VT RAYS (Raise Awareness for Youth Services) which includes a diverse group of adolescents and young adults (ages 16-26) committed to improving adolescent health and wellbeing.

Our Sex Ed Stakeholders workgroup, and the work of Vermont's Title X and PREP managers, is newly focused on parent and community engagement in adolescent sexual and reproductive health promotion. We want to focus on expanding our Essential Topics training beyond health educators and invite an audience of parents and caregivers to engage in the work.

The Youth Services Advisory Council promotes shared responsibility across state and community stakeholders for achieving positive outcomes for youth and young adults. The Council promotes, advocates for, and monitors the continued evolution of culturally competent, holistic, strengths-based service systems, advocates for improved quality of and access to services, and organizes policy responses to remove barriers to achieving these goals. Due to COVID-19 capacity issues as many members were deployed to the COVID-19 response, this group is planning to reconvene and revitalize in the fall of 2021.

The SSNC chairs the School Nurse Advisory Committee, which provides school nurses with guidance to ensure all school-aged children and youth receive the recommended age-appropriate care. MCH continues to reach out to engage parents in committee work. MCH works with our partners at Vermont Family Network (VFN) to assist us with direct family engagement in the development and revision of tools for school nurses.

Our HRSA MDRBD funding conducted interviews of women with lived experience with perinatal mood and anxiety disorders. VT's WIC program administers an annual participant satisfaction survey (https://www.healthvermont.gov/family/wic/plans-reports). Additionally, VT WIC has convened a Telehealth Advisory Council.

In addition to the examples above, VT Title V benefits from the input gleaned from stakeholders and family members' presence at VT's Autism Workgroup, Hearing Advisory Council, and Newborn Screening (NBS) Advisory Committee, and seats at the table of the Equity Outreach Collaborative, the Health Equity Advisory Commission, the Youth Services Advisory Council.

III.E.2.b.iii. MCH Data Capacity

III.E.2.b.iii.a. MCH Epidemiology Workforce

MCH Data Capacity: MCH Epidemiology Workforce

MCH epidemiology support in Research and Statistics include:

The Pregnancy Risk Assessment Monitoring System program consists of a full-time Coordinator (Public Health Analyst III) and two half-time Data Managers (Administrative Assistant B). The PRAMS Coordinator is responsible for overseeing the program, analyzing data. and collaborating with MCH staff, other health department staff and external partners. The Data Managers are responsible for data collection, including mailings and phone interviews, and data management. These positions are funded by the CDC PRAMS grant with additional state support.

The Birth Information Network Coordinator (Public Health Analyst III) is responsible for managing a registry for infants born with birth defects and other conditions and providing referrals to Children with Special Health Needs. This is a full-time position and is funded by the CDC's Environmental Public Health Tracking Program.

Another Public Health Analyst III in the R&S unit spends approximately half-time on MCH data. He is responsible for reviewing and updating the PRAMS sampling plan annually, drawing the monthly sample, processing the annual weighted data file, and conducting analyses. He also works extensively with the birth, fetal death, and abortion files. Along with the SSDI Coordinator he is now responsible for case finding for maternal mortality reviews. He is primarily state funded, with some time funded by Title V.

The Public Health Analyst III that supports the Oral Health Program spends approximately half-time on analyses related to pregnant women and children, including impact of increasing the Medicaid benefit for pregnant women on their dental utilization, dental claims for children, data from dental hygienists working in schools and WIC clinics, and overseeing the periodic Basic Screening Survey (BSS) for kindergarten and third graders. This position is funded by the CDC's Oral Health grant.

Since the CDC's MCH Epidemiologist was transferred from Vermont in September 2020, a Research and Statistics Analyst who is also the SSDI Analyst, has been responsible for reporting for HRSA's Maternal Depression and Related Behavioral Disorders Program. This position is state funded, but funding is provided from the MDRBD grant for time spent on this work.

The Research and Statistics Chief spends approximately half her time overseeing MCH analyses.

Funding provides for.25 FTE in injury surveillance. Over the last year, this has been shared by several analysts as the work evolved. We anticipate COVID-19 surveillance specific positions will relieve capacity challenges and allow this work to be assigned to one dedicated analyst moving forward.

The CDC's Health Disparities Grant will provide funding for a new Public Health Analyst II to focus on analyses of the WIC data. This position is currently being recruited for.

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

MCH Data Capacity: SSDI

The SSDI Coordinator is in the Research & Statistics (R&S) unit of the Public Health Statistics Section in the Division of Health Surveillance. He is a Public Health Analyst III and works full-time on MCH topics including support for the Title V program and grant. Types of analyses include school health data, WIC analyses, developmental screening reports, claims data and some analyses of PRAMS data. Funding for this position is provided by the HRSA SSDI grant, with supplemental funding from Title V.

As Vermont is a small state with a strong history of collaboration, analysts and leadership often wear multiple hats under the MCH epidemiology and health surveillance umbrella. For instance, SSDI work happens in partnership with evaluation activities for the HRSA-funded MDRBD program: Screening, Treatment, and Access for Mothers and Perinatal Partners cooperative agreement. Please see the Epidemiology Workforce and Other Data Collection Efforts sections for a discussion of these relationships.

III.E.2.b.iii.c. Other MCH Data Capacity Efforts

MCH Data Capacity: Other MCH Data Capacity Efforts

In addition to the data capacity described above, Vermont's MCH partnership with the Vermont Child Health Improvement Program (VCHIP) provides substantial data and analytic capacity and supports a deeper understanding of key MCH topics. For example:

- Through the University of Vermont's (UVM) data use agreement with the Green Mountain Care Board, the VCHIP's Health Services Research (HSR) team has full and ongoing access to Vermont's all-payer claims (VHCURES) data from 2008 to present. VCHIP's HSR Team analyzes population-level healthcare utilization data over time and by geographic region based on the maternal and child health priorities, in consultation with MCH as the administrators of Vermont's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program
- The Child Health Advances Measured in Practice (CHAMP) project creates a longitudinal approach to improving health outcomes for VT children, youth, and families. At its foundation is the creation of a network of practices that engage in collaborative improvement activities over time. Participating practices benefit from annual data collection and benchmarking of their results, access to annual "learning sessions" with peers focused on systems change and addressing key clinical content areas in need of improvement, as well as access to annual rapid, intensive quality improvement projects. This Maintenance of Certification (MOC) structured Quality Improvement (QI) projects include monthly data reporting and feedback, collaborative calls, and practice-specific quality improvement coaching
- In recent years, VCHIP and MCH are (finally) stood up the Perinatal Quality Collaborative-Vermont as the organizational framework through which maternal and child health quality projects are integrated, including data required for quality measures. Through collaboration, data analysis, and quality improvement activities, the Perinatal Quality Collaborative –Vermont will: provide support and education on best practices to perinatal health care professionals and community-based partners who care for this population; improve health care systems for the implementation of current guidelines and best practice recommendations; and convene collaborative meetings to improve perinatal care across the state. VCHIP and VDH are currently working on a data use agreement to increase the access to perinatal data in for the PQC to do our work.

VT publicly tracks, measures, and reports on data to achieve shared goals for improving public health. Most of our data sets or briefs/reports are available online. Our data explorer allows users to access this information, view trends over time, and visualize the indicators on Vermont maps. This data should be used to assess and understand health and well-being in VT.

VT completed its State Health Assessment (SHA) and State Health Improvement Plan (SHIP) in 2018. The SHA provides vital data for examining health inequities by race and ethnicity, gender, age, sexual orientation, disability, SES and geography. This serves as the basis for developing the SHIP 2019-2023, helping us prioritize goals and objectives for health, monitor trends, identify gaps and track progress. The SHIP includes strategies to improve health outcomes and reduce inequities in five priority areas: chronic disease, early childhood, mental health, oral health, and substance use disorder.

The HV2020 Quick Reference gives a quick look at the indicators. The HV2020 Midway Report Card presents a snapshot in time of how we're doing in meeting our targets about halfway to 2020. Scorecards are interactive "report cards" that show how well VT is doing relative to desired outcomes. They display statewide population data and program performance measures that support a transparent and accountable health department and include additional information on why the indicators are important and the actions we are taking to achieve those goals. Vermont is currently working on identifying measures for HV2030 and will publicly track and share data.

III.E.2.b.iv. MCH Emergency Planning and Preparedness

Emergency Preparedness

Prior to the COVID-19 pandemic, Vermont MCH had a minimal role in emergency preparedness planning or response. Vermont does have a written EOP which points to the Health Operations Center (HOC)/Incident Command System (ICS) as the organizing entity for emergency response. Title V program staff were not involved or consulted in the planning and development of the State's EOP, nor does it specifically consider the needs of the MCH population, which includes at-risk and medically vulnerable women, infants, and children.

Although all health department staff are trained in ICS and basic emergency preparedness and may be called up in an emergency (as in COVID), there historically is not a specific role for MCH staff. Recent examples of HOC activation did include MCH leadership: lead in schools/child care, PFOA in drinking water, and H1N1, not until COVID, was there a specific MCH-need and role.

MCH and COVID

COVID changed Vermont MCH's relationship with emergency preparedness planning and response; we expect that this will significantly improve Vermont's overall approach to addressing the unique needs of children and families.

The majority of Vermont MCH staff were deployed to the COVID HOC. Staff were assigned roles across the response including Operations leadership, Contact Tracing, MedTech—testing and vaccination, and the Health Equity and Community Engagement (HECE) team. MCH deployed to the Contact Tracing team quickly rose to leadership roles, either as Clinical Leads or COVID Care Coordinators. Clinical Leads were available 7 days a week, acting as a resource, mentor and subject matter expert in all things related to isolation and quarantine guidance. The COVID Care Coordinator position was created largely due to CSHN social workers identifying a need for an added layer of support for certain cases and contacts. They developed, implemented and filled this role throughout the pandemic, and continue to function as consultants for the contracted vendor who since took over this work. MCH staff also led up the HECE team based on their deep understanding of family engagement fostered through their Title V/MCH daily work.

In addition to these roles across the response, MCH stood up the School and Child Care Branch of the COVID HOC, which fell under the Operations Section reporting to the Incident Commander. Within days of the first cases of COVID in Vermont, it was apparent the impact that the pandemic would have on child and family serving systems and MCH leadership sprung into action to identify gaps and strategies to address these needs. Since March 2020, the School and Child Care Branch led the following:

- Developed policy and issued health and safety guidance related to school reopening, as well as child care and out-of-school-time care operations. Vermont was among the first in the state to reopen emergency child care and operate in-person education. MCH staff led a multi-stakeholder process to ensure that guidance was grounded in science and reflected the unique needs of these populations.

- In partnership with VCHIP, ensured pediatric health care providers had access to timely dissemination of credible, accurate information. partnership with VCHIP as one means of assuring timely dissemination of credible, accurate information. Beginning March 18, 2020, calls were conducted 4 days/week, which was reduced over time and are now monthly. There were 240 calls were conducted between 3/18/20 and 7/20/22 with 1,875 unique participants attending at least one call (the majority attend many calls). This unique connection to the provider community was instrumental in gathering feedback & garnering support for public health policy, guidance, the creation of tools and resources, and connecting providers to support efforts in their community during the ever-evolving pandemic (and the evolving evidence-base, knowledge/resources available for COVID-19).

- In partnership with VCHIP, MCH developed and issued clinical guidance and communication tools for pediatric health providers and school nurses on such topics as:

    - COVID-19 in Pediatric Patients Flow Chart (Pre-K – Grade 12) Triage, Evaluation, Testing, and Return to School
    - Return to Play After COVID-19 (Updated June 2021)
    - Cardiac Screening in Pediatric Patients After COVID-19 Infection

- Provided daily technical assistance to school administrators, school nurses, and child care and out-of-school time operators on implementing health and safety guidance.

- Conducted contact tracing and outbreak prevention and response for cases/outbreaks in schools and child cares; worked closely with the Epidemiology team to inform and implement protocols that address the unique needs of these facilities.

- Worked with the testing team to inform and implement school surveillance testing, as well as ensure testing protocols were child- and family-friendly. Stood up Test to Stay and Test at Home programs for both schools and childcares to ensure continuation of education and care. Currently, MCH is leading the development of Back to School guidance for the 2022-2023 school year, in partnership with our Epi team and the Agency of Education.

- Worked as part of the vaccine task team to ensure vaccine rollout addressed the needs of adolescents and families; developed strategies and working to target funding to address the unique circumstances of children and youth with special health needs that are frequently overlooked in mass vaccination clinics.

- Developed family-centric communication materials early on in the pandemic which spoke to addressing children and family mental health, children with special health needs and other MCH topics.

- Ensured that surveillance data represented the MCH population.

Lastly, MCH staff worked tirelessly to ensure continuous operations of WIC, home visiting, and newborn screening in the early phases and throughout the pandemic, as rules and guidance changes from state and federal authorities.

The work of the COVID response had a deep impact on our staff, partnerships, and programming. We believe that the lessons learned will be endured and that future emergency preparedness planning will be fortified with an MCH lens and leadership.

Outside of COVID, in partnership with Vermont Child Health Improvement Program (VCHIP), MCH works with the Health Departments Emergency Response for Children (EMSC) program to improve the quality of EMS and availability of appropriate resources and personnel with pediatric skills training for children across the continuum of health care settings in which this care is delivered (home, health care practices, hospital emergency departments, community settings).

- Collaborate with Health Department EMSC Program Coordinator to develop mutual awareness and coordination of activities in support of emergency preparedness among health care professionals (e.g. primary care, emergency medical services, emergency department clinicians, other hospital/specialty care clinicians, skilled nursing) statewide.
- Explore opportunities to provide training to emergency medical service professionals in basic quality improvement methods and tools, including use of data to inform practice improvement.
- Explore opportunities to conduct shared learning regarding emergency preparedness and response among primary care clinicians, EMS personnel, and Emergency Department personnel in communities.
- Conduct outreach to EMSC partners (health care professionals and local EMS agencies) to identify strategies in

response to needs identified in the primary care practice survey to improve readiness using current recommendations.
- Promote best practices (based upon AAP recommendations) for maintaining continuity of operations in the event of an emergency/disaster, including a template for a list of key contacts (pediatric leaders, pediatric experts, public health contacts, vendors, others) and their contact information to facilitate communication in an emergency.

The COVID pandemic showed the great importance of integrating MCH considerations into emergency preparedness plans. In order to commit to bettering future emergency responses, a representative from MCH, the Office of Local Health (OLH) and the Division of Emergency Preparedness, Response, and Injury Prevention (DEPRIP) are engaging in a Virtual Learning Community (VLC) hosted by the National Association of County & City Health Officials (NACCHO). The VLC is an opportunity to collaborate with other states and learn more about MCH-focused emergency preparedness. The MCH representative participates in monthly meetings and attended an emergency preparedness conference in April 2022.

In order to ensure the lessons learned are not forgotten, the MCH representative will complete further FEMA emergency preparedness trainings and take on the role of MCH Liaison with DEPRIP. MCH intends to strengthen the relationship with DEPRIP and ensure that MCH considerations are embedded in the State of Vermont's emergency plans. This partnership will allow DEPRIP to utilize the knowledge from the MCH representative to create a MCH focused exercise to assess the integration of MCH considerations into emergency planning, allowing a process for continual improvement.

III.E.2.b.v. Health Care Delivery System

III.E.2.b.v.a. Public and Private Partnerships

Health Care Reform & Title V Leadership

VT has a long history of leadership in health care reform policy designed to reach the goal of universal health insurance coverage & increasing access to quality & affordable health care. Ongoing federal & state healthcare reform activities & changes continue to impact pediatric care, including CSHCN. MCH works very closely with the prevention-focused Blueprint for Health & Women's Health Initiative, supporting planning & implementation of VT's 1115 Medicaid waiver.

VCHIP, with funding & support from MCH, completes a yearlong QI project with providers throughout Vermont. Multiple State fiscal years (FY) overlap normal Title V reporting periods. The FY20 QI topic was "Sharpening our Focus on ADHD: Using Guidelines & Partnerships to Improve Outcomes." The fall Learning Session & subsequent collaborative effort focused on assessing for co-occurring mental disorders associated with ADHD, such as emotional or behavioral conditions including suicidal ideation. The aim was to improve knowledge & skills for the evaluation & treatment of ADHD in children & adolescents, & to assure documentation of impairment in more than one setting. The current topic was "Strengthening Vermont's system of high-performing pediatric medical homes." Components of the project anticipated to be included are: (1) Screening & follow-up for recommended preventive services (blood lead testing, vision screening, hearing screening, oral health, Social Determinants of Health; & Developmental Screening). (2) Maximizing the use of practice-based care coordination resources. (3) Aligning practices with health reform payment incentives. The FY22 project will be a second year of this topic. Some expected changes to this year's project include: (1) incorporating additional measures: parental depression & social emotional screening & follow-up; (2) Maximizing the use of practice-based care coordination resources; (3) Racial & Health Equity; & (4) Aligning practices with health reform payment incentives. Next year's year-long QI project is focused on adolescent and youth mental health and dovetails beautifully with Vermont's HRSA-funded Pediatric Mental Health Care Access grant.

Perinatal Quality Collaborative

The Perinatal Quality Collaborative—Vermont (PQC-VT) is a relatively new collaborative structure. Although Vermont has a long and successful history of implementing quality projects in obstetrical, neonatal, and pediatric care through partnership between the Vermont Department of Health (VDH) MCH Division and VCHIP, the PQC-VT is a relatively new structure. Vermont has made significant improvements in the care of pregnant Vermonters, newborns and infants through initiatives like the OB-Outreach, Alliance for Innovation on Maternal Health (AIM), Vermont Regional Perinatal Health Project, and Improving Care for Opioid-Exposed Newborns. However, Vermont lacks a collaborative structure able to knit together systems (health care and community services) across the perinatal period and into early childhood. This CDC opportunity will provide the newly formed PQC-VT with the infrastructure to create this continuum of support.

In October of 2020, all VCHIP's pregnancy, newborn and infant initiatives were unified under the PQC-VT in partnership with MCH. The mission of the PQC-VT is to optimize care and health outcomes in pregnancy and infancy through collaboration and continuous QI. The PQC-VT improves care and health outcomes of Vermont's pregnant people, newborns and their families by:

- Setting Perinatal Outcome Priorities: Actively engage perinatal health care professionals, MCH public health experts and community-based partners in developing a common agenda by highlighting current successes and gaps in perinatal care and identifying focusses for pregnancy and infant health outcomes.
- Providing Outreach and Education: Build relationships across sectors including hospitals, outpatient practices, community-based organizations, state health programs, and families to address perinatal issues, and provide opportunities for collaborative learning on best practices.
- Advancing QI Efforts: Mobilize perinatal health care teams in continuous QI efforts for improved health outcomes, and disseminate successful system approaches. Develop quality metrics appropriate for perinatal health care.

- Monitoring Health Care Outcomes: Analyze perinatal and public health datasets to gauge QI work and opportunity, evaluate program implementation, and perform health outcomes surveillance.

The PQC-VT, has organized and unified VCHIP's pregnancy, newborn and infant initiatives to coordinate QI efforts, education and outreach activities, and perinatal priorities. Through these initial efforts, it is clear the PQC-VT needs outreach coordination, additional data analytics support, and community birthing hospital expertise in perinatal QI. In the coming year(s), Vermont plans to cement the PQC-VT organization and move it from concept to action.

Other Health Systems Innovations

As the COVID-19 pandemic was emerging, MCH leveraged our existing partnership with VCHIP as one means of assuring timely dissemination of credible, accurate information. Beginning March 18, 2020, calls were conducted 4 days/week. The initial target audience consisted of pediatric & family medicine practices throughout the state. Content included streamlined & pediatric-focused clinical guidance, virtual sharing of strategies (e.g., how to triage provide testing & clinical care, including via telehealth), & a Q&A. The target audience quickly expanded to include a broad array of community partners, including school nurses and child- & youth-serving organizations. As of June 2022, calls are conducted once a week, with plans to reevaluate as we approach the fall & school reopening. Throughout, we have continuously adjusted this process in response to participant feedback.

There have been over 240 calls as of June of 2022. This unique connection to the provider community was instrumental in gathering feedback & garnering support for public health policy, guidance, the creation of tools & resources, & connecting providers to support efforts in their community during the ever-evolving pandemic (& the evolving evidence-base, knowledge/resources available for COVID-19).

In an effort to provide universal access to a range of health, economic, & human services, VT is implementing the Center for the Study of Social Policy's Developmental Understanding & Legal Collaboration for Everyone (DULCE) approach at five sites across the state. DULCE partners include hospital-owned, independent & FQHC sites, Parent Child Centers & VT Legal Aid. A trained DULCE Family Specialist from a PCC is integrated in a pediatrician's office to meet with all families of infants 0-6 months at well-child visits. DULCE offers the opportunity for communities to knit together services that address SDOH & are best suited to the strengths, challenges, & interests of families.

MCH continues to provide infrastructure & convening support to school-based health centers who wish to learn from each other & collaborate. We have begun to assess SBHC status & identify current & new contacts since the pandemic put much of this working together on hold. School Liaisons update an inventory of SBHC & provider relationships with schools & support local efforts to form SBHCs. MCH does much of this work through VT's SBHC Peer Collaborative, a way to share information, problem solve, network, & support effort. MCH has reached out to the School Based Health Alliance to gather feedback & support from national SBHC experts. This work was put on hold since the beginning of the pandemic, but we are looking forward to renewed efforts this year. MCH will also partner with the Youth Health Improvement Initiative at VCHIP to develop an assessment tool for existing SBHCs, identify common assessment measures, consider training & development opportunities. YHII will be surveying our SBHC peer collaborative members, & will share findings with MCH & stakeholders. This work is ongoing due to difficulties with response rates while our school/provider partners are still heavily engaged with pandemic related activities.

MCH Coordinators & School Liaisons promote *Bright Futures* EPSDT periodicity schedule, topic specific initiatives ie: promoting annual well-child visits or universal developmental screening with health care providers & community partners (including schools). Promotion includes verbal communications, written resources, website updates, support for regional community meetings, etc. The COVID-19 pandemic has demonstrated the importance of these relationships & community connections. We aim to maintain this level of provider engagement and build upon improved coordination & communication with health care providers & health care systems delivery & community stakeholders

III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

Health Care Delivery and Title XIX Medicaid IAA

VDH & the Department of Health Access (Medicaid) have a strong working relationship. As part of the same Agency of Human Services (AHS), VDH & Medicaid work jointly on policy issues impacting women & children, have data sharing agreements, & systematically address funding for the MCH population. DVHA convenes a monthly Medicaid Exchange & Advisory Committee (MEAC); Health Department Commissioner's Office leadership has a role participating in this Committee. The group reports to Medicaid leaders about necessary policy change to improve outcomes.

Outreach & Informing

Title V is closely linked with EPSDT-funded initiatives & efforts to promote the administration of Medicaid & improve health for children & adolescents. Key program elements of EPSDT in VT are administered within MCH & coordinate closely under interagency agreements with DCF & the state Medicaid agency. MCH manages grants to the VT chapter of the AAP & the AFP to improve population-based health outcomes & access to preventive services for Medicaid-eligible children & youth, & their families. Often the work done through these grant efforts benefit all children & youth in VT. MCH's annual grant to the VT Child Health Improvement Program (VCHIP) is designed to improve health outcomes for Medicaid-eligible children & youth & their families through population-based health services, research, & quality improvement. A monthly Primary Care & Public Health Integration meeting convenes the leadership of MCH, VCHIP, AAPVT, VT AAFP, Planned Parenthood, ObGyn, & internal medicine to tackle key public health issues for pregnant individuals, children, adolescents, & young adults. We are currently updating the structure and attendance of this meeting to be more inclusive, on account of the lessons learned from our engagement with the pediatric community throughout COVID.

In 2018 MCH was selected to participate in a National MCH Workforce Development Center TA opportunity. MCH (in partnership with Medicaid) proposed the creation of a multi-year EPSDT outreach & informing plan. This work is ongoing. Following this, MCH successfully applied to the CDC/Harvard T.H. Chan School of Public Health's MCH Program Evaluation Practicum in Jan 2019 to create an evaluation plan on current EPSDT outreach & informing efforts to provide an improvement framework including gathering input from individuals & families enrolled in Medicaid. Interns through the Title V MCH Internship Program implemented portions of that the plan. Their work primarily included hosting focus groups with families & call center surveys with our Medicaid office to help inform our work. We plan to continue to use information from this work to guide efforts moving forward (temporarily on hold due to COVID).

Health Care Financing/Waivers

VT has a long history of leadership in creating health care reform policy designed to reach the goal of universal health insurance coverage and increasing access to quality and affordable health care. Ongoing federal and state healthcare reform activities and changes continue to impact pediatric care, including CSHCN.

In 2004, VT developed the prevention-focused Blueprint for Health to help primary care practices manage patients with one or more chronic conditions. The Blueprint has added an extensive program of self-management for patients, Community Health Teams to support patients and providers and has been rolling out intensive practice redesign across the state to achieve 100% coverage of Advanced Patient-Centered Medical Homes.

In fall 2005, VT secured approval for Section 1115 Medicaid Waiver, the "Global Commitment waiver" (GC). The waiver imposes a cap on the amount of federal Medicaid funding available to VT for nearly all Medicaid expenditures. It also includes all Medicaid administrative expenses. In exchange for taking on the risk of operating under a capped funding arrangement, the waiver allows VT to use federal Medicaid funds to refinance a broad array of its own, non-Medicaid health programs, and a greater level of program flexibility. The Global Commitment Waiver was just reapproved. Vermont MCH anticipates using this flexibility to finance our DULCE program more sustainably. Additionally, Vermont is working in close

partnership with Medicaid to submit an amendment to provide additional funding for sustained home visiting and adoption of Parents-as-Teachers, as a second evidence-based home visiting model in Vermont.

In 2011, the Legislature passed Act 48, creating Green Mountain Care, a publicly financed health care program designed to contain costs and to provide comprehensive, affordable, high-quality health care coverage for all VT residents. The act sets out 14 principles as a framework for reforming health care in VT and expands the list ongoing health care reform efforts. The act creates an independent, 5-member board to oversee nearly all aspects of health care in the state.

Vermont's All-Payer Model is changing the way health care is delivered and paid for, with the goal of keeping the state's health care spending in check and improving the quality-of-care Vermonters receive. It gives health care providers the flexibility to provide services like telehealth, group visits, and coordination with fellow providers that were previously not billable. And it holds insurers and providers jointly accountable for the quality and cost of care they provide to Vermonters. The Model pays for care based on value not volume, driving improved outcomes and enhancing the quality of care. It encourages increased communication and coordination between health care providers, especially those who are caring for the sickest or highest-risk patients. It helps ensure Vermonters are connected to the right care, at the right place, at the right time. And by shifting the focus to preventive care, the Model helps patients catch and treat small health problems before they turn into big issues.

The All-Payer Accountable Care Organization Model Agreement (sometimes referred to as the All-Payer Model, APM, the "Model", or the "Agreement") is an agreement between Vermont and the federal government that allows Medicare to join Medicaid and commercial insurers to pay for health care in a different way. VT's primary ACO, OneCare, has demonstrated significant successes & achieved considerable savings, as shown in a recent impact analysis. OneCare has an established pediatric subcommittee with the former MCH Director as a member. This group is currently looking for the right methodology to stratify risk for pediatric populations that previously used disease burden. Child health providers are eager to have a child's SDOH contribute to the assigning of risk for increased resource allocation & care coordination.

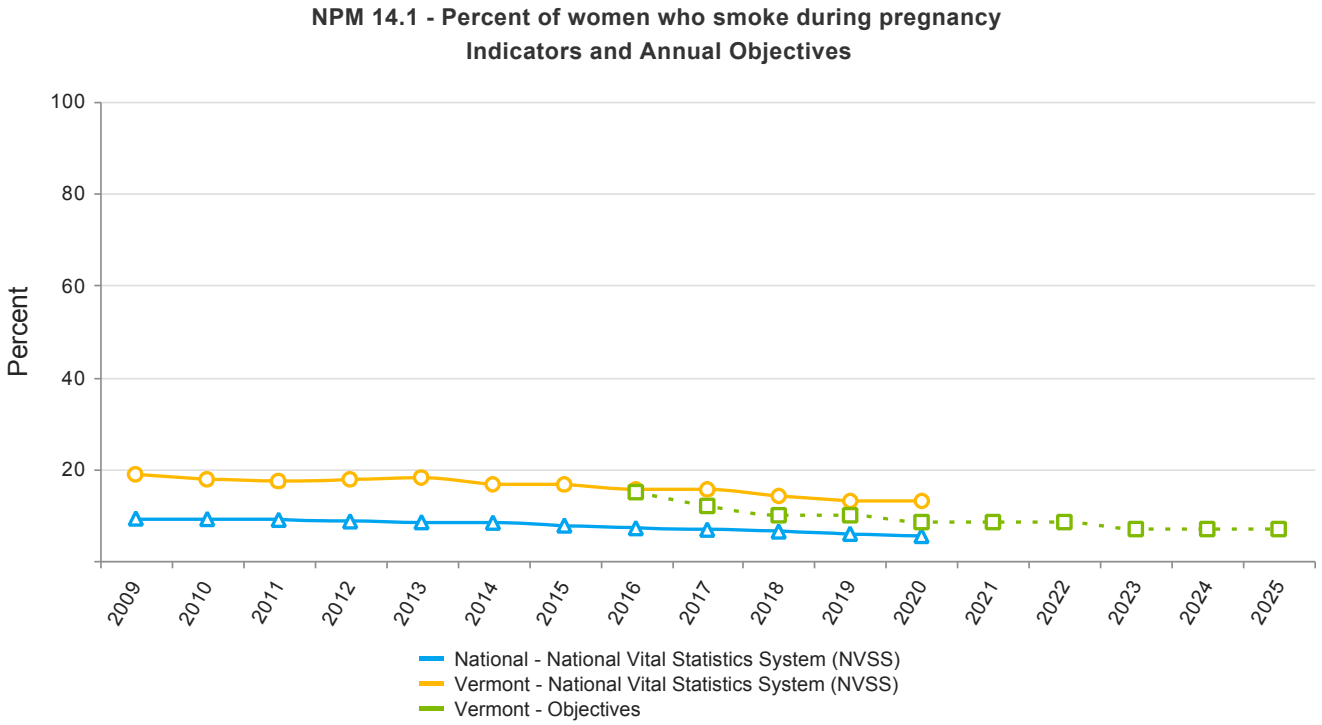
The Agency of Human Services (AHS) is the adopting authority for the Immigrant Health Insurance Plan administrative rule. The Immigrant Health Insurance Plan was enacted by the Vermont General Assembly in Act 48 of 2021 & is codified in state statute at 33 V.S.A. chapter 19, subchapter 9.
The Immigrant Health Insurance Plan was created to establish Dr. Dynasaur-like coverage for certain Vermont residents (children under 19 years of age & pregnant individuals) who have an immigration status for which Medicaid coverage is not available, including migrant workers who are employed in seasonal occupations in Vermont, & who are otherwise uninsured.

In establishing the Immigrant Health Insurance Plan, the General Assembly expressed their intent that the hospital, medical, dental, & prescription drug benefits & eligibility criteria for coverage should align to the greatest extent practicable with the benefits & eligibility criteria of the Dr. Dynasaur program. This program will begin July 1, 2022. Program information, including the application, will be posted to the Immigrant Health Insurance Plan page on the DVHA website as it becomes available.

III.E.2.c State Action Plan Narrative by Domain

Women/Maternal Health

National Performance Measures



Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	12	10	10	8.5	8.5
Annual Indicator	15.5	15.5	14.2	13.2	13.1
Numerator	881	868	758	697	667
Denominator	5,676	5,587	5,348	5,284	5,073
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2016	2017	2018	2019	2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	8.5	7.0	7.0	7.0

Evidence-Based or –Informed Strategy Measures

ESM 14.1.1 - % of pregnant smokers who register with the QuitLine or QuitOnline

Measure Status:				Active	
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	5	5	7	7	10
Annual Indicator	2.5	2.4	6.2	6.3	8.4
Numerator	19	16	37	35	47
Denominator	769	654	599	558	558
Data Source	QuitLine and Vital Statistics	QuitLine and VT Vital Statistics	QuitLine and VT Vital Statistics	QuitLine and VT Vital Statistics	QuitLine and VT Vital Statistics
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	10.0	10.0	10.0	10.0

State Performance Measures

SPM 3 - Percent of Women advised by a healthcare worker to abstain from alcohol during pregnancy

Measure Status:					Active
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			85	87	90
Annual Indicator	83.6	85.1	83.5	84.1	84.7
Numerator	4,596	4,587	4,321	4,301	4,160
Denominator	5,499	5,388	5,176	5,116	4,910
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	90.0	90.0	90.0	90.0

State Action Plan Table

State Action Plan Table (Vermont) - Women/Maternal Health - Entry 1	
Priority Need	
Reduce the risk of chronic disease across the lifespan	
NPM	
NPM 14.1 - Percent of women who smoke during pregnancy	
Objectives	
By 2023, increase the percentage of pregnant women who contact 802Quits (or other cessation resources) by 25%	
By 2023, increase the percentage of families with young children who contact 802Quits (or other cessation resources) by 25%	
Strategies	
1. Implement new social marketing campaign (“One More Conversation”) to communicate risks of substance use during pregnancy, targeted to health care professionals, pregnant women, and circles of supports (partners, families, friends).	
2. Collaborate with Medicaid to promote billing among pediatricians and Ob/Gyns for cessation counseling.	
3. Work with local WIC offices and home visiting programs to ensure all clients have access to smoking cessation resources/ referrals (802Quits Network): a) Educational and promotional materials for all WIC clients; b) Regular chart audits of WIC clients to assure appropriate referral and follow-up.	
4. Support outreach/ promotion of 802Quits with medical/ social service community: a) Regional MCH coalitions promote messaging around the risks of smoking in pregnancy and cessation resources; b) MCH Coordinators in local district offices round at local birth hospitals to identify patients who smoke and provide resource and referral; c) MCH Coordinators in local district offices share 802Quits outreach materials with partners.	
5. Digital promotion of 802Quits pregnancy protocol (incentive payments, increased access to NRT, uncapped counseling sessions)	
6. Work collaboratively with the Vermont chapter of ACOG to strengthen its membership and provide training and organizational support to ensure key public health messaging/ content is integrated into clinical services	
7. Work with the Title X family planning network to support and strengthen referrals to 802Quits, and promote messaging around the risks of smoking in pregnancy and cessation resources as part of their preconception health counselling and Reproductive Life Planning efforts	
ESMs	**Status**
ESM 14.1.1 - % of pregnant smokers who register with the QuitLine or QuitOnline	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Vermont) - Women/Maternal Health - Entry 2

Priority Need

Ensure optimal health prior to pregnancy

SPM

SPM 3 - Percent of Women advised by a healthcare worker to abstain from alcohol during pregnancy

Objectives

By the end of 2025, increase to 90% the percentage of women that advised by a healthcare worker to abstain from alcohol during pregnancy.

By late 2023, outreach to 100% of prenatal and pediatric providers regarding the risks of alcohol use during pregnancy (if COVID-19 allows).

Beginning in late 2022, annually outreach to 75% of pregnant women, and their circles of care, the risks of alcohol use during pregnancy (due to COVID-19, this work may not reach 75%, but we are keeping it as a goal).

Strategies

1. Implement new social marketing campaign (“One More Conversation”) to communicate risks of substance use during pregnancy, targeted to health care professionals, pregnant women, and circles of supports (partners, families, friends) that is informed by the data and a formative research report that was part of the first phase of this project.

2. Collaborate with the Vermont Blueprint for Health on the Women’s Health Initiative and reproductive health and family planning providers to support women’s health specialty practices to communicate risks of alcohol, smoking or vaping tobacco and cannabis use in pregnancy, and conduct IPV screening and contraceptive counseling.

3. Expand the use of One Key Question to promote pregnancy intention screening in primary care and targeted preconception and family planning counseling.

4. Identify and develop promotional and educational tools and materials on preconception health for the: a) VDH website; b) distribution to health care providers and community partners; and c) distribution to the general public.

5. Work collaboratively with WIC, nurse home visiting (Strong Families Vermont), and other home visiting programs and families to ensure preconception health planning and communicate risks of alcohol use and other substance use in pregnancy with clients.

Women/Maternal Health - Annual Report

Women/Maternal

Perinatal Quality

Vermont MCH works in close partnership with the Vermont Child Health Improvement Program to assess, monitor, and improve perinatal quality, which includes measures of prenatal care. In partnership with MCH and VCHIP, the Perinatal Quality Collaborative/OB initiatives works to:

- To strengthen and expand a network of obstetric providers and nurses at hospitals throughout Vermont and New Hampshire that serve Vermont births and collaborate to improve the quality of care provided to pregnant people and infants.
- To improve access, coordination, and quality of care, including prenatal, perinatal, and preconception care, provided to pregnant people and infants.
- To establish prenatal care standards and recommendations by standardizing quality assessment, benchmarking, and reporting.
- To identify potential recommendations for changes in policy and payment for obstetrical care of women.

Additional information regarding the perinatal quality collaborative is provided in the perinatal/infant narrative sections.

Maternal Depression

Vermont's MCH program was awarded a five-year HRSA cooperative agreement: Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program. Vermont's program, *Screening, Treatment and Access for Mother and Perinatal Partners* (STAMPP), aims to improve the mental health and wellbeing of pregnant and postpartum women and their families and children. Our objectives are to:

1. Assess resources, gaps and opportunities in our existing system of care
2. Increase the capacity of Vermont's health care providers to educate, screen, diagnose, prevent, and treat maternal depression and other related behavioral disorders
3. Increase the capacity of Vermont's mental health system to diagnose, and treat maternal depression and other related behavioral disorders, including the exploration and implementation of telemedicine and technology innovations
4. Increase the capacity of the human service workforce to screen and support women at-risk for maternal depression and other related behavioral disorders
5. Identify and support innovative financing options to support the screening, diagnosis, and treatment of maternal depression and other related behavioral disorders
6. Ensure access to comprehensive maternal depression and educational information and support and treatment options
7. Develop up-to-date, real-time referral resources at the community level; and
8. Conduct a comprehensive evaluation

STAMPP works collaboratively with the Department of Mental Health, Department of Vermont Health Access (Medicaid and Women's Health Initiative), Department for Children and Families, VCHIP, UVM Medical Center, Vermont's designated community mental health centers, Help Me Grow and MIECHV. Please see the Perinatal and Infant Health section for additional information.

Reproductive Health

Two years ago the preventive reproductive health program changed to adolescent and reproductive health as some staff

focus areas had shifted. The Director of Adolescent and Reproductive Health (formerly preventive reproductive health) works closely with the Title V Director to leverage reproductive health programming in a collaborative and administratively efficient manner and determine common goals and activities between Title V and funding sources related to reproductive health, such as the Family Planning Program and the Personal Responsibility and Education Program (PREP). This collaborative approach under MCH leadership supports outcomes such as those reflected in the national and state performance measures addressing women's preconception health, adolescent birth rates, interpregnancy spacing, intended pregnancy, and prenatal care access/utilization.

The Division of MCH has overseen Title X funded clinical services that are contracted from MCH to Planned Parenthood of Northern New England (PPNNE) and are offered at PPNNE sites statewide for more than four decades. In 2019, the Health Department made the decision to relinquish Title X funding due to the Final rule issued by HHS/OPA that would have prevented the health department and our longstanding subrecipient from providing the full range of family planning and reproductive health care services for Vermonters. In the absence of Title X funding the state replaced these funds as part of contingency planning for FY20 and FY21 to allow for the continuation of these essential services in the absence of federal funding.

VT recently applied and was awarded Title X funding for a 5-year funding period. We are in the process of reestablishing our Title X program. There have been several changes that have and will continue to impact our efforts, including the closure of 4 Vermont based Planned Parenthood health centers and one in New Hampshire that also serves Vermont patients, as well as the broader shifting landscape related to the Supreme Court overturning Roe v. Wade. We are assessing impacts and gaps and working closely with partners, such as the Women's Health Initiative, to make sure we are well coordinated, able to identify and respond to gaps in a timely manner, to ensure that comprehensive family planning services remain available. In our most recent Title X application we built in a new position to support several key areas of MCH work. We will hire a Program Specialist in the fall of 2022 who will support Title X work, as well as Title V, and some of our mental health and perinatal health efforts.

The context in Vermont is one that is highly supportive of ensuring continued access to the highest quality comprehensive reproductive health care services. The Agency of Human Services recognizes that universal access to quality, culturally sensitive healthcare, including reproductive health care, is essential for the health and wellbeing of Vermonters. Ensuring health and wellbeing of Vermonters is core to the Agency's mission. Vermont law codifies that it is a fundamental right that reproductive health care decisions remain between a person and their health care provider. While there is serious concern about the challenging national landscape, Vermont leaders are stepping up. Our Legislature and our Governor support access to important reproductive health care and are taking action to ensure care is safe and available here in Vermont. Governor Scott provided public notice on Proposition 5, an additional step in ensuring the right for reproductive care here in our state.

Proposal 5, a proposed amendment to the Vermont Constitution passed by the General Assembly, will appear on the November 2022 general election ballot. Section 72 of Chapter II of the Vermont Constitution and Chapter 32 of Title 17 of the Vermont Statutes Annotated require the Governor to give public notice of the proposed amendment by proclamation.

"Vermont has a long tradition of supporting a woman's right to choose. These decisions are deeply personal and belong between a woman and her health care provider, free from government interference," said Governor Scott. "In Vermont, we solidified the right to choose in law, and now Vermonters have the opportunity to further protect that right in our constitution. It is more important than ever to make sure the women in our state have the right to make their own decisions about their health, bodies, and their futures. In light of the recent decision by the Supreme Court of the United States, I thank members of the General Assembly and other advocates for their foresight and work to bring this question to the November ballot."

MCH also provides oversight for the Medicaid grant funding to PPNNE via ACA provisions allowing PPNNE to be reimbursed for clinical services to patients with incomes under 200% FPL. This program allows PPNNE to serve uninsured and underinsured low-income clients at the time of the appointment and use the clinic visit to enroll the client in Vermont's public health care insurance system. MCH is working with our partners in Medicaid eligibility to ensure that patients with incomes

under 200% FPL are covered in all health care settings. We are presently engaged with Medicaid in discussions related to our waiver to explore opportunities to integrate the family planning option more fully into our state Medicaid program in 2023.

The MCH reproductive health workgroup had several successes over the past several years, including addressing some of the recommendations outlined in our most recent three-year Title X Needs Assessment. This workgroup was essential in informing our strategies related to promoting women's and maternal health and to collaborating across the system to reduce redundancies and ensure coordination of services. It has also helped to enhance partnerships. Membership has included: primary care and family practices, Ob/Gyn, Title X (Planned Parenthood), FQHCs, MCH Coordinators from the Office of Local Health, an adolescent medicine specialist, Vermont's Child Health Improvement Program (VCHIP) and other state agencies addressing reproductive health (Medicaid, Agency of Education).

Some of the outcomes of the workgroup have included creating a contraceptive referral form (read more below); collaborating with Medicaid to improve rates of post-partum insertion of LARC by establishing an add-on payment, which was further advanced by Medicaid in the current reporting period to include an add on payment that covers the full cost of the device; and collaborating with the Blueprint for Health, Vermont's health reform initiative, on the Women's Health Initiative (WHI), to enhance psychosocial screening for women and to improve access to LARC in women's specialty practices (OB/Gyn and PPNNE). The Reproductive Health Workgroup was paused several years ago as many members also served on the Blueprint Women's Health Initiative's Steering Committee and wanted to avoid redundancy. This work continued to be paused during the COVID response as well. Now that VT has reentered the Title X program a reproductive health advisory will be reconvened in the fall of 2022.

The Vermont Department of Health has been a key partner throughout the process of planning the Women's Health Initiative, and Planned Parenthood, the Title X service provider, has been engaged in the initiative since its inception. Through the Women's Health Initiative, women's health specialty providers (including Title X), are providing enhanced health and psychosocial screening in clinical settings. New staff, training, and payments support effective follow-up to provider screenings through brief, in-office intervention and referral to services for mental health, substance use disorder, trauma, intimate partner violence, food and housing. The Women's Health Initiative helps ensure that women's health providers, Patient Centered Medical Homes, and community partners have the resources they need to help women be well, avoid unintended pregnancies, and build thriving families. The Women's Health Initiative supports practices in building enhanced screenings into regular health care visits. Women identified as at-risk in the areas of mental health, substance use disorder, intimate partner violence, or access to food and housing are immediately connected to an initiative-funded social worker for brief intervention and counseling and referral to more intensive treatment as needed. Each social worker is a member of the Community Health Team and available to connect women with the local network of health, social, economic and community service providers. Women also receive comprehensive family planning counseling and services. Those who tell their providers they do not want to have a baby in the coming year will have immediate and affordable access to a broad range of contraceptive options, including LARC. Women who wish to become pregnant receive preconception counseling and services. While some of these efforts were paused or stalled during COVID, there is a renewed commitment to working in an integrated, well-coordinated, collaborative way to ensure the highest quality reproductive health services for Vermonters.

The Director of Adolescent and Reproductive Health supervises the MCH Adolescent Health Program Manager (formerly the PREP Coordinator), as well as the MCH Injury Prevention Coordinator, which supports increased alignment of efforts across these interconnected areas of work. In addition, the Director now supervises a Public Health Nurse Administrator who oversees the state's EPSDT program, and a broad body of work related to children and adolescents in health care settings.

Adolescent Sexual Health:

PREP awards are granted to community organizations to educate young people on both abstinence and contraception to prevent pregnancy and STIs, and covers three adult preparation topics: healthy relationships, healthy life skills, and adolescent development. The program targets youth ages 10 to 19 who are homeless, in foster care, live in rural areas or in

geographic areas with high teen births, or come from racial or ethnic minority groups. The program also supports pregnant and parenting youth under 21. Making Proud Choices continues to be the primary curriculum used by PREP sites. More generally in VT, PREP programs use a combination of resources to teach a consent lesson and an LGBTQ+ Inclusivity lesson before they begin the PREP curriculum. Facilitators use the Vermont Network Against Domestic and Sexual Violence's recently revised Consent Campaign, ETR's Affirmative Consent and LGBTQ Inclusivity Handbooks, and other resources.

We had our first PREP site visit, which was virtual. This provided a rich opportunity for us to showcase several our implementing program sites, highlight our partnerships and receive TA. We are in the process of reassessing the structure of our program, consulting with other states about their models, and moving towards leveraging our partnership with VT Afterschool to serve as an umbrella organization for our PREP program. This approach would reduce some of the administrative tasks and enable the MCH Program Manager to engage in more training, TA, monitoring, and partnership building.

The PREP Program Manager/Adolescent Health Program Manager was fully deployed to our Health Operations Center as part of the COVID-19 response in late May of 2020. During this time, the Director of Adolescent and Reproductive Health covered many aspects of our MCH work, including PREP. The Adolescent Health Program Manager role as a health equity technical advisor was critical to our state's COVID-19 response, and in this role, she has managed a team of six. This experience has further enhanced future PREP activities. While PREP implementation has been very challenging due to COVID-19, some other work related to sexual health education in our state has been ongoing, with some important successes happening over the past several months.

For the fifth year we have a Title V funded contract with Dr. Erica Gibson, Adolescent Medicine Specialist at the University of Vermont Children's Hospital. Dr. Gibson has provided a wide variety of trainings to PREP staff over the past years and this work has expanded to include pediatricians, family practice physicians, afterschool staff, and school-based health educators. Trainings have been in person and via webinars on several different topics; Adolescents and LARC, Adolescents and STIs, and Adolescents and Emergency Contraception.

Dr. Gibson has also supported some new work related to eating disorders. Dr. Gibson is the medical director of an adolescent eating disorders clinic at UVMMC and played a key role in help to planning and lead a one-day training on multidisciplinary approaches to eating disorders. The MCH Director of Adolescent and Reproductive Health also served on this planning committee.

MCH continues to collaborate with the Agency of Education, and several community partners through the Sexual Health Education Stakeholders Group on workforce development activities related to improving sexual health education in schools and community-based settings, as well as to support the implementation of the Condom Availability Law and share resources, guidance, and sample templates for procedures that were created to support schools with the implementation of the law. Efforts have included offering a webinar through the Vermont School Nurses Association on the new law and collaborating with community partners to offer educational sessions to Vermont health educators through the VT Higher Education Collaborative on Essential Topics in Sexual Health Education. We also continue to collaborate with Elevatus to support attendance in their 3-day Sexuality Educator training for people who work with people with Intellectual and Development Disabilities. By the end of January 2022 over 50 people had been trained in the Elevatus curriculum through support from MCH.

Injury and Violence Prevention:

MCH oversees the CDC Rape Prevention and Education (RPE) grant, that supports the expansion of primary prevention efforts related to sexual violence within the statewide domestic and sexual violence coalition, with their member agencies, and community partners. Based on an extensive stakeholder engagement process in the previous year, a five-year state action plan and evaluation plan were developed. The five-year plan aims to prevent sexual violence (SV) perpetration and victimization by using a public health approach to decrease SV risk factors and increase SV protective factors; selecting, implementing and evaluating prevention strategies based on the best available evidence across multiple levels of the Social

Ecological Model (SEM), with an increasing emphasis on community-level strategies; and through partnerships and linkages that support using strategies to address shared risk and protective factors across multiple forms of violence. The plan also supports local level efforts in key focus areas:

1. Partnering with youth and support their leadership in implementing individual & relationship level programs and initiatives
2. Growing youth activism, leadership and voice, leveraging existing programs and resources.
3. Equipping adults to support and partner with youth to prevent sexual violence, utilizing the Youth Thrive and WholeSomeBodies frameworks
4. Implementing an Askable Adults social norms campaign to engage adults in sexual violence prevention

The focus populations outlined in the plan are: youth ages 12-18, with a focus on youth of color, LGBTQ youth, youth with disabilities and youth living in poverty, and adults engaged with youth.

Our long-time injury prevention coordinator retired in April 2021. This position was reclassified to a non-nurse and includes violence prevention. We hired a MCH Injury and Violence Prevention Program Manager in September 2021 who oversees all violence and injury relation topics including our RPE work. This has been a rich opportunity to further streamline and enhance coordination across our work in the realm of injury and violence prevention.

The Director of Adolescent and Reproductive Health, with support from Title V leadership and funding, works to increase services and systems for reproductive health and specifically for women who may be at risk of domestic and interpersonal violence. Over the years, Title V funding has enabled MCH to renew several long-planned ideas for key improvements in services and systems for women. MCH has chaired the Domestic Violence Advisory Group (DVAG) at VDH and participates on the Agency of Human Services' Domestic Violence Steering Committee, allowing for both cross-departmental and agency-wide approach to addressing domestic violence. This group heightens awareness of domestic and sexual violence by such activities as community education, coordination across state child and adult service systems, monitoring violence related data, updating state policies and procedures to address violence against women, and providing training and resources for state employees. There have been changes to these groups due to staff turnover across the Agency and due to COVID-19 and staff deployments. We will be working to identify the best next steps and optimal structure for the future of this work in the coming year.

The Director of Adolescent and Reproductive Health is also a member of Vermont's Domestic Violence Fatality Review Commission. The purpose of the Commission is to collect data and conduct in-depth reviews of domestic violence-related fatalities in Vermont with the goal of making policy recommendations to prevent future fatalities. The Commission's report includes data on children killed in a domestic-related-incident and refers these cases to Vermont's Child Fatality Review Team (Division of MCH ensures representation on Child Fatality Review Team, see Child Health Domain). MCH has worked closely with injury prevention surveillance staff over the past several years to provide support to the Chair for the DV Fatality Review Commission to make recommendations for changes to the structure and format of the annual report, as well as with data reporting, preparation of tables and graphs, etc., to make the findings and recommendations more meaningful and impactful. This work is ongoing.

Another critical advancement has been a newly created position within the Agency of Human Services, the Director of Trauma Prevention and Resilience Development, which sat within VT's health care reform initiative. Over the past year this position was transitioned into the Department of Mental Health. MCH leadership represent the health department on an agency-wide team that works closely with the new director to help set priorities and identify and plan activities related to workforce development needs across AHS related to trauma and resilience.

Substance Use in Pregnancy

To address Vermont's high rate of tobacco-use in pregnancy, nurse home visitors, parent educators, and WIC staff regularly

screen pregnant women for tobacco use and refer to the Quit Line resources and medical follow up. The IMR Collaborative Improvement and Innovation Network (CollN) supported a closer coordination and strategic direction of the prenatal tobacco use cessation activities between MCH and the Health Department Tobacco Control Team. Over the years, we have worked with the Tobacco Control Program to bring evidence-based training on prenatal tobacco use (SCRIPT) to health care providers. We have also developed a contingency management pilot study in Rutland County to provide cessation counseling and incentives (up to $1100) to pregnant women based on national research out of the University of Vermont, which launched in spring 2018 and is currently being evaluated.

Although Vermont has high rates of substance use in pregnancy, several efforts are underway to improve this. Vermont has engaged in several activities to support families with substance use disorder (SUD). A few examples include:

- Prior to COVID, Vermont MCH along with our partners in the Health Department completed a formative evaluation regarding substance use in pregnancy in Vermont to inform future messaging efforts with prenatal providers and families. These efforts resulted in the development of the "One More Conversation" campaign which was stalled due to COVID, but will be formally launched this fall. One More Conversation encourages prenatal providers and patients to continue to dialogue around substance use in non-stigmatizing and supportive conversations.
- Vermont's HRSA funded initiative described above: Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program aims to increase screening rates for maternal depression, anxiety and substance use and test innovative referral and treatment strategies.
- Vermont is participated in ASTHO's Opioid Use, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative (OMNI) Learning Community and is currently developing an action plan to address postnatal support for families with SUD, including more streamlined referral into services such as evidence-based home visiting and early intervention.
- Vermont is one of several states to implement DULCE (Developmental Understanding and Legal Collaboration for Everyone). Project DULCE is a national demonstration project in pediatric practices, sponsored by the Center for the Study of Social Policy in Washington D.C. DULCE is an innovative intervention through which pediatric primary care clinical sites proactively address social determinants of health, including SUD, to promote the healthy development of infants from birth to six months of age and provide support to their parents. A key feature of the DULCE intervention is a Family Specialist, who is a member of the pediatric team, and connects families to resources based on parents' needs and priorities. DULCE employs the Medical-Legal Partnership model to provide families more intensive assistance obtaining concrete supports, when needed. The DULCE intervention incorporates a Strengthening Families Protective Factors approach and provides optional home visits.
- The Improving Care for Opioid-exposed Newborns (ICON) project at VCHIP partners with the Vermont Department of Health and the University of Vermont Children's Hospital to improve health outcomes for opioid-exposed newborns. Improved health outcomes are achieved by provision of educational sessions on up-to-date recommendations and guidelines to health care professionals who provide care for opioid-dependent pregnant women and their infants.
- Hub and Spoke is Vermont's system of Medication Assisted Treatment, supporting people in recovery from opioid use disorder. Nine Regional Hubs offer daily support for patients with complex addictions. At over 75 local Spokes, doctors, nurses, and counselors offer ongoing opioid use disorder treatment fully integrated with general healthcare and wellness services. This framework efficiently deploys opioid use disorder expertise and helps expand access to opioid use disorder treatment for Vermonters. Pregnant individuals are a priority population in Vermont's system.
- Vermont's CHARM (Children and Recovering Mothers) Team, led by KidSafe Collaborative, is cited as a case model for collaboration in working with pregnant women with an opioid abuse history in this new SAMHSA publication. KidSafe convenes this team in partnership with UVM Medical Center, UVM Children's Hospital, Howard Center, LUND, VT Department of Health, VT Department for Children and Families/Family Services Division, and others.

Partnerships

Vermont's tobacco control programming sits within the Division of Health Promotion and Disease Prevention. We work closely on tobacco-use in pregnancy strategies. Likewise, we work closely with our Office of Local Health and the regional MCH Coordinators.

For more than 10 years, a monthly Primary Care and Public Health Integration meeting convenes the leadership of MCH, VCHIP, VT AAP, VT AAFP, Planned Parenthood, ObGyn physicians, and primary care internal medicine providers, to coordinate various projects that cross borders. This group is and will continue to be a strong partner in advancing women's and maternal health in Vermont.

The American Congress of Obstetricians and Gynecologists (ACOG) can be an exceptional partner in moving these strategies forward. In the past, Vermont's Chapter of ACOG was not well coordinated or integrated with public health. In recent years (pre-COVID) years we have worked closely with ACOG members to assess their needs to strengthen the state ACOG chapter. As a result, a quarterly webinar series was developed to support members connecting with each other and with public health colleagues across both clinical and public health topics. Topics included presentations on screening and referral for domestic violence, an update on the Blueprint for Health's Women's Health Initiative and how to get involved, smoking and alcohol use during pregnancy, maternal depression, among other important public health topics. These were placed on hold during COVID and are currently being reevaluated.

As described throughout this report, a key partner across all population domains is the Vermont Child Health Improvement Program (VCHIP). VCHIP is a population-based child and adolescent health services research and quality improvement program of the UVM.

Title V works collaboratively with WIC and Vermont's MIECHV program staff and families to ensure that preconception health planning and pregnancy spacing counseling is incorporated in client visits. Likewise, we plan to work closely with leadership of Vermont's other home visiting programs to disseminate this messaging.

Women/Maternal Health - Application Year

Women/Maternal:

MCH leadership continues to serve on several statewide steering groups, including the Blueprint Women's Health Initiative that helps ensure that women's health care providers, Patient Centered Medical Homes, and community partners have the resources they need to help women be well, avoid unintended pregnancies, and build thriving families. The initiative focuses on several key domains, including, best practice approaches to contraceptive counselling, substance use and mental health screening, brief intervention and referral, interpersonal violence screening and referral, and food insecurity. The coordination and collaboration with the Women's Health Initiative will continue to be critical as we have also recently reentered the Title X program after leaving in 2019 due to the broader challenging landscape around the Title X program.

We would like to revisit a project that was paused due to the COVID response whereby we will work with the PRAMS Coordinator and the YRBS Coordinator to develop data briefs that show the increased rates of pregnancy intendedness in our state, a declining adolescent pregnancy rate, and increased use of the most effective forms of birth control across the adolescent and adult populations. We will highlight some of the key initiatives and efforts related to improving access to the full range of contraceptives, with a focus on the most effective methods. This baseline understanding will be especially important to examine considering the impact of COVID-19 on family planning services in Vermont. It will also be important considering the recent Supreme Court decision overturning Roe v. Wade.

MCH has reconvened the Maternal Mortality Review Team and will be revising our legislation to allow for a more robust review process. Additionally, through our partnership with VCHIP, we will:

- Facilitate the receipt and submission of data from each hospital in the state for Alliance for Innovations in Maternal Health (AIM) related to the implementation of the Postpartum Hemorrhage Safety Bundle on the implementation (process and structural measures) and outcomes
- Explore statewide severe maternal morbidity rates and benchmark that information against nationwide data using race-stratified data, as well as explore obstetric interventions and outcomes at the University of Vermont Medical Center based on race, ethnicity, and country of origin
- Provide four educational webinars for OB providers on clinical practice updates and quality improvement
- Pursue enrollment feasibility of the Centering Pregnancy model of care for New American families

While paused during the COVID response, MCH plans to continue to work in collaboration with the Women's Health Initiative to work with stakeholders to promote the integration of One Key Question into clinical practice, home visiting, and other community settings. MCH has communicated with Power to Decide to explore their TA and training opportunities related to One Key Question and to get direction on how to align with the national effort, obtain materials, and identify TA options for the year ahead. Power to Decide has expanded their training and TA to include working more intentionally with home visiting programs, an area that we will continue to explore in the year ahead. Due to COVID-19 this work has been paused. We will revisit this approach in the fall and winter 2022-2023 to determine the best next steps.

Vermont's high rates of substance use in pregnancy—including use of alcohol, tobacco, cannabis and other substances — compared to other states have forced us to look more deeply at our messaging and strategies to support prenatal providers, pregnant women, and their circles of support. Our prior 0-4-9 (zero alcohol for nine months of pregnancy) campaign demonstrated no change on health care provider's advice to pregnant women on this topic, as evidenced in PRAMS data. In addition, rates of cannabis use have increased and are expected to increase as Vermont's legalization expands.

The MCH program and communications staff continue to work jointly with the divisions of alcohol and drug abuse programs, recently renamed the division of substance use prevention, and the tobacco control program (part of the health promotion and disease prevention division) to help perinatal care providers in Vermont educate and support their patients to lower the rates of substance use in pregnancy. We have contracted with Small Mammal Advertising to focus on helping health care professionals effectively talk to patients about substance use; and share the clear message that: "there is no safe amount."

With guidance from clinicians developed a campaign that encourages providers and patients to talk about substance use in pregnancy. The idea is to promote “One More Conversation,” since we know that this topic is discussed infrequently during pregnancy. These regular conversations will give clinicians more opportunities to discuss the importance of avoiding substances during pregnancy and will invite patients to talk about their behaviors.

MCH staff and the Vermont’s Tobacco Control Team are having ongoing conversations regarding how to further advance our performance measures around reducing smoking during pregnancy. The following are currently planned, Vermont Title V has the following planned for the coming year.

- Incorporation of this planning into Vermont’s new perinatal collaborative.
- Regional MCH Coordinators will work with local WIC offices to ensure all clients have access to smoking cessation resources/referrals (802Quits). Strategies include:
    - Distribution of educational and promotional materials for all WIC clients
    - Regular chart audits of WIC clients to assure appropriate referral and follow-up
- Digital promotion of 802Quits pregnancy protocol (e.g. incentive payments, increased access to NRT, uncapped counseling sessions)
- Training and supports for home visitors on this topic and referral resources.
- MCH staff will work with the Tobacco Control Team to support outreach/promotion of 802Quits with the medical/social service community, through the following:
    - Regional MCH coalitions promote messaging around the risks of smoking during pregnancy and cessation resources
    - Regional MCH Coordinators share 802Quits outreach materials with partners

MCH continues to provide leadership for the HRSA-funded *Screening, Treatment and Access for Mother and Perinatal Partners* (STAMPP) program. We will work over the next year to integrate our MCH work aimed at screening for maternal depression and related behavioral disorders, and connection to resources, and begin full implementation of the program.

We will continue our systemic work to prevent domestic and sexual violence prevention in partnership with home visitors, MCH Coordinators, and other agency and community partners. Efforts include:

- Plan for additional training on Connected Parents, Connected Kids evidence-based training from Futures without Violence on domestic violence and home visiting. Additional work is needed to ensure that home visitors receive ongoing support and that all new home visitors can build this competency on an ongoing basis
- Regional MCH Coordinators participate in local domestic sexual violence community response and/or prevention teams. In the plan year we will assess how this work is progressing and document what the current priorities include
- MCH leadership participates on the statewide Domestic Violence Fatality Review Team, the Sexual Assault Nurse Examiners Board (SANE), the Vermont Anti- Human Trafficking partners meeting, and has chaired a department level Domestic Violence Advisory Group, which is part of an AHS-wide Domestic Violence Steering Committee. The latter two groups have been paused due to AHS staff turnover and the COVID response. We will assess this work in the coming year to determine the best direction forward
- We will explore participation on the Vermont Council on Domestic Violence and the Domestic Violence Accountability Committee
- Continue to advocate for domestic and sexual violence surveillance through incorporation of questions into BRFSS and other statewide surveys

Vermont has worked this year to eliminate siloes and coordinate efforts of organizations focused on building resiliency among the citizens and within communities of Vermont. The State of Vermont is fortunate in that the New England Public Health Training Center (NEPHTC) helped launch the Vermont Resilience Messaging Project (VRMP) and continues to sustain this cross-cutting public education campaign to build a more equitable and resilient Vermont for all.

The VRMP has created a set of messages and common language to unite the many efforts to foster resilience and build flourishing communities across the state of Vermont. The VRMP vision supports an integrated statewide system where all Vermonters can find and fully utilize the resources they need to thrive, individually and collectively, in the face of adversity. The VRMP will:

- Promote community norms around a shared responsibility for the health and well-being of all children
- Reduce stigma around help-seeking
- Enhance connectedness to build resiliency in the face of adversity

VRMP collaboration and coordination across partner agencies and organizations supports widespread integration of resilience messaging for all Vermont audiences and allows this messaging to be informed by parents, caregivers, and providers of all types. VRMP strategic partners include: The Agency of Human Services, the Vermont Department of Health, the Vermont Department of Corrections, the Department of Mental Health, the Director of Trauma Prevention and Resilience Promotion, Help Me Grow, Building Flourishing Communities, Vermont Afterschool, and the Vermont Public Health Association. VRMP efforts to promote family and community resilience support Vermont's pandemic recovery efforts and our Governor's Vermont Forward Plan.

The VRMP achieves collective goals through community-specific actions. Examples of community-specific actions this year include addressing social determinants of health, reducing toxic stress, expanding afterschool programming to priority populations, supporting families to be able to use positive parenting practices with their children, and maintaining a statewide resource directory with real-time information on resources, supports, and treatment providers that address trauma, maternal depression, perinatal mood and anxiety disorders (PMADs), and related substance abuse disorders for children and families. Additional VRMP activities and work products this year include:

- Creation of a resilience messaging toolkit for diverse audiences
- Increased utilization of approved messaging across public and private partners
- Increased number of stakeholders serving as ambassadors for integrated messaging with their peers and other organizations
- Newsletters, outreach, and promotional activities
- Trainings and ongoing TA for stakeholder organizations

We have a host of strategies planned for the coming year that we anticipate will have significant positive impact on improving dental rates for pregnant people:

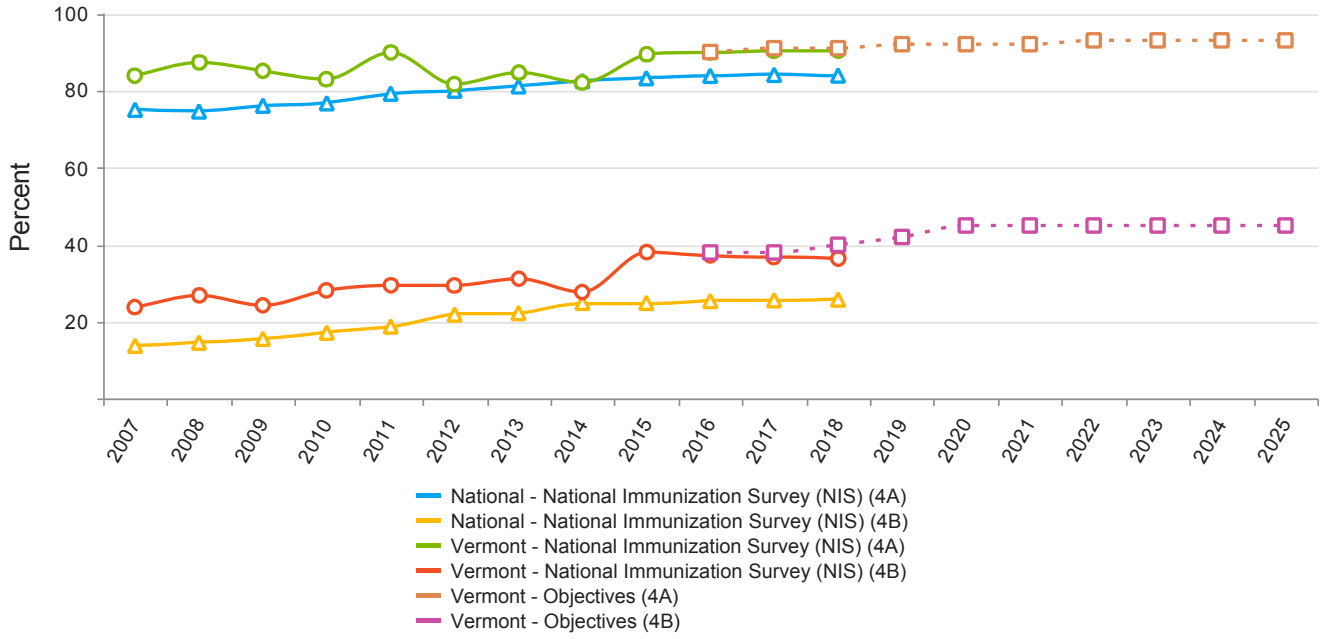
- Vermont MCH supports a portion of the salary of the Oral Health Director in the Health Department's chronic disease division; this funding supports programmatic planning as it relates to the MCH population
- Regional MCH Coordinators in district offices work in tandem with co-located public health dental hygienists to assess the local dental health landscape and share resource availability with health care providers and community partners
- Public health dental hygienists (PHDH) provide oral health risk assessment, screening, education and information to families enrolled in WIC
- MCH Coordinators and PHDHs in district offices provide outreach to Ob/Gyns and dentists regarding: a) the expanded Medicaid benefit for pregnant and postpartum (up to 60 days) women (removal of cap); b) *Bright Futures* guidelines; and c) support to see children beginning at age one
- MCH leadership serves on the statewide oral health coalition
- Home visitors work with clients to do oral health screening and referrals to dental homes
- Regional MCH coalitions promote oral health messaging

Please note: Only those strategies that link with national and state performance measures are identified in the Action Plan Table for this section.

Perinatal/Infant Health

National Performance Measures

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months
Indicators and Annual Objectives



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	91	91	92	92	92
Annual Indicator	81.9	89.3	89.9	90.2	90.4
Numerator	4,748	4,773	4,919	4,650	4,936
Denominator	5,797	5,345	5,471	5,154	5,461
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	93.0	93.0	93.0	93.0

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	38	40	42	45	45
Annual Indicator	27.7	38.0	37.2	36.8	36.5
Numerator	1,560	1,976	1,946	1,811	1,921
Denominator	5,637	5,195	5,227	4,926	5,257
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	45.0	45.0	45.0	45.0

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - % of 10 Step compliant or designated Baby-friendly hospitals

Measure Status:					Active
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	16.7	25	33.3	33.3	41.7
Annual Indicator	16.7	16.7	18.2	18.2	18.2
Numerator	2	2	2	2	2
Denominator	12	12	11	11	11
Data Source	Program-level data	Program-level data	Program-level data	Program-level data	Program Data
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	50.0	50.0	50.0	50.0

State Action Plan Table

State Action Plan Table (Vermont) - Perinatal/Infant Health - Entry 1
Priority Need
Promote optimal infant health and development
NPM
NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months
Objectives
By 2024, increase the number of designated “Breastfeeding Friendly Employers” by 10%
By 2024, increase the percentage of WIC recipients who utilize a peer counselor by 10%
By the end of 2023, develop local level breastfeeding implementation plans informed by state-level strategic plan
By 2024, implement 50% of strategic priorities identified in breastfeeding strategic planning process.
Strategies
1. Continue to convene and improve Vermont’s Perinatal Quality Collaborative (PQC-VT), including new QI project on birth certificate quality
2. Implement Vermont’s Breastfeeding Strategic Plan and local action plans, developed pre-COVID
3. Promote “Baby Friendly” hospital initiative and Vermont 10-Steps approach to improve maternity care practices in support of breastfeeding
4. Provide electric breast pumps to eligible WIC participants who are separated from their baby or working to increase milk production and not receiving Medicaid pump.
5. Coordinate training opportunities with the Vermont Lactation Consultants Association (VLCA), Home Health Agencies, Parent-Child Centers, Children's Integrated Services, Strong Families Vermont (home visiting), Help Me Grow, Head Start, EFNEP, AAP VT Chapter, medical care providers, and non-traditional partners (such as Recovery Coaches and informal peer networks).
6. Maintain the statewide breastfeeding peer counseling program. Maintain bi-lingual peer counselors who speak languages that are currently dominant in our communities.
7. Continue to promote awareness of Vermont breastfeeding laws and the breastfeeding provisions of the Affordable Care Act.
8. Conduct public health “detail visits” to OB, Pediatric, and Family Practice provider offices to strengthen the collaboration between WIC and health care providers with the goal of increasing rates of exclusive breastfeeding.
9. Promote and support community-clinical linkages to increase professional and peer support and care coordination.
10. Offer breastfeeding education to early childhood educators through professional development training opportunities and embed breastfeeding education and support in VT’s Quality Improvement and Rating System (QRIS).

ESMs	Status
ESM 4.1 - % of 10 Step compliant or designated Baby-friendly hospitals	Active

NOMs
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Report: Perinatal Infant

WIC and Breastfeeding

WIC (the Special Supplemental Nutrition Program for Women, Infants, and Children), which is administered under the Title V MCH Director, provides individualized nutrition counseling, breastfeeding promotion and support, health screening and referral, and specific nutrient dense foods to income and nutrition risk eligible pregnant, postpartum and breastfeeding women and infants and children who are under age 5. WIC families use a “WIC branded” EBT card to purchase their prescribed WIC foods at authorized retail grocers. WIC integrates or coordinates with other programs such as EPSDT, Lead Poisoning Prevention, Immunizations, Children’s Integrated Services, nurse home visiting, family planning and birth defects prevention. WIC manages a comprehensive and innovative breastfeeding education and support program in all districts and consistently has the highest WIC breastfeeding rates in the northeast region. Vermont WIC has been a strong presence in promoting child health, addressing maternal and childhood overweight and obesity, and increasing breastfeeding. WIC will continue to play a key role in Title V activities to increase breastfeeding rates as described below.

Breastfeeding peer counseling has been shown to increase breastfeeding initiation, duration, and exclusivity. The Vermont WIC program provides peer counseling services to women in all 12 local health offices: completing program expansion statewide in early 2022 with the support of additional funding from USDA.

Vermont Medicaid added coverage for in-home lactation management services provided by licensed professionals with IBCLC credentials beginning June 2018. This has increased access for in-home lactation consults for Vermonters with Medicaid insurance, primarily in Chittenden, Addison, and Lamoille counties. One of the Chittenden County providers will travel 2 hours for home visits, extending the coverage into surrounding counties. During COVID, providers shifted to virtual support as needed. Vermont has a large number of IBCLC-credentialed individuals, but many are not working in professions licensed by the State and therefore are not eligible to become Medicaid providers. Families in areas without access to a home visiting IBCLC Medicaid provider may receive home visits through the Strong Families Vermont nurse home-visiting program or receive in-office lactation consults through their pediatric office or hospital out-patient lactation clinic.

The latest National Immunization Survey breastfeeding data (for children born in 2017) shows that overall, Vermont has not met either of the HP 2030 goals for exclusive breastfeeding. The MICH-15 goal is for 42.4% of infants to be exclusively breastfeeding at 6 months, and the MICH-16 goal is to increase the proportion of infants who are breastfed at 1 year to 54.1%.

The CDC Breastfeeding Report Card for 2020 shows that Vermont scored 82 compared to the National average of 79 on CDC’s national survey of Maternity Practices in Infant Nutrition and Care (mPINC) based on responses from the 2018 survey. The survey assesses maternity care practices and provides feedback to encourage hospitals to make improvements that better support breastfeeding. In 2018, 8 of 12 eligible hospitals in Vermont participated (67%). NOTE: The mPINC survey was redesigned in 2018. Results from the 2018 mPINC survey cannot be compared with results from previous mPINC surveys.

Fifteen percent of pregnant WIC participants received peer counseling services in 2019, down from the 25% who received services in 2018.

In order to enhance Vermont’s rates of breastfeeding initiation and duration, Vermont MCH developed, shared and began to promote a new Vermont Breastfeeding Strategic Plan broadly across the state and support local coalitions and communities to select the priorities for action. In May 2019, Vermont convened a stakeholder meeting to begin the process of identifying and selecting statewide strategies to increase the rates of breastfeeding initiation, exclusivity, and duration. Participants

included lactation consultants, home health, Children's Integrated Services, Building Bright Futures regional staff (early childhood coalitions), local health department nurses, and other key players. These recommendations were culled and then prioritized based on measures such as: impact, economic and social cost, and feasibility for implementation/change. The final strategic plan was published and promoted in early fall 2019. The plan is organized around the CDC best practices:

Strategy 1	Maternity Care Practices
Strategy 2	Professional Education
Strategy 3	Access to Professional Support
Strategy 4	Peer Support Programs
Strategy 5	Support for Breastfeeding in the Workplace
Strategy 6	Support for Breastfeeding in Early Care and Education
Strategy 7	Access to Breastfeeding Education and Information
Strategy 8	Social Marketing
Strategy 9	Addressing the Marketing of Infant Formula

MCH nurses at the local district health offices were due to convene with local-level leaders to identify and implement strategies in their health care and community settings in April 2020. This work has been put on hold due the public health response to COVID-19. Additionally, a formative assessment, conducted by the Vermont Child Health Improvement Program (VCHIP) was conducted. Results will help inform next steps to address: Maternity care practices, lactation education and training, and postpartum support. The assessment results were received in February 2020. Work to refresh the strategies and activities is planned for fall 2022.

DULCE and Touchpoints

Through braided funding from the Department of Health, including the CDC Overdose to Action grant and Title V funding, One Care, the Center for the Study of Social Policy, the American Rescue Act, and one region's Parent Child Center, Vermont implements the DULCE (Developmental Understanding and Legal Collaboration for Everyone) model in six pediatric offices in Vermont (one new site in 2022). DULCE places a Family Specialist employed by the area's Parent Child Center in the pediatric office to meet with all families with a baby 0-6 months of age. The Family Specialist provides screening, connection to services and supports, anticipatory guidance on milestones, and partners with families to meet their needs. This universal program for all babies is accepted by most families in the practice.

DULCE practices worked with the national team to roll out a new data system for the approach. Sites implemented substance use screening at their practices and received technical assistance in screening workflows and referral pathways. All six sites participated in CQI with VCHIP including monthly meetings to review data and implement PDSA cycles. The DULCE statewide contracted coordinator retired in mid-2022, and MCH facilitated the transition to program management at the division. MCH is in discussion with the Department of Health Access regarding Medicaid support of DULCE and with private insurers to explore additional models of financial support. Vermont applied for the Transforming Pediatrics in Early Childhood notice of award. If selected, Vermont will build, centralize, and streamline DULCE infrastructure and roll out the approach to three additional sites in Vermont with a focus on communities with the highest Medicaid populations and/or higher proportions of Vermonters with racial and ethnic diversity to address health equity.

After years of efforts to spread the Touchpoints approach across sectors who work with children and families, Vermont became an official Brazelton Touchpoints site in late 2021. The Touchpoints strengths-based Parent Assumptions and Guiding Principles inform the DULCE model and are used during 2- and 4-month well-child pediatric visits. The Touchpoint approach is a way of providing care to families (from pregnancy to early childhood) by understanding development and supporting relationships. It is our assumption that when parents work with supportive professionals, they become more confident in their parenting and form strong, resilient attachments with their children, laying the foundation for children's early learning and healthy development.

With one-time funding from OneCare Vermont (ACO) to cover training costs, the TP site was established at VCHIP to leverage the infrastructure and existing relationships with VDH, MCH, and our network of statewide pediatric providers to create a sustainable site. VCHIP convened a diverse TP strategic planning group implementation team, which has been meeting monthly since April 2021. MCH leaders and staff participate in TP strategic planning and obligate human and financial resources to the TP site. Our MCH Help Me Grow Coordinator is one of four new Touchpoints trainers to join the cohort of existing trainers to ensure broad representation. Our MCH Early Childhood Director was trained as part of the first cohort in Vermont's most rural region, the Northeast Kingdom that included 21 participants representing sectors such as: medical (prenatal and pediatric), early care and education (Northeast Kingdom Community Action, Parent Child Centers, Head Start/Early Head Start), Children's Integrated Services (home visiting, early intervention), and WIC.

Perinatal Quality Collaborative

PQC-VT is a relatively new collaborative structure. Although Vermont has a long and successful history of implementing quality projects in obstetrical, neonatal, and pediatric care through partnership between the Vermont Department of Health (VDH) MCH Division and VCHIP, the PQC-VT is a relatively new structure. Vermont has made significant improvements in the care of pregnant Vermonters, newborns and infants through initiatives like the OB-Outreach, Alliance for Innovation on Maternal Health (AIM), Vermont Regional Perinatal Health Project, and Improving Care for Opioid-Exposed Newborns. However, Vermont lacks a collaborative structure able to knit together systems (health care and community services) across the perinatal period and into early childhood.

In October of 2020, all VCHIP's pregnancy, newborn and infant initiatives were unified under the PQC-VT in partnership with MCH. The mission of the PQC-VT is to optimize care and health outcomes in pregnancy and infancy through collaboration and continuous QI. The PQC-VT improves care and health outcomes of Vermont's pregnant people, newborns and their families by:

- Setting Perinatal Outcome Priorities: Actively engage perinatal health care professionals, MCH public health experts and community-based partners in developing a common agenda by highlighting current successes and gaps in perinatal care and identifying focusses for pregnancy and infant health outcomes.
- Providing Outreach and Education: Build relationships across sectors including hospitals, outpatient practices, community-based organizations, state health programs, and families to address perinatal issues, and provide opportunities for collaborative learning on best practices.
- Advancing QI Efforts: Mobilize perinatal health care teams in continuous QI efforts for improved health outcomes, and disseminate successful system approaches. Develop quality metrics appropriate for perinatal health care.
- Monitoring Health Care Outcomes: Analyze perinatal and public health datasets to gauge QI work and opportunity, evaluate program implementation, and perform health outcomes surveillance.

The PQC-VT, has organized and unified VCHIP's pregnancy, newborn and infant initiatives to coordinate QI efforts, education and outreach activities, and perinatal priorities. Through these initial efforts, it is clear the PQC-VT needs outreach coordination, additional data analytics support, and community birthing hospital expertise in perinatal QI; Vermont plans to cement the PQC-VT organization and move it from concept to action.

Through a grant agreement to VCHIP and under the PQC structure, faculty research and disseminate evidence-based guidelines and current best practice recommendations in perinatal care. For instance, Vermont implemented Alliance for Innovation on Maternal Health's (AIM) Postpartum Hemorrhage Safety Bundle with the 11 birthing hospitals. Hospitals maintain ongoing awareness of the learning and training needs of clinical providers of perinatal care and respond via an evidenced based approach to disseminate current practice guidelines. Furthermore, Maternal Fetal Medicine and Neonatal Medical faculty at UVM Medical Center conduct six Perinatal Transport Conferences via telemedicine for perinatal health care providers at Vermont hospitals. These conferences employ an evidence-based approach using published guidelines/protocols, public health priorities, and current best practice reflecting national research and clinical experience in

VT.

Vermont's Maternal Mortality Review Panel (MMRP) was established by legislation in May 2011 to conduct a comprehensive, multidisciplinary review of maternal deaths in Vermont for the purposes of identifying factors associated with the deaths and making recommendations for systems changes. Vermont legislation requires an annual report from VDH and DVHA on high-risk pregnancy -- existing programs, scope of services including case management and people as identified as high-risk. A new chair and clinical abstractor have been put in place and the MMRP has resumed meeting quarterly to review the backlog of cases from the Covid-19 hiatus. The renewed MMRP work has been informed by national and state focuses on health equity and the recommendations put forth by this panel will inform aspects of upcoming enhanced PQC work.

Comprehensive Obstetrical Services Program, administered by OB/GYN, University of Vermont Medical Center, 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, contraception counseling, and referrals to Help Me Grow for service coordination and connection to intensive services for women living with substance use disorder.

Help Me Grow, Support Delivered, Home Visiting, and Early Childhood Comprehensive Systems

To increase use of our Help Me Grow (HMG) centralized information and referral hub, we have strategically aligned Title V and MIECHV efforts with two HRSA grants: Early Childhood Comprehensive Systems (ECCS), known as the Vermont Integration Project Prenatal- to-Three (VIP-3) and our maternal depression grant, known in Vermont as Screening, Treatment, and Access for Mothers and Perinatal Partners (STAMPP) program. We are re-visioning our HelpMeGrowVT.org website with a STAMPP program new brand and communications campaign highlighting the importance of perinatal mental health. Support Delivered is designed to raise awareness around the prevalence of perinatal mood and anxiety disorders (PMADs) and bridge connections between expecting and new parents and statewide perinatal mental health resources. The array of resources includes mental health clinicians with training and/or specialized expertise in perinatal mental health, virtual clinical support groups, parenting support groups, information on wellness and stress reduction, and other offerings (both in-person and virtual). HMG has been maintaining a real-time database with information on mental health services, supports, and clinicians with specialized PMAD evidence-based training. Materials have been disseminated to medical providers, mental health providers, and community organizations serving the perinatal population and include HMG postcards. The social media and digital campaign and print materials will link to HelpMeGrowVT.org and drive both providers and families to refer to and connect with HMG.

Through our VCHIP implementation arm of MCH for health improvement projects and initiatives, VCHIP has developed an internal early childhood team across multiple QI projects to coordinate a QI initiative on addressing referrals to the HMG resource hub and our MIECHV Strong Families Vermont Nurse Home Visiting services amongst perinatal and pediatric providers. VCHIP analyzed data from multiple surveys and sources to better understand awareness of HMG and other community-based resources among medical providers. Information on Support Delivered and referring to HMG for connection to PMAD services was presented to Blueprint for Health facilitators, the Women's Health Initiative, and Community Health Teams. The HMG resource hub saw an increase in referrals from health care providers because of these promotion efforts.

Vermont Title V is the recipient of the federal MIECHV funding. Close to completing four years of implementation of the Maternal Early Childhood Sustained Home Visiting (MECSH) model, we have worked hard to ensure a comprehensive statewide and local early childhood home visiting system. Evidence-based home visiting has been fully integrated into Children's Integrated Services (CIS) as one of five core, specialized services. This integration ensures that participants are directed to the most appropriate service.

There are many positive aspects of the VDH MIECHV program over this reporting period. Highlights include: 1) achieving our

continuous quality improvement (CQI) aim to increase the percentage of completed depression referrals by 19%. We surpassed this goal, increasing the overall percentage from 54% to 96.9%; 2)all MESCH home visiting nurses completed a 14-hour training with Master Trainers on the Promoting First Relationships (PFR) curriculum; 3) partnering with MECSH USA consultants to convene a virtual five-day MECSH Foundations Training for four new nurse home visitors and one new nurse supervisor; 4) use of the MECSH data management system to track program progress, outcomes, and ensure continuous quality improvement (CQI) across project goals and objectives; 5) working to reduce health disparities and eliminate structural barriers by securing additional American Rescue Plan Act funding to support the business costs of translating materials into 15 different languages. Furthermore, during MIECHV's most recently completed Demonstration of Improvement performance measure period, Vermont demonstrated that our MESCH program results in improvements for eligible families participating in at least four out of the six benchmark areas specified. We improved our rates in all four completed referral benchmarks over this last year.

Another achievement to be noted was the MIECHV program's efforts to address maternal depression during this past reporting period. The Vermont Department of Health (VDH) and Department of Mental Health are partnering on *Screening, Treatment, & Access for Mothers & Perinatal Partners grant* (STAMPP), a five-year cooperative agreement funded by HRSA to help expand perinatal mental health services in Vermont. One of the objectives of the STAMPP grant is to increase capacity of mental health providers to serve the perinatal population. We provided advanced level training to Nurse Home Visitors in perinatal mood and anxiety disorders, substance abuse related disorders, trauma, and other mental health conditions affecting pregnant women and new moms. The MECSH team was informed about the launch of the Support Delivered campaign and resources. As part of our CQI work over the past two years, MECSH nurses have been encouraged to utilize HMG to obtain information about mental health clinicians with training and/or specialized expertise in perinatal mental health or refer to HMG for care coordination to get clients linked to services.

Our MCH home visiting team has been working in partnership with the Division of Vermont Health Access (DVHA) and the Governor's Director of Health Care Reform to use Global Commitment Medicaid Dollars to expand evidence-based home visiting programs statewide. Home visiting is a key priority of the Governor and VDH, as outlined in the State Health Improvement Plan. A new VDH position was created to support state-wide implementation of the PAT program. Appropriation of funding and staffing to support the expansion of evidence-based home visiting resulted in an extensive amount of work to expand MECSH and Parents as Teachers (PAT) program, an evidence-based family support home visiting model under the CIS Strong Families Vermont Home Visiting continuum.

Our statewide Ages and Stages Questionnaires (ASQ) Online Enterprise system is hosted by HMG for all Vermont providers and families. An example of a system/policy change has been the required use of HMG's ASQ online system by MIECHV Strong Families Vermont Home Visiting sites. All six MIECHV program sites are now trained and using this system. As Vermont rolls out evidence-based Parents As Teachers model, our family support home visitors will also be trained to use the ASQ online system.

Injury Prevention

Title V MCH injury Prevention continues its existing Infant Safe Sleep programming. Vermont has had elements of an infant safe sleep prevention program but never a fully developed system that was based on research utilizing comprehensive messaging. Beginning in 2017, Vermont contracted with JSI, Inc. to conduct formative research and develop a system for comprehensive messaging based on the findings. In order to obtain a Vermont specific perspective, interviews were conducted with Vermont parents and health care providers. Key findings have been applied to several products, such as slide presentations to be used with professionals and parents, updated Health Department website and Facebook, a video on how to create a safe crib environment, and a training for hospital nursing staff. The MCH Coordinator in Vermont's most populous county: Chittenden County has been working very closely with the New American communities to support the integration of these messages. In 2019, Vermont MCH began work with VCHIP to establish a QI project with Birthing Unit staff statewide, creating nurse trainings and process for crib audits. This work is ongoing, although the MCH Coordinators in the VDH District Offices were deployed to the COVID 19 response and unable to engage in education and outreach for

much of the period beginning March 2020. Due to Vermont's decreased COVID 19 case count, many MCHC's will be able to revive their local outreach to hospitals, providers, and families in fall and winter 2021-2022.

Newborn Screening and Early Hearing

Vermont has a robust Newborn Screening Program (NBS), with exceptional outcomes. Since 2019, Vermont has been screening for all 35 core conditions on the Recommended Uniform Screening Panel (RUSP). The NBS program works closely with hospitals, health care providers, and parents in the implementation of the program and assures that the program operates according to current standards of practice. The Vermont Newborn Screening Program is made up of a small but dedicated team of staff and clinicians who work to ensure that newborns are screened in a timely fashion and receive essential follow up services for abnormal results. Vermont's program is undeniably thorough; staff cross-reference birth records and hospital census data with laboratory reports to make sure all infants have documentation of screening or refusal. This important work has continued uninterrupted during the COVID-19 pandemic. Staff quickly transitioned to a mostly remote model. This has improved efficiency without compromising outcomes. All babies with out-of-range screening results have promptly received follow up testing or have been referred for diagnosis and management despite challenges presented by the pandemic. The NBS program was quick to reach out to hospitals and health care providers with information about newborn screening in the context of COVID-19 and has worked to address ongoing concerns and challenges.

The Newborn Screening Program Coordinator engaged clinicians, the screening laboratory, and experts in the field to update the NICU protocol for babies screened in Vermont. This protocol was updated to be more reflective of the Clinical Laboratory Standards Institute's (CLSI) recommendations for screening. This new protocol has been successfully implemented and is the result of months of dialogue and engagement with key stakeholders.

The NBS program continues to provide hospitals with quality improvement reports that detail their performance on key indicators such as timeliness and specimen quality. In FY21, the program altered the format and frequency of the QA reports to allow for quality improvement in real time. These reports have been effective in engaging hospital staff and helping them examine internal processes and regularly review specimen collection technique.

The Vermont Early Hearing Detection and Intervention Program (VTEHDI) works with hospitals and other community providers, including Early Head Start, home-birth midwives, audiologists, early intervention educators, and primary care professionals to provide newborn and early periodic hearing screenings, audiological diagnosis and early intervention services. The program provides support, education, training, and clinical care management to families and their babies, and to community providers. These partnerships ensure timely hearing re-screening, referrals for diagnostic testing and entrance into early intervention services for newborns, infants and children identified with hearing loss throughout early childhood. As part of Children with Special Health Needs and with federal and state funding, VTEHDI contracts with organizations that support family engagement and parent to parent support. Vermont Hands & Voices and the Deaf, Hard of Hearing and DeafBlind Educational Services Program (single point of entry for early intervention) are two examples of organizations that provide support to families. Additionally, VTEHDI supported learning community opportunities for families and professionals that included the 2022 Virtual EHDI Annual Conference, 2022 Hands &Voices Leadership Conference and The CARE Project Facebook Live Sessions. The VTEHDI program, in collaboration with the MCH/CSHN Family Parternships Consultant, continued to work closely to review program materials including letters and pamphlets and VTEHDI Website updates that were implemented in the Spring of 2022.

VT EHDI audiology staff participates in the coalition for educational guidelines, "Optimizing Outcomes for Students who are Deaf and Hard of Hearing (NASDSE)". During this past year the coalition planned and developed a training plan to be implemented with Special Education Directors in the fall of 2022.

Vermont's early intervention program collaborates with a CDC funded project entitled Outcomes and Developmental Data Assistance Center for EHDI Programs (ODDACE). The purpose of the project is to expand public health capacity to gather, analyze, and use intervention and developmental outcome data of children who are deaf or hard of hearing between birth

and 6 years of age throughout the United States. The data collected aims to increase our understanding of factors that impact the outcomes of children who are deaf or hard of hearing at the state and national level.

The Program Director for VTEHDI serves on the Governor appointed Deaf, Hard of Hearing and DeafBlind Advisory Council that makes recommendations to the legislature for improving the lives of children and adults that are Deaf, Hard of Hearing or DeafBlind. The Council members include Deaf Community adults, Hard of Hearing adults, DeafBlind adults, Parents, Educators, ASL Interpreter, Teacher of the Deaf, Speech Language Pathologist, Audiologist, Agency of Education representative and Agency of Human Services representative.

The challenges faced by VTEHDI during this past year were the continued impact of the COVID 19 Pandemic, deployment of staff to support the efforts of the pandemic and the ransomware cyber-attack on Vermont's largest birthing center and health network.

VTEHDI works with state and national agencies and organizations to achieve the National EHDI goals of:

1. Screen hearing by 1 month of age,
2. Diagnose hearing loss by 3 months age
3. Entrance into early intervention by 6 months of age.

Perinatal/Infant Health - Application Year

Action Plan: Perinatal and Infant

Vermont will continue to work with the Maternal Early Childhood Sustained Home Visiting (MECSH) model consultants and home health agency leadership and direct service staff to support the fourth year of our MIECHV funded nurse home visiting program. We will continue our partnership with Help Me Grow (HMG) Vermont and the Building Bright Futures State Early Childhood Council to address a shared priority to advance health equity and address structural racism and inequitable access to services and social and structural determinants of health. Strategies include screening for health disparities and linking families to a variety of services and basic need supports. MIECHV participants will use the HMG resource hub to support access and ensure family connection to services. We will create more opportunities for services to be accessible, culturally and linguistically appropriate, and offered with cultural humility by leveraging community health workers to engage priority populations, including Abenaki/indigenous and New American immigrant/refugee families, in partnership with a CDC Health Equity grant and HRSA's Early Childhood Comprehensive System (ECCS): Health Integration Prenatal-to-Three Program. Additionally, we will increase referrals for mental health services and supports for MECSH clients through provider training, use of innovative evidence-based programs to address maternal depression and increase access to treatment, and existing state referral pathways and expanding partnerships. Strategies include promotion of the recently launched Support Delivered Campaign perinatal mental health materials and new HRSA MCHB Mental Health Hotline.

Vermont is working hard to expand and sustain evidence-based home visiting, using Global Commitment funds to expand MECSH and implement Parents as Teachers (PAT) home visiting with delivery fully integrated into Vermont's early childhood system of care. In the coming year, Vermont will reconvene the Home Visiting Alliance post pandemic to further engage a broad base of stakeholders to support statewide integration and sustainability of the home visiting continuum.

In the coming year, Vermont Title V has several proposed strategies aimed at promoting safe sleep practices in hospital and community settings:

- Collaborate with Birthing Center Nurse Managers on promoting safe sleep prevention activities with Birthing Unit nurse staff, provide safe sleep guideline/policy for their hospitals, create nurse training curriculum on infant safe sleep, identify barriers to implementation via crib audits and provide coaching and technical assistance to identify strategies to overcome these barriers. This work continues as a deliverable through our grant with the Vermont Child Health Improvement Program (VCHIP). VCHIP has regularly met with Birth Managers, birth hospitals are conducting crib audits, and QI data is being assessed for feed back to the hospital nurse leaders.
- MCH Coordinators in District Offices will assist with providing essential training to hospital staff, pediatric practices, and community partners on safe sleep, as well as partner with local organizations to promote crib distribution programs. The outreach and training to hospital staff was not able to happen due to COVID 19; however, plans are to renew this outreach as the need for COVID response eases in our Districts.
- Continue to coordinate with Department for Children and Families on the development of safe sleep protocols for their staff for both foster placement families and childcare settings.

To enhance Vermont's rates of breastfeeding initiation and duration, MCH plans to resume promotion of the Vermont Breastfeeding Strategic Plan broadly across the state to support local coalitions and communities. MCH nurses at the local district health offices are planning to reconvene with local-level leaders to refresh implementation strategies in their health care and community settings this fall. This work was put on hold due the public health response to COVID-19.

Vermont added a sixth site to the Developmental Understanding and Legal Collaboration for Everyone (DULCE) program. Family Specialists are experts in their community culture, strengths, and needs and work collaboratively with the pediatric practice, the Parent Child Center, and other supports and service providers in the community and state. Family Specialists proactively addresses social determinants of health, promote the healthy development of infants, and provides support to their parents and caregivers. In the coming year, we are exploring expansion in the Northeast Kingdom of Vermont, a rural and traditionally underserved community in the northeast corner of Vermont.

Vermont is the first DULCE site in the US to implement substance use screening with caregivers. All sites utilize CQI to inform system and practices improvements. In the upcoming year, sites will focus on training and technical assistance related to intimate partner violence and substance use screening, the implementation of a statewide family advisory council model, rollout of a new family exit survey workflow, and increasing referrals and connections to Help Me Grow for all DULCE families. Vermont continues to explore additional opportunities for sustainability and funding including Medicaid, private insurers, and competitive grant and cooperative agreement applications such as Transforming Pediatrics in Early Childhood cooperative agreement released by HRSA in the spring of 2022.

After years of efforts to spread the Touchpoints approach across sectors who work with children and families, Vermont became an official Brazelton Touchpoints site in late 2021. The Touchpoints (TP) approach is a way of providing care to families (from pregnancy to early childhood) by understanding development and supporting relationships. Used during 2- and 4-month well-child pediatric visits, the Touchpoints strengths-based Parent Assumptions and Guiding Principles will continue to inform the DULCE model and the implementation of new sites. With one-time funding from OneCare Vermont (ACO) to cover training costs, the TP site was established at VCHIP to leverage the infrastructure and existing relationships with VDH, MCH, and our network of statewide pediatric providers to create a sustainable site. The first TP training occurred in the Newport region with a mixed group of early childhood providers and professionals with plans for additional regional trainings in the coming year.

We will align Title V efforts with our HRSA Early Childhood Comprehensive Systems (ECCS), or Vermont Integration Project Prenatal- to-Three (VIP-3), grant opportunity. The spread of TP is a key VIP-3 strategy to increase professional leaders engaged in state-level maternal and early childhood initiatives, as well as enhance equity by building professional capacity to deliver culturally and linguistically responsive care to Vermont's most vulnerable families. Another strategic alignment is to increase use of our Help Me Grow (HMG) resource hub, a one-stop-shop coordinated information and referral system, by health care providers, early educators, and families. Help Me Grow next steps include:

- Support family wellbeing by offering community activities and events that help families learn about and nurture their child's development.
- Strengthen the resource hub database to include more mental health services.
- Raise awareness and increase use of the resource hub.
- Increase use of *Help Me Grow*'s ASQ Online platform among health, education, and human service providers to ensure earlier identification of developmental concerns and increase kindergarten readiness.

Vermont's Newborn Screening Program is continuing progress towards several goals in the coming year: increasing the use of Health Information Technology to maximize efficiency and improve results reporting, working to strengthen follow up procedures for the four newest conditions added to the RUSP, reducing rates of initial unsatisfactory screens, and increasing outreach to families and providers about newborn screening.

In the coming year, the NBS Program aims to enhance service delivery by pursuing electronic reporting of results to hospitals and providers. This initiative has been more complex than anticipated and is ongoing from the last reporting period. The program has translated the newborn screening brochure into multiple languages, but third-party review was delayed due to COVID-19. This is now on track to be completed in the next few weeks and we look forward to sharing these materials with families. The Newborn Screening Coordinator is currently involved with a workgroup looking to improve the communication of abnormal NBS results to families. As a result of this workgroup, the copy for the NBS website has been updated to be more approachable and include more helpful resources. Communication tools have been shared on listservs for pediatricians and midwives, and the Newborn Screening Coordinator is currently holding meetings with other entities such as WIC, Maternal Child Health nurses, and the Early Hearing Detection and Intervention group to discuss how outreach and education can be improved during the prenatal period. Another goal for this period is to incorporate lessons learned from the COVID-19 pandemic into an updated COOP plan. Some foundational work for this has already began, including logistics and funding for third-party follow up coverage should staffing be limited or unavailable within the state

program.

In partnership with VCHIP, Vermont launched a Perinatal Quality Collaborative (PQC-VT). The goal of the PQC-VT is to optimize health outcomes for Medicaid-eligible women and infants by improving access, efficiency and coordination of care and services. The PQC-VT provides the organizational framework through which maternal and child health quality projects are integrated, including data required for quality measures. Through collaboration, data analysis, and quality improvement activities, the PQC-VT will: provide support and education on best practices to perinatal health care professionals and community-based partners who care for this population; improve health care systems for the implementation of current guidelines and best practice recommendations; and convene collaborative meetings to improve perinatal care across the state. This year the PQC-VT will focus on integrating the collection and analysis of data by health equity indicators to examine perinatal care access and quality for historically or currently oppressed populations. The PQC-VT plans to address birth certificate data quality and identify inequities in the collection of data related to race, ethnicity and SDOH. Additional upcoming projects are to build effective and sustainable linkages between clinical care and community-based teams to provide comprehensive and equitable perinatal care, as well as non-clinical support services across the perinatal period. Insights from the MMRP will be incorporated into PQC-VT efforts to improve clinical care and support systems to prevent severe maternal morbidity in the post-partum period, with a focus on post-partum warning signs for non-obstetrical providers, such as emergency departments and first responders, and addressing substance use disorder supports and interventions for parenting people. The PQC will also support rollout of the second Alliance for Innovation on Maternal Health's (AIM) safety bundle on Hypertensive Emergency in Fall 2022.

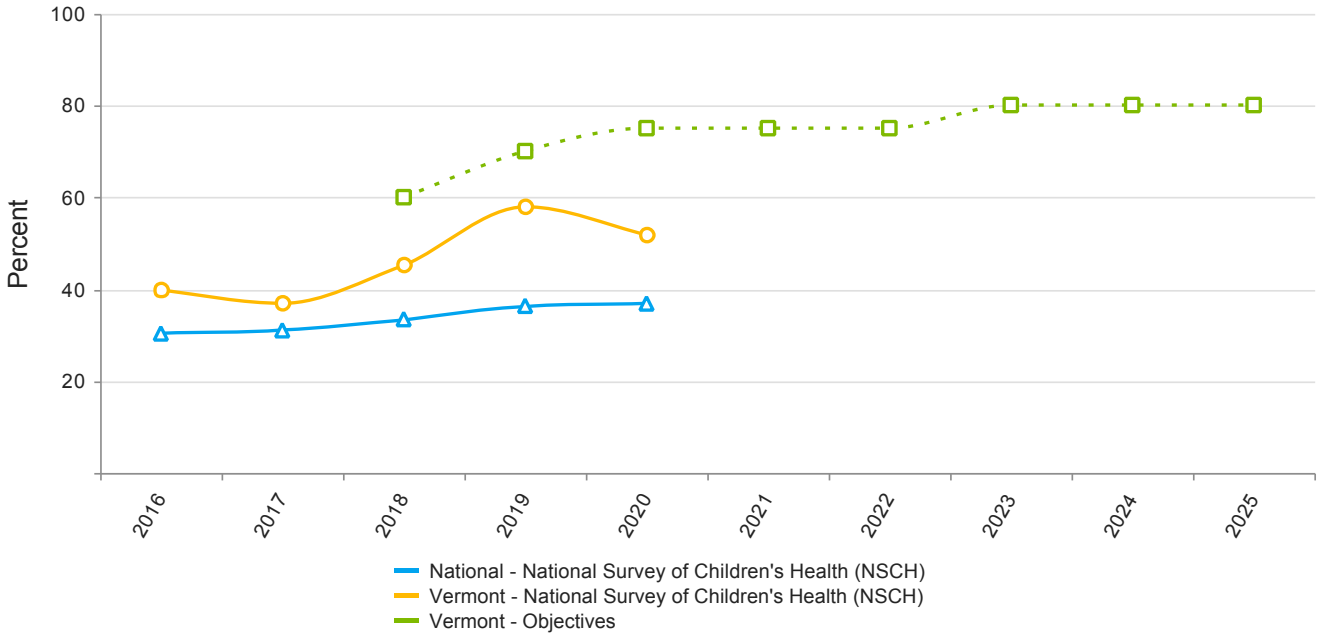
Please note: Only those strategies the link with national and state performance measures are identified in the Action Plan Table for this section.

Child Health

National Performance Measures

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		60	70	75	75
Annual Indicator	39.7	37.0	45.3	57.8	51.8
Numerator	5,111	5,399	6,939	7,281	5,882
Denominator	12,865	14,604	15,303	12,592	11,351
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	75.0	80.0	80.0	80.0

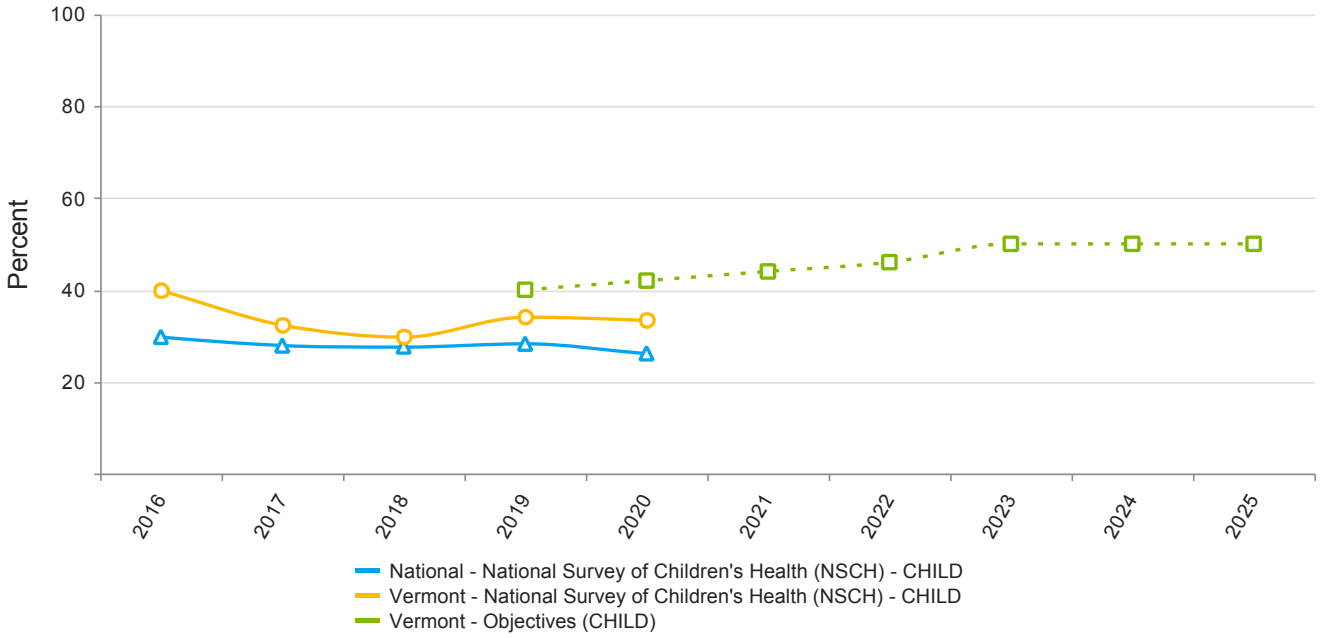
Evidence-Based or –Informed Strategy Measures

ESM 6.1 - Number of providers trained in developmental surveillance and screening

Measure Status:				Active	
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			150	100	50
Annual Indicator			352	224	224
Numerator					
Denominator					
Data Source			Program Data	Program Data	Program Data
Data Source Year			2019	2020	2020
Provisional or Final ?			Final	Final	Provisional

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	50.0	50.0	50.0	50.0

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day
Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CHILD					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			40	42	44
Annual Indicator	39.7	32.4	29.9	34.1	33.5
Numerator	14,153	12,528	11,872	12,757	12,572
Denominator	35,688	38,672	39,659	37,374	37,570
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

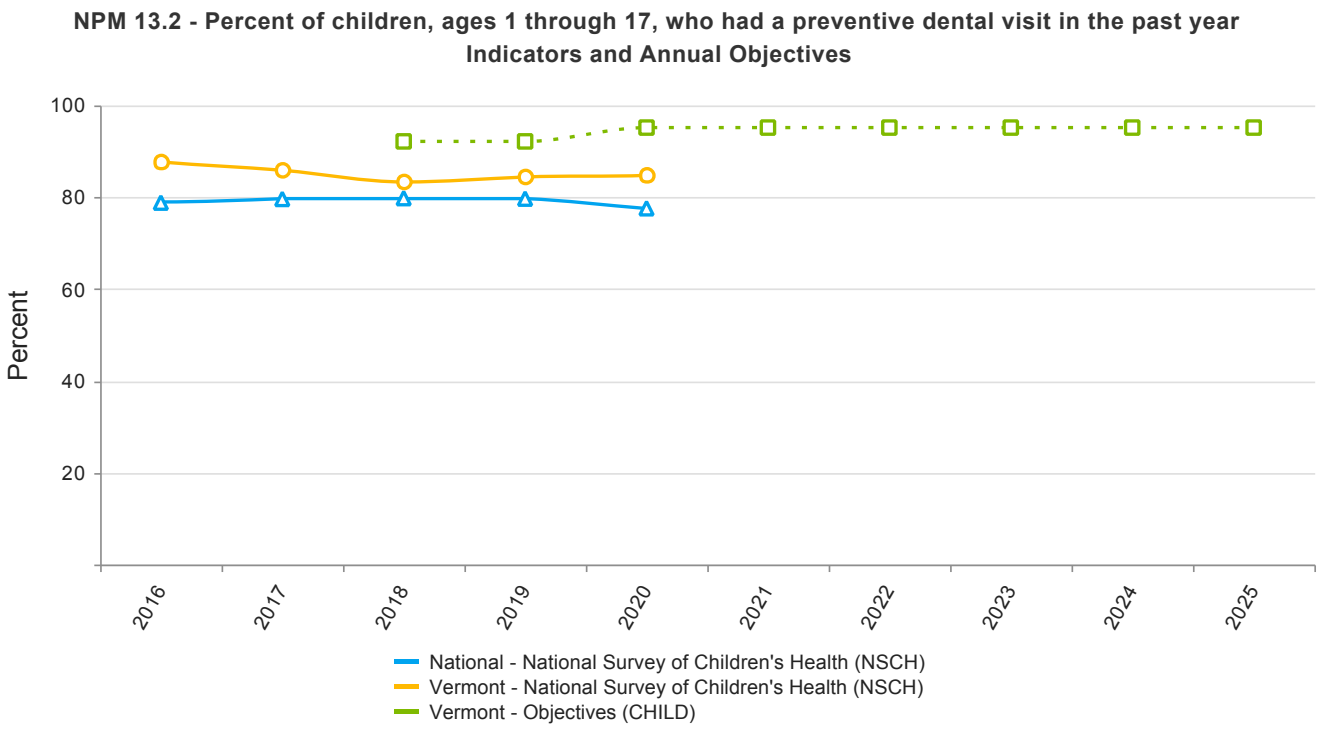
Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	46.0	50.0	50.0	50.0

Evidence-Based or –Informed Strategy Measures

ESM 8.1.1 - Number of classrooms or schools that sign on to 3-4-50, including a commitment to daily recess

Measure Status:				Active	
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			12	12	12
Annual Indicator			9	4	0
Numerator					
Denominator					
Data Source			Program Data	Program Data	Program Data
Data Source Year			2019	2020	2021
Provisional or Final ?			Final	Final	Final

Annual Objectives				
2022	**2023**	**2024**	**2025**	
Annual Objective	12.0	12.0	12.0	12.0



NPM 13.2 - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		92	92	95	95
Annual Indicator	87.4	85.7	83.3	84.3	84.5
Numerator	98,305	95,571	91,502	92,788	91,792
Denominator	112,465	111,490	109,884	110,125	108,658
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	95.0	95.0	95.0	95.0

Evidence-Based or –Informed Strategy Measures

ESM 13.2.1 - # of students participating in Vermont's 802Smiles Network of School Dental Health Programs receiving oral health services

Measure Status:				Active	
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			3,000	3,100	3,300
Annual Indicator	1,606	1,422	3,088	3,088	3,088
Numerator					
Denominator					
Data Source	Oral Health Program	Oral Health Program	Oral Health Program	Oral Health Program	Oral Health Program
Data Source Year	2016-17	2017-18	2018-19	2018-19	2018-19
Provisional or Final ?	Final	Final	Final	Provisional	Provisional

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	3,400.0	3,500.0	3,500.0	3,500.0

State Performance Measures

SPM 1 - % of children 6 month to 5 years who meet all 4 flourishing items

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	83	84	86	88	90
Annual Indicator	67.6	67.6	86.7	83.2	82.3
Numerator	22,213	24,152	31,277	28,178	25,654
Denominator	32,842	35,708	36,090	33,879	31,183
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016-17	2018	2018-19	2019-20
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	90.0	90.0	90.0	90.0

State Action Plan Table

State Action Plan Table (Vermont) - Child Health - Entry 1
Priority Need
Achieve a comprehensive, coordinated, and integrated state and community system of services for children
NPM
NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
Objectives
By 2024, increase the percentage of pediatric, family practice, human service providers, and early educator trained in valid developmental and social/emotional screening tools to 20%
By 2024, increase the number of families who access a centralized resource hub (HMG/ Vermont 2-1-1) by 20%
By 2024, increase HMG calls and referrals from providers by 20%
By 2024, increase HMG follow up to families to ensure successful connection by 20%

Strategies
1. Promote and offer developmental monitoring and screening via Help Me Grow (HMG) Vermont – a comprehensive system that ensures that early detection of developmental and behavioral concerns leads to the connection of young children and their families to community-based services and medical homes: a) Host the Ages and Stages Questionnaires (ASQ) Enterprise Online System for families and providers to access screening tools at HelpMeGrowVT.org; b) Integrate HMG's ASQ Enterprise Online system with the Universal Developmental Screening Registry (USDR); c) Embed developmental monitoring tools, as a complement to screening, in early childhood settings and medical homes (e.g. CDC's Act Early program materials, Bright Futures)
2. Offer trainings and activities for families and providers to increase their understanding of early child development, including social and emotional development, to address disparities, promote equity, and strengthen families: a) Ensure family engagement and ongoing family and consumer partnership; b) Offer Touchpoints training to pediatric health care providers and OBGYNs; c) Embed CDC's LTSAE tools and resources in OBGYN practices
3. Train providers to conduct developmental monitoring and screening and to use HMG's ASQ Online system, which will be integrated with Vermont's developmental screening registry, to ensure each child reaches their full potential: a) Train providers to use HMG's ASQ online system; b) Strengthen partnerships with Vermont's ACOs to leverage opportunities to focus on improving developmental screening rates; c) Create networking opportunities for providers from different sectors to align cross-sector Child Find efforts, improve access, and better support children and families; d) Scale up and spread ongoing training, individual TA, and coaching on developmental and social determinant screening for early childhood professionals across sectors (e.g. training with community of practice/coaching component). Offer VT Northern Lights professional development CEUs for early educators.
4. Ensure communities are fully plugged into a reliable grid of resources — including elements such as quality early care and learning opportunities, healthy food, and supportive relationships – to ensure that all children have what they need to thrive: a) Strengthen the resource grid by plugging families and communities into mental health supports and services including perinatal mood and anxiety disorders and trauma; b) Continue to update the list of mental health providers with expertise in perinatal mood and anxiety disorders and trauma treatment
5. Deliver care coordination and follow-up for families accessing the HMG resource hub to ensure young children get connected to the services they need at an early age when the benefit is greatest

ESMs	Status
ESM 6.1 - Number of providers trained in developmental surveillance and screening	Active

NOMs
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Vermont) - Child Health - Entry 2

Priority Need

Reduce the risk of chronic disease across the lifespan

NPM

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Objectives

By 2024, outreach to 50% of WIC families with FitWIC physical activity and nutrition material

Increase the number of classrooms or schools that sign on to 3-4-50, including a commitment to daily recess by 50% by 2024

Strategies

1. Fund (in part) the Physical Activity and Nutrition Director in the Health Department's chronic disease division to provide leadership in this area.

2. Broadly promote the 3-4-50 initiative to early care and learning settings and schools to promote physical activity within the context of the school day and to parents and communities beyond the school day

3. Offer bonuses in our early care and learning quality rating system: Step Ahead Recognition System (STARS) for nutrition and physical activity

4. Working with Vermont's early care professional development system (Northern Lights at the Community College of Vermont) to increase professional development opportunities in physical activity and nutrition for early care and learning providers

5. Broadly promote the use of Vermont's FitWIC: materials for parents and their preschoolers. FitWIC Activities will help foster child health and development through active physical play: http://www.healthvermont.gov/sites/default/files/documents/2016/11/cyf_FitWIC-Activity-Book.pdf

6. Provide increase parent education through provider offices about the importance of physical activities in schools and how to advocate for that or how to find out what is already happening in schools

7. Increase distribution of AAP policy statement Crucial Role of Recess http://pediatrics.aappublications.org/content/131/1/183

ESMs	Status
ESM 8.1.1 - Number of classrooms or schools that sign on to 3-4-50, including a commitment to daily recess	Active

NOMs

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

State Action Plan Table (Vermont) - Child Health - Entry 3

Priority Need

Reduce the risk of chronic disease across the lifespan

NPM

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Objectives

By 2024 increase the percentage of children who access preventive oral health care in the past year.

Strategies

1. Fund (in part) the role of the Oral Health Director in the Health Department's chronic disease division to provide oral health planning and programming related to pregnant women and children

2. MCH staff and the Oral Health Director will work with Communications and VT Oral Health Advisory Panel members to promote the implementation of Vermont's oral health periodicity schedule: current best practice guidance to pediatricians, family medicine providers, dentists, and families

3. MCH Coordinators work in tandem with co-located public health dental hygienists to assess dental health landscape and share resource availability with health care and community partners

4. Public health dental hygienists (PHDH) provide oral health assessment, fluoride varnish and silver diamine fluoride application, education & information to families enrolled in WIC

5. To increase the uptake of dental visits among pregnant women and young children, MCH Coordinators and PHDHs partner at the District office level provide outreach to: a) Ob/Gyns regarding: a) the expanded Medicaid benefit for pregnant women; b) Bright Futures guidelines; b) Dentists regarding a) evidence-based oral health practice; b) support for seeing patients beginning at age 1; c) Pediatricians regarding: a) oral health education and referral to a dental home; and b) fluoride varnish

6. MCH leadership serves on the statewide oral health advisory panel

7. Regional MCH coalitions promote oral health messaging

8. Work collaboratively with the Vermont chapter of ACOG to strengthen its membership and provide training and organizational support to ensure key public health messaging/ content is integrated into clinical services

9. Work collaboratively with the Chronic Disease and Disability Advisory Group to promote access to preventive oral health care for VT children with intellectual disabilities.

10. Provide oversight to the 802Smiles Network of school dental health programs in participating schools to help to ensure that every child has access to preventive, restorative and continuous care in a dental office

11. MCH leadership serves on the 802Smiles Network of school dental health programs Planning Committee, which is dedicated to expanding the availability of school-based dental health services in VT

ESMs	Status
ESM 13.2.1 - # of students participating in Vermont's 802Smiles Network of School Dental Health Programs receiving oral health services	Active

NOMs
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (Vermont) - Child Health - Entry 4

Priority Need

Promote protective factors and resiliency among Vermont’s families

SPM

SPM 1 - % of children 6 month to 5 years who meet all 4 flourishing items

Objectives

By 2024, increase the percentage of families accessing HMG that received positive parenting information/resilience resources by 50%

Strategies

1. Partner with Agency of Human Services Trauma Prevention and Resilience Director and serve on agency-wide steering committee to help set priorities and identify and plan activities related to workforce development needs across the Agency

2. Incorporate the Strengthening Families Framework and Youth Thrive into all relevant work, with an emphasis on preventing and mitigating the impact of toxic stress

3. Enhance utilization of HMG VT by providers and consumers/caregivers: a) Evaluate the impact of HMG VT by asking protective factors survey questions to understand the extent to which the system is strengthening families and enhancing protective factors; b) Promote the protective factors to parents and professionals via HelpMeGrowVT.org and Facebook@helpmegrowvt

4. Domestic and sexual violence prevention activities: a) Continue Healthy Moms, Happy Babies evidence-based training on domestic violence and home visiting; b) MCH Coordinators in local district offices participate in local domestic/ sexual violence community response and/or prevention teams; c) MCH leadership participates on the statewide Domestic Violence Fatality Review Commission; d) MCH leadership participates in the Blueprint for Health’s Women’s Health Initiative and advises on domestic violence screening, referral and response and other key content areas related to family planning, and preconception health; e) Domestic and sexual violence surveillance through incorporation of questions into BRFSS

5. Educate providers and community partners on the impact of Adverse Childhood Experiences and mitigating strategies: a) Present epidemiological data to a variety of professional audiences on ACEs; b) Participate in state and local community planning sessions to address trauma in health care, schools, and communities

6. Continue to provide leadership and technical assistance around COVID recovery and pandemic-related mental health concerns among children and families, in partnership with child care, schools, and out-of-school programming.

Child Health - Annual Report

Child

Vermont's Title V program, the Health Department, and Agency of Human Services is continuing to focus on the prevention of trauma and toxic stress and addressing social and structural conditions of health to support individual, family, and community resilience (flourishing) and health equity. Prior to the pandemic and more so now, Vermont's MCH program is at the center of all these discussions and efforts. Resilience and equity are also central to the strategies of Vermont's SHIP: Invest in programs that promote resilience, connection and belonging, and includes approaches core to Vermont's MCH mission:

1. Home Visiting – Expand access to an array of home visiting services for families who have young children or are expecting
2. Strong Families – Promote the Strengthening Families approach to strengthen protective factors and mitigate the impact of adverse experiences
3. Resilient Youth – Expand community-based opportunities such as mentoring, peer support and after-school programs to build resilience and protective factors among youth

Key highlights of our MCH partnerships and collaborations this year include:

- Vermont Afterschool was endorsed by the Governor to realize his goal of universal afterschool and offers strengthening programs like Building Flourishing Communities, a proven public health model to increase resiliency and lifelong health outcomes
- Youth Thrive Training: A framework which supports staff working with youth by providing information and tools which encourage strengths base approaches, viewing behaviors as normal stages of development, and productive interventions
- Vermont's HRSA Early Childhood Comprehensive System: Health Integration Prenatal-to-Three (P-3) Program, known as Vermont Integration Prenatal-to-Three (VIP-3), is strengthening partnerships between our early childhood and maternal and child health sectors. VIP-3 priorities include: 1) using existing infrastructure to identify gaps, assets, and areas of duplication; 2) promote family leadership; 3) increase participation of health providers in use of our Help Me Grow Resource Hub; and 4) develop and implement innovative financing, health, and equity strategies to improve policies, services provision, and outcomes for P-3 families.

Addressing social conditions of health which impact *Optimal Child Development,* a priority area in Vermont's State Health Improvement Plan (SHIP), has become more urgent in light of the continued impact of the COVID-19 pandemic on Vermont's children and families. Vermont continues to make gains in screening across multiple domains, including social conditions of health, and works to ensure earlier access to existing resources for overall family resilience and wellbeing with Help Me Grow. Offering a one-stop-shop information and referral resource hub, all callers are screened for food security using the Hunger Vital Sign™ tool. HMG links families to services and stays in touch so families receive support before, during, and after they are connected. Key highlights include:

- HMG received 1,343 incoming calls and 106 referrals (during the reporting period)
- HMG made 1,602 follow up calls
- The 2020-2021 Hunger Vital Sign™ screening results indicate an increased concern about food access, but a decrease in reports of families running out of food than in the previous year.
- Referrals for perinatal mood and anxiety disorders (PMADs) increased when a new media campaign to raise awareness launched in 2020. HMG staff made over 171 referrals for 26 individuals.

Routine screening across multiple domains of development, including screening for social determinants of health, closes gaps in kindergarten readiness and promotes resiliency and positive outcomes even when children have challenging

experiences, such as a pandemic, poverty, violence, and trauma. HMG provides training on use CDC's *Learn the Signs. Act Early.* Program tools for family-engaged developmental monitoring and use of developmental screening tools, to help families better understand their child's early development and identify concerns so that young children get connected to the services they need at an early age when the benefit is greatest. HMG aligns screening efforts across settings to improve early identification by offering free access to a statewide Ages and Stages (ASQ) Online system, which will be integrated with Vermont's developmental screening registry, to improve communication and coordination among providers and reduce screening duplication. Developmental screening is a Blueprint for Health and Accountable Care Organization (ACO) quality measure that child health care providers can fulfill by using the registry. Vermont's developmental screening guidelines encourage participating practices and providers to access and review developmental screenings completed by community providers to inform their surveillance and screening activities during health supervision visits. Key highlights of this work include:

- Between 2020 to 2021 HMG trained 423 health care and human service providers, early childhood educators, and others to conduct developmental and social/emotional screening and to refer families for further evaluation and services.
- HMG provided comprehensive training that was followed by coaching to nine early childhood education programs on how to use developmental screening tools, with cultural responsiveness, and connect families to needed resources.
- Over 9,000 children are currently enrolled in childcare programs that have received HMG training. This includes well over 2,000 preschoolers that are better prepared to learn and succeed as they enter kindergarten. This is enough children to fill almost half of Vermont's kindergarten classrooms.
- The proportion of young children receiving at least one developmental screening in the first three years of life increased from 46.6% in 2015 to 57.5% in 2020.
- With the need for telehealth, tele-home visiting, and virtual classrooms during the pandemic, use of HMG's ASQ Online system increased exponentially. By the end of 2020, 2,325 developmental screenings had been completed online. By the end of 2021, this number had grown to 6,418 with over 660 screenings focused on social-emotional development. The ASQ Online screening data will be integrated with Vermont's Developmental Screening Registry for increased communication, coordination, and population data.

HMG works with community partners to strengthen families and build their resilience so that all Vermont children can reach their full potential. Families participate in activities that build supportive relationships and teach coping skills to counterbalance things like poverty, toxic stress, and trauma, which can negatively impact child wellbeing. Key outcomes this year include:

- HMG held 47 community outreach events and, by shifting outreach to virtual platforms, reached almost 38,000 families.
- HMG trained 902 providers and families in the following topics: trauma-informed practices and building resilience, social and emotional development, accessing resources, preparing young children for school, equity, anti-racism, and gender inclusive teaching strategies.
- Almost all families reported getting their needs met and indicated they had an increased understanding of child development and felt able to access services.

As mentioned in previous reports, Vermont works within the 3-4-50 framework to draw attention to health behaviors that, if followed, will help prevent chronic disease. This framework goes further to engage organizations in a variety of sectors (communities, worksites, retail establishments, schools and childcare programs asking them to commit to promoting these healthy behaviors through policy changes in their organization. Specifically, in schools and childcare programs, 3-4-50 calls out ways to help children learn healthy behaviors from the start. Tips for each include ways to help children eat healthier foods, be more physically active and, for older children, information and skills that will help them say no to tobacco use. The 3-4-50 tips and sign on sheets build from simple, effective interventions to more complex but longer lasting policy changes that will solidify strong nutrition and physical activity programs and prevent tobacco use initiation. Before this work period, 31 childcare programs and schools had signed on, in addition to organizations that serve children, youth and families including human services organizations, recreation departments, afterschool programs, libraries and churches. VDH Offices of Local Health are available to provide technical assistance to schools and childcare programs to help them sign on and to continue

to build on their successes. Vermont Title V supports the salary of the child physical activity and nutrition director in Vermont's division of health promotion and disease prevention.

Vermont Department of Health staff have predominantly been detailed to work on the pandemic response since March 2020. Because of this, efforts such as 3-4-50 engagement have needed to be in the background, with staff ready to take inquiries from organizations interested in 3-4-50, but not actively recruiting new organizations. Additionally, these organizations have been occupied in their own pandemic responses. Because of this our expected number of new schools and childcare programs engaging in 3-4-50 is less than we had hoped for this period, with only one childcare program signing on to 3-4-50.

Oral Health is another SHIP and Title V priority area. Title V partially funds the salary of the VDH Oral Health Director, who coordinates the Local District Office Public Health Dental Hygienist (PHDH) program. "Embedded" public health dental hygienists in our local district office WIC clinics conduct oral health risk assessments, fluoride varnish and silver diamine fluoride application, and link pregnant women and children to local oral health services and dental homes. PHDHs also provide community education (e.g., health fairs, wellness events) and provide training to medical and dental providers to promote early (by age one) preventive dental care. Lastly, they support Office of Oral Health programs such as community water fluoridation and the 802Smiles Network of School Dental Health programs.

MCH partnered with the Office of Oral Health to update Vermont's EPSDT periodicity schedule for dental services to align with the newly released 4th edition of, Bright Futures. MCH has also partnered with VCHIP, AAP VT, and other community partners to arrange 8 regional Bright Futures 4th edition rollout events around the state. MCH staff and the Oral Health Director worked with Communications and the VT Oral Health Advisory Panel members to promote Vermont's new oral health periodicity schedule: current best practice guidance to pediatricians, family medicine providers, dentists, and families.

Vermont's 802Smiles Network of School Dental Health programs help to ensure that every child has access to preventive, restorative, and continuous care. The network is an umbrella that consists of the various tiers of school dental health program that exist in the state. Different tiers include case management (school-linked programs), the provision of preventive care in schools (school-based programs), and school-based clinics that offer both preventive and restorative care on site.

Vermont's Oral Health program partners with the University of Vermont's Office of Primary Care and Area Health Education Centers (AHEC) to coordinate From the First Tooth trainings for primary care providers throughout Vermont, offering first time trainings as well as refresher courses at no charge to the practice. This program helps primary care providers integrate the following practices as standard of care for young pediatric patients: 1) Assess the oral health of young children; 2) Apply fluoride varnish to help prevent tooth decay; 3) Educate parents and caregivers about pediatric oral health; and 4) Make dental referrals. MCH leadership serves on the statewide oral health advisory panel, 802Smiles Network of School Dental Health Programs Planning Committee, and will work with the oral health program and chronic disease and disability advisory group to promote oral health for VT children with intellectual disabilities.

The Vermont Oral Health program developed a communications campaign to keep oral health on the radar during the pandemic. We distributed 3,724 dental kits containing a toothbrush, dental floss, a timer, and a bookmark (with tips for good oral health and resources to find a dentist) to 38 schools in Vermont and plan on distributing kits to additional schools during the upcoming school year. Previously, the program implemented a basic screening survey of VT children: https://www.healthvermont.gov/sites/default/files/documents/pdf/oral_health_survey_1617.pdf
Plans are underway to conduct another survey during the 2022-23 school year.

Partnerships

MCH has adopted the framework in AMCHP's *Roadmap for Collaboration among Title V, Home Visiting, and Early Childhood Systems Programs* to strengthen collaboration and shared priorities across Title V MCH programs, MIECHV, our

HRSA ECCS VIP-3 project, and HRSA Maternal Depression and Related Substance Abuse Disorders Program partners. Following Roadmap recommendations, MCH has formed an internal early childhood unit to align early childhood work and opportunities and implement Roadmap recommendations. This includes prioritizing family leadership and health equity under the guidance of our new MCH Health Equity Team Lead and VDH's Health Equity and Community Engagement (HECE) Team. MCH efforts have been expanded by VIP-3 implementation partners including: the Vermont Department of Health, Help Me Grow Vermont, Department of Vermont Health Access (DVHA); Vermont Children's Health Improvement Project's (VCHIP), the Building Bright Futures (BBF) Early Childhood State Advisory Council (SAC) network, and United Ways of Vermont. Additional critical partners include child and family serving agencies and professionals, Vermont State Agency representatives, Agency of Education, family leaders and the BBF Families and Communities Committee, cultural brokers, and Vermont's MCH health system partners [e.g. American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP), American College of Obstetricians and Gynecologists (ACOG), American College of Physicians (ACP), Blueprint for Health, VDH's Health Equity and Community Engagement (HECE) Team, Medicaid and other health payer systems like OneCare Vermont.]

Vermont's oral health and physical activity and nutrition programs sit within the Division of Health Promotion and Disease Prevention. Likewise, we work closely with our Office of Local Health and the regional MCH Coordinators and School Liaisons.

Child Health - Application Year

Child

Towards achieving Vermont's performance measure regarding childhood physical activity: we are planning the following strategies (also dependent on COVID-19):

- Ongoing Title V funding in support of the Physical Activity and Nutrition Director in the Department's Division of Health Promotion and Disease Prevention
- Broadly promote the 3-4-50 initiative to early care and learning settings, after school care, and schools to promote physical activity within the context of the school day and to parents and communities beyond the school day. 3-4-50 is the Health Department's cross-sector initiative to engage individuals, worksites, schools, cities and towns and faith-based communities in better understand the overwhelming impact of chronic disease and inspire them to take action to change. This is particularly important now, as we are seeing the effects of chronic disease on COVID-19 outcomes
- Continue to advocate for nutrition and physical activity standards being added to our early care and learning quality rating system: Vermont's Quality Improvement and Rating System (QRIS)/Step Ahead Recognition System (STARS). The preliminary language has been added to the drafted revision, which will go through final review this year.
- Work with Vermont's early care professional development system (Northern Lights) to increase professional development opportunities in physical activity and nutrition for early care and learning providers
- Broadly promote the use of Vermont's FitWIC: materials for parents and their preschoolers; FitWIC Activities will help foster child health and development through active physical play
- Promote the implementation of the 10 schools who have new and improved school wellness policies and increase the number of schools willing to work on their wellness policies
- Provide increased parent education through provider offices about the importance of physical activities during the school day, whether school is online or in person. Information about how to learn more and advocate for physical activity during the school day should be shared with parents. We are committed to this strategy but recognize the need to be mindful of provider bandwidth due to COVID-19
- Increase distribution of AAP policy statement Crucial Role of Recess

In the coming year, we plan to increase use of Help Me Grow (HMG) Vermont by health, early education, human service providers, and families, leveraging our HRSA Early Childhood Comprehensive Systems (ECCS), or Vermont Integration Project Prenatal-to-Three (VIP-3), grant opportunity to do so. HMG will continue to align regional *Child Find* screening and referral efforts to build family resilience across the family home, medical home, and child's early learning environment. We will host and increase use of the Ages and Stages Questionnaires (ASQ) Enterprise Online System for families and providers. We will fully integrate the ASQ Online system with Vermont's developmental screening registry, an effort delayed by COVID-19, to improve communication and coordination for earlier identification of developmental concerns and remove a system barrier by obviating the need for manual screening data entry. We will continue to coordinate *HMG* activities with Vermont's ACOs and the Blueprint to leverage health reform and enhanced payment opportunities. Help Me Grow next steps include:

- Support family wellbeing by offering community activities and events that help families learn about and nurture their child's development.
- Strengthen the resource hub database to include more mental health services.
- Raise awareness and increase use of the resource hub.
- Increase use of *Help Me Grow*'s ASQ Online platform among health, education, and human service providers to ensure earlier identification of developmental concerns and increase kindergarten readiness.

In the coming year, Vermont Title V has several proposed strategies aimed at reducing childhood injury:

- Provide public health leadership in the prevention and approach to child maltreatment
- Support statewide implementation of evidence-based home visiting programs that have demonstrated effect in improving parenting practices
- MCH Coordinators at the District Office level serve as members of local Child Protection Teams
- MCH leadership serves on the Vermont Citizen's Advisory Board (VCAB) to examine policies, practices, and procedures of the Vermont's child protection agency, and provide for public outreach and comment to assess the impact of current procedure and practice on Vermont children and families
- MCH leadership serves on Vermont's Child Fatality Review Team and works with this team to update data gathering, assessment, and review procedures. Key areas of concern are infant safe sleep, suicide, and motor vehicle accidents.
- MCH Coordinators at the local level coordinate with the Department for Children and Families to improve the health status of children in state custody (Fostering Healthy Families)
- Vermont contracts with a Child Safe Physician to provide medical leadership and case-specific consultation for community efforts and coordination around child abuse and neglect and trauma response
- Work with the Child Safe Physician and VDH Health Statistics to perform analysis of morbidity and mortality due to child abuse and neglect.
- Organize and implement trainings for MCH home visitors on child home safety with a specific emphasis on rural families.
- Provide injury prevention leadership through regular webinars with childcare providers through Let's Grow Kids.

In the coming year, Vermont has several planned strategies aimed at improving the oral health of children:

- Vermont MCH supports a portion of the salary of the Oral Health Director in the Health Department's chronic disease division; this funding supports programmatic planning as it relates to the MCH population
- MCH staff and the Oral Health Director will work with Communications and Vermont Oral Health Advisory Panel partners to promote the implementation of Vermont's oral health periodicity schedule: current best practice guidance to pediatricians, family medicine providers, dentists, and families
- Provide oversight to the 802Smiles Network of School Dental Programs to help to ensure that every child has access to preventive, restorative, and continuous care in a dental office
- Regional MCH Coordinators in district offices work in tandem with co-located public health dental hygienists to assess the local dental health landscape and share resource availability with health care providers and community partners
- MCH Coordinators and PHDHs provide outreach to pediatricians regarding, a) oral health education and referral to a dental home, and b) fluoride varnish application.

MCH is working in close partnership with the Department of Mental Health and other partners in the HRSA-funded Pediatric Mental Health Care Access grant. Through this opportunity, Vermont is standing up a Child Psychiatry Access Program, which provides real-time psychiatric and care coordination support to pediatric primary care providers. CPAP will also link into the HMG Resource Hub. This team is also working on standing up broader efforts to integrate mental health and primary care.

Vermont continues its commitment to promoting protective factors and resiliency among Vermont's families and leveraging Title V activities to do so. Planned strategies include:

- Continue to incorporate the *Strengthening Families* framework into all relevant work, with an emphasis on preventing and mitigating the impact of toxic stress and with special attention to the inclusion of *Strengthening Families* into the

release of *Bright Futures 4th edition.*

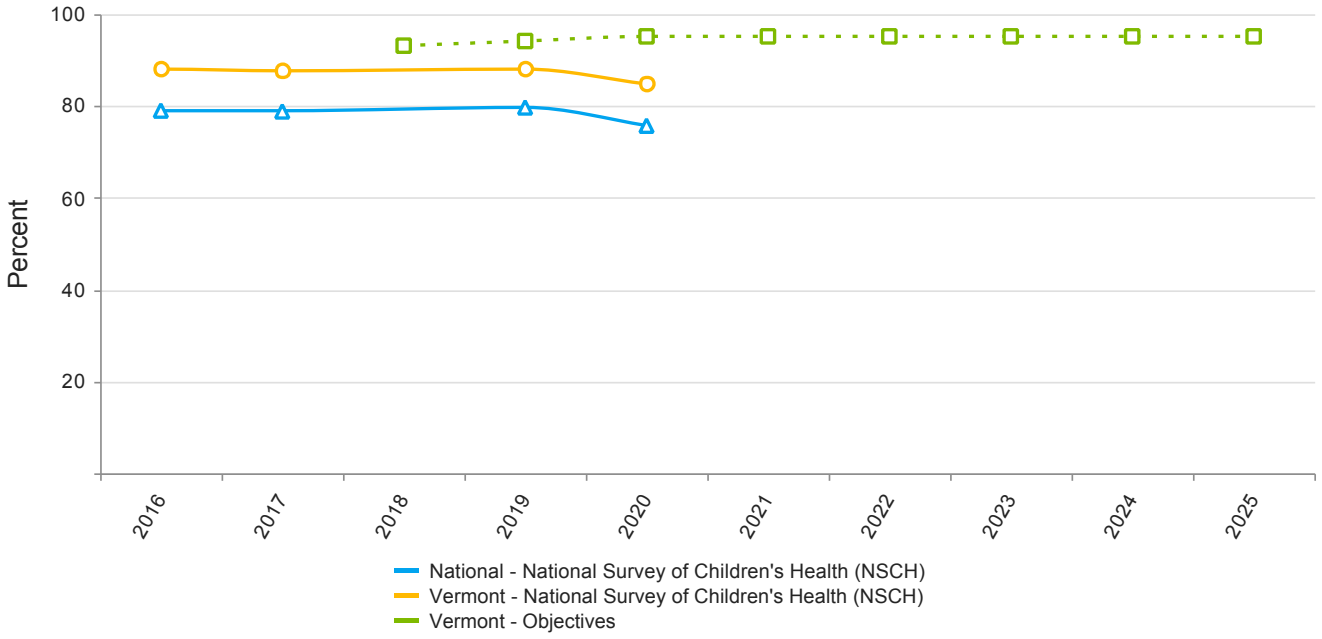
- Our Adolescent Health Program Manager recently transitioned into a new role in MCH to serve as the Division Health Equity Team Lead. We have recently hired a new Adolescent Health and Youth Initiatives Program Manager. In addition to managing the division's adolescent sexual and reproductive health work, this new staff member will continue to work closely with VT Afterschool on several initiatives that support youth leadership, youth voice, and the formation of youth councils. VT Afterschool continues to oversee Youth Thrive, which utilizes the most current science on adolescent brain development, trauma, and resilience. Regional communities of practice were formed in Vermont to support local implementation of the Youth Thrive Framework. MCH has also partnered with VT Afterschool on trainings and TA for MCH staff related to transformative social and emotional learning.
- HMG is grounded in the Strengthening Families framework and staff continue to refine and promote protective factors strategies to use during telephone conversations with families. HMG will continue to survey families using protective factors questions to evaluate impact, including if families improve their ability to access services and have a better understanding of their child's development.
- We will continue to spread the Touchpoints approach across sectors who work with children and families. After years of efforts to spread this approach, Vermont became an official Brazelton Touchpoints site in late 2021. The Touchpoint approach is a way of providing care to families (from pregnancy to early childhood) by understanding development and supporting relationships. It is our assumption that when parents work with supportive professionals, they become more confident in their parenting and form strong, resilient attachments with their children, laying the foundation for children's early learning and healthy development. The Touchpoints strengths-based Parent Assumptions and Guiding Principles inform the DULCE model and are used during the two- and four-month well-child pediatric visits. The first Touchpoints Training occurred in the Newport region with a mixed group of early childhood providers and professionals with plans for additional regional trainings in the coming year.
- We will continue to educate providers and community partners on the impact of Adverse Childhood Experiences and mitigating strategies by presenting epidemiological data to a variety of professional audiences on ACE and by participating in state and local community planning sessions to address trauma in health care, schools, and communities
- We will support the Vermont Family Based Approach whose long-term goal is to help the well remain illness free, prevent at-risk children from developing psychiatric illness, and intervene comprehensively on behalf of children and families challenged by emotional or behavioral disorders

Please note: Only those strategies the link with national and state performance measures are identified in the Action Plan Table for this section.

Adolescent Health

National Performance Measures

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		93	94	95	95
Annual Indicator	88.0	87.4	87.4	88.0	84.8
Numerator	40,460	35,604	35,604	38,754	35,611
Denominator	46,004	40,737	40,737	44,020	42,018
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2016_2017	2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	95.0	95.0	95.0	95.0

Evidence-Based or –Informed Strategy Measures

ESM 10.1 - Number of public schools implementing the PATCH for Teens curriculum as part of their Health Education Curriculum

Measure Status:				Active	
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			5	10	15
Annual Indicator			0	0	0
Numerator					
Denominator					
Data Source			Program Data	Program Data	Program Data
Data Source Year			2019	2020	2021
Provisional or Final ?			Final	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	25.0	35.0	35.0	35.0

State Performance Measures

SPM 2 - % of adolescents that feel they matter to people in their community

Measure Status:	Active				
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	55	58	60	63	65
Annual Indicator	60.5	60.5	58.2	58.2	58.2
Numerator	16,108	16,108	14,285	14,285	14,285
Denominator	26,614	26,614	24,524	24,524	24,524
Data Source	YRBS	YRBS	YRBS	YRBS	YRBS
Data Source Year	2017	2017	2019	2019	2019
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	65.0	66.0	66.0	66.0

SPM 4 - Percent of high school students who made a plan to attempt suicide in the past 12 months

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective			8	8	8
Annual Indicator		11.2	13.4	13.4	13.4
Numerator		3,048	3,454	3,454	3,454
Denominator		27,166	25,727	25,727	25,727
Data Source		YRBS	YRBS	YRBS	YRBS
Data Source Year		2017	2019	2019	2019
Provisional or Final ?		Final	Final	Final	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	7.0	7.0	7.0	7.0

State Action Plan Table

State Action Plan Table (Vermont) - Adolescent Health - Entry 1
Priority Need
Youth choose healthy behaviors and thrive
NPM
NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
Objectives
By 2024, increase awareness among health care providers of the importance of annual preventive health visits for adolescents to 75%
By 2024, increase awareness among parents/ caregivers and patients (adolescents) on the importance of preventive health visits for adolescents to 75%
By 2024, increase access to preventive health visits in medical homes and school-based health centers by 20%

Strategies

1. Continue to support Vermont RAYS, with the goal to actively engage adolescents and young adults in goals and strategies to create more youth-friendly services in the primary care sites, building opportunities for meaningful youth engagement, and elevating youth voices in MCH communications campaigns and outreach strategies.

2. Partner with practices to increase both access to and quality of well care visits for the adolescent and young adult. Identify local barriers to adolescent well-care visits and help identify and test new strategies to ameliorate these barriers, through TA and QI coaching provided by the VCHIP, Youth Health Improvement Initiative.

3. MCH Coordinators and school liaisons will promote Bright Futures 4th edition with health care providers and community partners (including public schools), including annual well care visits for all school-aged children and youth. Promotion may range from general awareness related activities such as ensuring providers and community partners are aware that Bright Futures is Vermont's EPSDT periodicity schedule, to topic specific initiative's such as promoting annual well care visits for adolescents, or universal developmental screening as recommended by Bright Futures. Promotion may include verbal communications, distributing specific written resources, describing initiatives, website updates, support for regional community meetings, etc.

4. Explore opportunities to further assess and convene school-based health centers in Vermont schools through a peer collaborative approach, and promote connections to medical homes, lessons learned, and shared performance measures

5. Fund a travel and committee work stipend for School Nurse participation in Vermont's School Nurse Advisory Committee whose primary role is to: a) review/ update the Standard of Practice: School Health Services manual; b) maintain and update the new school nurse orientation; c) Strengthen school nurse workforce development. Each of these items reflects Bright Futures, EPSDT administrative objectives, medical and dental home access, coordination with providers, and reducing barriers to accessing care

6. VDH School Liaisons and the Vermont Child Health Improvement Program will provide TA and strategies to school nurses to facilitate connections between schools and medical homes

7. Identify and develop communication materials and social media strategies for providers, parents/ care takers, and adolescents, to be used in tandem with EPSDT outreach and informing letters, school nurse materials, and patient handouts, as informed by our work on creating a multi-year EPSDT outreach and informing plan

8. Strengthen partnerships with Vermont's ACOs to leverage opportunities to focus on improving adolescent well-care visits

9. Maintain several new web pages promoting adolescent health, school health, the Whole School, Whole Community, Whole Child model, and Bright Futures, and more

10. Identify and work with key community partners that serve Vermont's New American population to identify outreach and engagement strategies to promote messaging around annual well-care visits and other child preventive health measures

11. Promote the PATCH for Teens Toolkit with Health Educators in public schools serving youth.

12. Support Adolescent Medicine Specialist to train and provide TA to youth serving community providers, school-based health educators, and health care practices related to adolescent sexual and reproductive health

13. Revisit our most recently updated sports clearance form and health information to reflect plain language, and be informed by youth which highlights the importance of annual well care visits

14. Leverage newly formed or reinvigorated relationships (established during the COVID-19 pandemic) between medical homes and School Nurses to continue to improve communication, consultation, team-based care, and increase and improve access to preventive services

ESMs	Status
ESM 10.1 - Number of public schools implementing the PATCH for Teens curriculum as part of their Health Education Curriculum	Active

NOMs
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (Vermont) - Adolescent Health - Entry 2

Priority Need

Youth choose healthy behaviors and thrive

SPM

SPM 2 - % of adolescents that feel they matter to people in their community

Objectives

By 2024, increase the number of middle and high schools participating in youth empowerment projects by 50%

By 2024, increase the number of Vermont youth trained on M3 by 50%

By 2024, increase the percent of youth that agree or disagree that in their community they feel they matter to people to 63%

Strategies

1. Continue the highly successful "Getting to Y" program – “Getting to Y” is an opportunity for students to take a lead in bringing meaning to their own YRBS data, and take steps to strengthen their school and community based on their findings by addressing risks and promoting strengths

2. Provide training to school-based youth-adult teams on concrete tools to dispel the common myth that intelligence is fixed and how the brain processes information (Personal Power and Community Connections (P2C2)); schools receive ongoing coaching and support as they implement these training activities

3. Collaborate with VT Afterschool Inc. to support activities that enhance opportunities for positive youth development, leadership and youth voice, and training of afterschool professionals

4. Partner with the Governor’s team and state leadership around the expansion of equitable summer and afterschool opportunities (funded in part by regulated cannabis revenue)

5. Participate in the VT9to26 coalition and look for opportunities to promote MCH priority areas identified by our Adolescent Health Unit

6. Provide leadership to the Youth Systems Advisory Council, a statewide initiative to support collaboration and coordination across youth serving systems.

7. Provide leadership to the Youth Thrive Statewide Implementation Team, and promote Youth Thrive as a key framework to support positive youth development

State Action Plan Table (Vermont) - Adolescent Health - Entry 3

Priority Need

Children live in safe and supported communities

SPM

SPM 4 - Percent of high school students who made a plan to attempt suicide in the past 12 months

Objectives

By 2024, increase the percentage of youth and adults screened for suicidality in the primary care setting by 25%

Strategies

1. Participate on the Vermont Suicide Prevention Coalition and the Vermont Suicide Data Committee
2. In partnership with the Vermont Child Health Improvement Program, collect and report on quality improvement data from pediatric practices on depression screening
3. Promote suicide screening in primary care using the nationally recognized Zero Suicide approach
4. Continue to have MCH and DMH Leadership engaged for the AYA CoIIN for systems improvement in screening youth for depression and other factors that may lead to suicidality
5. Support presence of Umatter Youth and Young Adults Mental Health Wellness Promotion and community Action in 10 schools statewide
6. MCH Injury Prevention Coordinator participates on the VT Child Fatality Review Team and can use the reviews of youth suicide deaths to assess upstream prevention and include in formal recommendations in the annual legislative report
7. Develop a youth suicide prevention plan (as congruent with Title V MCH action planning) within the upcoming VT Injury Prevention plan that is being written using the newly released VT Injury Burden Document
8. Assess and act upon data analyses as produced by VDH injury data staff, NVDRS reporting, and ED-SNSRO surveillance of suicidality in emergency departments
9. Further develop and implement project with VCHIP on provider screening for youth suicide ideation, creating a plan, or suicide attempts
10. Develop working relationship with Department of Mental Health Child Adolescent and Family Unit to coordinate prevention approach with mental health community clinical treatment services. Incorporate stressors on youth from COVID-19

Adolescent Health - Annual Report

Adolescent

Vermont's Title V is closely linked with EPSDT-funded initiatives and efforts to promote the administration of Medicaid and improve health for children and adolescents including connections with Vermont's school health services and their school systems. This partnership allows the advancement of performance measures addressing access to health insurance, medical and dental homes, access to well care visits as recommend by *Bright Futures*, overweight and obesity, injury prevention, child maltreatment, youth empowerment and engagement, and mental health and wellness.

Certain key program elements of EPSDT in Vermont are administered within MCH and coordinate closely under interagency agreements with DCF and VT's Medicaid agency. Services for children (families making up to 312% FPL) include: ensuring all children have health insurance, education on preventive health care/age-appropriate health screening; assistance with scheduling medical/dental/health-related appointments; assistance in locating providers to establish medical and dental homes; information/ referral on health and community services, and targeted follow-up. MCH manages grants to the Vermont chapter of the American Academy of Pediatrics (AAPVT) and the Vermont Academy of Family Physicians (VAFP) to improve population-based health outcomes and access to preventive services for Medicaid-eligible children, youth, and their families. Often, the work done through these grant efforts benefit all children and youth in Vermont. MCH's annual grant to the Vermont Child Health Improvement Program (VCHIP) is designed to improve health outcomes for Medicaid-eligible children and youth (and their families) through population-based child and youth health services research and quality improvement.

MCH works with school personnel to promote the administration of Medicaid for school-aged children and youth through the State's school-based health access program, Medicaid Administrative Claiming, and encourages the use of funds, reimbursed to schools through this program, to be used towards school health-related personnel and population-based health initiatives (through the creation of an Annual Reinvestment Plan). Annual reinvestment planning encourages the use of the Health Department's annual School Nurse Report and Youth Risk Behavior Survey data. Priorities included: school health services and school nurses; school counselors; implementation of the CDC's *Whole School, Whole Community, Whole Child (WSCC)* model; student assistance professionals for substance abuse prevention, screening, and referral; dental hygienists to connect at risk kids with dental services in a dental home and other efforts related to the 802 Smiles Network's different tiers ; establishing, maintaining, and implementing WSCC teams who may work on programs and policies that support health and academic achievement across their local education agency (LEA); purchase and effective utilization of electronic health records for school health services; supporting student-led YRBS analysis program (*Getting to 'Y'* offered by our partners at Up for Learning); Healthy school environment (including school climate and physical environment); tobacco use prevention; and more.

The State School Nurse Consultant (SSNC) is located within the Division of MCH. This role helps to further Title V efforts and promotes the administration of Medicaid while reducing barriers to access and use of services. The SSNC aligns the *Standards of Practice: School Health Services Manual* with current school nursing best practice and concepts of the National Association of School Nurses' *Framework for 21st Century School Nursing Practice* to provide technical assistance on school health services, and related policies and procedures. The SSNC maintains and updates the new school nurse online orientation, which is required by the Agency of Education for school nurse licensing, in collaboration with the School Nurse Advisory Committee. The SSNC is also engaged with the work of the National Association of State School Nurse Consultants, and the Vermont State School Nurses' Association. Additionally, the Health Department received "Public Health Crisis Response" funding which we plan to use towards offering trainings to support school nurse leadership workforce development, & grants to LEAs to support investment & implementation of school nurse leadership vision for selected LEAs.

The SSNC chairs the School Nurse Advisory Committee, whose tasks include continuous improvement and revision of the *Standards of Practice: School Health Services Manual,* the online new school nurse orientation, implementation of the

Essential School Health Services model, and school nurse workforce development Content in the Manual is validated and verified through expert, legal, and MCH leadership review. The work of the School Nurse Advisory Committee guides school nurse practice within Vermont to ensure all school-aged children and youth receive the recommended, age-appropriate care, as described by *Bright Futures,* and that chronic health conditions are managed effectively for the best possible outcomes. The School Nurse Advisory Committee is comprised of school nurses from different locations around the state, the president of the Vermont State School Nurses Association, an appointed professional from the Agency of Education, an APRN that specializes in children and families, and the SSNC. The committee regularly connects with various subject matter experts and leaders in the state to discuss content areas related to their specialty. The School Nurse Advisory Committee continues to look for parent and student input to assist in the development and revision of resources and tools for school nurses throughout the state. We plan to reach out in the future to partners such as Vermont Family Network (VFN) who work with and advocate for families and individuals with special health needs, to assist us with direct family engagement in the development and revision of tools for school nurses.

Over the past year, several MCH staff collaborated, coordinated, and assisted with Vermont State School Nurses' Association sponsored school nurse town hall meetings. These meetings provided opportunities to support school nurses, who were important partners in the COVID-19 pandemic response, by ensuring they had the most current information (even when information changed frequently), respond to their questions and concerns, and gather input for future considerations in the pandemic response and the related materials created in partnership with the Agency of Education, the Department of Children and Families, the Health Department, and others.

The Health Department School Liaisons (Public Health Nurses in each of the 12 Offices of the VDH Offices of Local Health) work with the SSNC, school nurses, and other school staff to assist families in obtaining health insurance and to encourage them to access medical and dental homes for regular preventive care or to address potential special health needs through engagement of our school and community partners (not direct service to the public) using a population-based approach. School Liaisons engage local schools and school personnel (i.e. school nurses and school counselors) to monitor their student and family population for those that are uninsured and connect them with Vermont Health Connect (VT's health insurance exchange) or assistor organizations. School Liaisons often have strong relationships with local primary care providers and can assist with addressing issues that may impact coordination or communication between school nurses and local practices. These relationships were formed, reestablished, enhanced, or reinvigorated during the last year, as schools and providers provided support and leadership locally to further our ongoing efforts at the Health Department and with the Schools and Childcare Branch of our Health Operations Center (HOC) for the pandemic response work.

Due to substantial disruption of in-person school from the COVID-19 pandemic, the Health Department (specifically including members of the MCH division and Health Surveillance), Agency of Education, members of the pediatric infectious disease community, and other State and community partners worked to create evidenced based guidance for the 20-21 and 21-22 school years. MCH leadership and the Schools and Childcare Branch is very proud of our efforts to support access to in-person education for children and youth. MCH's relationship with the provider and education communities facilitated connections which ensured evidence-based guidance was in place so that students could access their education and other needed services best provided in-person. The School Liaisons were in an excellent position to promote vital connections between medical homes and schools to plan for in-person classes in the fall, while supporting a new or reinvigorated interest in the role of the school physician in providing consultation or education for operationalizing local school reopening. The liaison's long history of promoting this type of relationship will continue to be very helpful moving forward. As the impact of COVID-19 cases and information about the virus evolved, MCH served as a key partner to help update school (and out of school time care) guidance. The Schools and Childcare branch helped to clarify guidance, answer tough questions, and connect with Health Department and Agency of Education partners to get clarification or aid in decision making as needed. The Schools and Childcare branch answered calls and emails from the public and other State partners and helped provide clinical guidance and consultation. When a case of COVID-19 impacted a school, we provided guidance and supported outbreak prevention response work. Through targeted, evidence-based work, the Health Department effectively minimized the impact of COVID-19 cases on in-person education (and extracurricular experiences), helped to ensure schools remained open, and minimal transmission of COVID-19 cases in schools.

Schools may choose to use the *Bright Futures* sports clearance well child form which was recently updated but not yet rolled out to schools due to other competing priorities as well as the ongoing impact of COVID-19 on the last two school years. The updated version better highlights the importance of annual well care and provides families with action steps they can take to access well care. Additionally, the Health Department (and Agency of Human Services as a whole) began to increase the emphasis on the use of "plain language" to improve how we message important health related information with the public this year. We would like to review the most current iteration of this document during the next grant period and update it using this plain language lens in partnership with VCHIP and the Primary Care Public Health Integration work group. We plan to work on roll out in the next school year (2022-23).

Supporting youth during the COVID 19 pandemic has been a priority area and elevating youth voice has also been an important part of our work. VT RAYS is a specialty youth group focused on adolescent and young adult public health issues, with a particular interest for improving access and utilization of preventive health services. Under the leadership of the Youth Health Improvement Initiative at the Vermont Child Health Improvement Program (VCHIP), and in partnership with the Health Department, the RAYS have the unique ability to connect with primary care practices throughout Vermont to help identify adolescent health priority areas, increase engagement, and improve quality of youth services. Additionally, VCHIP provides opportunities to bring the youth perspective to other state partners and stakeholders, creating an impact at the policy level. In its current capacity, VCHIP continues to serve as a liaison between youth and the medical community, public health entities, and other state and/or national stakeholders. VCHIP faculty provide content expertise and facilitate integration of youth voice and experience. In an effort to improve sustainability, we have explored opportunities to collaborate with similar youth focused organizations including VT Afterschool. As leaders in facilitating youth groups and youth leadership trainings, VT Afterschool offers an opportunity to strengthen the impact of youth voice and help build youth leadership skills. VT Afterschool, VCHIP and MCH have met several times to discuss this future collaboration. Our collaborative work during the reporting period engaged youth in initiatives that addressed health equity, the impact of COVID 19 on youth, developing youth focused COVID education materials, addressing behavioral needs of youth, providing youth friendly services, and providing culturally responsive care. Additionally, the State Youth Advisory Group met over during the summer of 2021 to address health equity. This group of young people included members of the VT RAYS and the facilitated discussions resulted in the State Youth Advisory Group Health Equity Report. This report has been shared with the medical and public health community and includes youth recommendations for professionals in the field as they consider inequities and barriers to accessing health care, behavioral health care, and after school activities (known as "the third space").
Our partners at VCHIP have been incredibly helpful with supporting a platform to keep primary care providers including pediatricians up to date on COVID-19 related information. Starting at beginning of the pandemic, VCHIP hosts 30-to-45-minute calls 3-4 days a week for providers. Calls were co-led by VCHIP and the MCH Director (who then became our division's medical director) at the Health Department. Attendance frequently reached over 100 providers. This platform has provided a place for increased connectedness between public health and primary care during this crisis. Feedback from providers has frequently informed materials, impacted testing process and procedures, and provided important narrative for what is occurring on the frontlines in relation to the COVID-19 response in healthcare settings. We also see this increased connection as an opportunity to promote the role of the school physician as part of the local level supports needed for schools as they planned how to implement guidance for reopening, and supported efforts to promote the importance of vaccination for eligible youth 12 and over. Providers around the state hosted webinars for youth and families to answer questions about COVID-19 and the vaccine (in collaboration with the VT AAP chapter). We hope these relationships continue long after the pandemic as they are important for our efforts related to supporting the administration of Medicaid at the local level.

VCHIP supports medical homes, stakeholders, and other partners who care for and provide services to adolescent and youth adults through the maintenance of the Adolescent and Young Adult Resources web page. New content is added as relevant topics, resources, or tools are developed or revised.

MCH partnered with VCHIP's, Youth Health Improvement Initiative and the Wisconsin-based, PATCH (Providers and Teens Communicating for Health) program to promote the use of, PATCH for Teens Toolkit. This program provides youth, school

health educators, health-related professionals, youth workers, and other adults the materials and resources needed to teach young people about their rights and responsibilities in health care settings. Learning objectives include: teens will understand the importance of learning to manage their own health care experiences; teens will learn how to advocate for their own health and wellbeing in health care settings; teens will explore steps they can take to make sure they get the care they need and deserve. PATCH materials were purchased but are not yet distributed. Due to competing priorities the last two years, and the end of in person classes during the winter/spring of the 19-20 school key VDH personnel's deployment to support Schools and Childcare Branch HOC pandemic response duties, we have not recruited high school sites to participate in using the curriculum yet. We plan to revisit recruitment in the next school year (2022-23). COVID-19 response and recovery efforts were the main priority during the previous school year.

In addition to improving adolescent well care visits, Vermont aims to promote healthy behaviors among youth through an empowerment model. Vermont MCH joined with other organizations in partnering with UP for Learning who leads teams of school personnel and youth in the *Getting to Y'* program. *Getting to 'Y'* is an opportunity for students to take a lead in bringing meaning to their own Youth Risk Behavior Survey data and taking steps to strengthen their school and community based on their findings by addressing risks and promoting strengths. Following a participatory action research model, teams attend a training day to learn tools and strategies to organize their own retreat to analyze data, producing a "Student Executive Summary." This summary includes priority strengths and areas of concern they identified at their retreat, and a preliminary plan of action, based on an exploration of root causes. Examples of the student's work can be found in the Getting to 'Y' newsletters located here. UP for Learning adapted what was normally a day long in-person training into virtual training ensuring students were still able to access and participate in this important program during the 20/21 school year. Additionally, Getting to 'Y' was added to AMCHP's Innovation Station Evidence Based Best Practice Database last year, and the Health Department will now consider Getting to 'Y' an evidence-based practice. UP for Learning and the Health Department were scheduled to present on this innovative program at last year's AMCHP conference which was delayed due to the pandemic. We did present the same content in August for a virtual version of the conference which was well attended and received. Additionally, UP for Learning youth and adults joined AMCHP as co-presenters at the Adolescent Health Initiative's 2021 Conference on Adolescent Health.

During the planning phase for Vermont's 2020-2024 CDC/RPE grant program, sub-recipient organizations recruited cohorts of youth to partner with organizations in their sexual violence prevention efforts. UP for Learning facilitated an online Youth-Adult Partnership Learning Series to build a foundation of knowledge and skills for these partnerships. UP for Learning is currently facilitating a four-session online planning process where youth-adult teams are working together to learn and plan for the sexual violence prevention efforts the teams will implement during the grant period. Youth co-lead all sessions with staff from Up for Learning.

MCH is also continuing to support Personal Power and Community Connections (P2C2) (formerly known as M3: Mindset, Metacognition and Motivation). The more students know about how they learn and believe in their potential as learners, the more successful they will be. The P2C2 project is a means to these ends. Personal Power & Community Connections guides and empowers youth and adults to create nurturing learning environments. In partnership, participants will explore the skills necessary for personal growth and wellbeing and how to effectively contribute to a healthy and just society by infusing social and emotional strategies with:

- METACOGNITION – how we learn
- MINDSET- beliefs about our ability
- MOTIVATION – level of learning engagement

When youth develop the skills to recognize, understand, and address their own needs, they are better able to take risks as learners, and are more confident in their abilities to contribute to their community. A school culture based on these principles will increase student engagement and self-efficacy, build intrinsic motivation through metacognitive strategies, and foster a growth mindset for both educators and students. Our support of this approach connects work on youth empowerment, in partnership with our Division of Substance Use Programs.

The abrupt ending of in-person education in 19-20 and the ongoing school precautions in 20-21 school years due to the COVID-19 pandemic caused schools to adjust their expectations and outcomes for activities related to these two programs (Getting to Y and P2C2). The UP team rapidly prototyped resources to meet the needs arising in the field. Resources were created with the understanding that they could be used during remote learning and could also be adapted for in-person learning. UP for Learning continued to hold regular meetings with teams using Zoom and Google Meets. UP for Learning adapted and responded to individual teams' needs and designed training and support to meet these needs. A sense of the adaptation and work required during the pandemic can be gleaned in the GTY 2020-2021 Newsletter.

Weekly newsletters have become essential communications for UP during COVID-19. From communicating how we are responding as an organization to sharing resources for engaging youth, we have found that these have been well received from our partners and supporters. Resources from UP have been shared with a larger audience and we are able to provide relevant and engaging resources for our educational community. Resources include:

- UP's Remote Advisory Resource: Structures and Routines for Virtual Advisories
- UP's Ideas to Support Remote Dialogue/Connections/Engagement
- UP and Shelburne Farm's Cultivating Pathways to Sustainability Project-Based Resource for Learnings and Educators to support distance learning.

Over the past several years, MCH has partnered with the Center for Health and Learning to support funding for Umatter for Youth and Young adults. Umatter YYA "is a youth leadership and engagement initiative. The goal is to promote mental health wellness: healthy coping mechanisms among youth and young adults, and the ability to recognize when a peer needs help and how to provide it. The aim is to foster healthy community cultures for youth and young adults that promote mental health and resiliency, and which address issues such as bullying and substance abuse prevention within a continuum for prevention through recovery. *Umatter YYA* is carried out with the support of adult facilitators who work with youth and want support opportunities that teach skills that foster resilience and create norms for self-care and help-seeking in schools and community settings. *Umatter YYA* has a Youth Leadership Council that helps to plan and lead training events and advise on special projects and program design. *Umatter YYA* trains young people on personal skills such as strength and risk assessment, coping and stress management, recognizing warning signs of mental health distress, awareness of the importance of depression screens and well-care visits, and knowing how to get help. These young people become peer leaders and work with other youth to bolster these skills. They work together as a team to plan and implement a Community Action Project (CAP). CHL works with schools and community-based programs to identify young people to participate. Youth Leadership Council members and Adult Facilitators advise on curriculum design and all participants inform evaluation. Due to COVID they made several creative adaptations, including transitioning many of their materials into an online learning format, and offering programming "a la carte", which has led to more options for programming and has increased reach.

The MCH Adolescent Health Unit team did not meet due to staff COVID-19 deployments. We will resume our meetings in the fall 2022 to identify priorities, assess the impact of COVID on our work and identify best next steps for our shared efforts related to adolescent health and wellbeing. A few examples of key topic areas are school health, injury prevention, Youth Thrive, adolescent well care visits, sexual and reproductive health, youth engagement and voice. In the past our unit has sought the expert insight of our partners from the University of Minnesota who is involved with the State Adolescent Health Resource Center and the Adolescent and Young Adult Health National Resource Center. We look forward to reconnecting with these resources in the fall.

During the COVID-19 response this group played an important role in advising the Communications Team on topics related to adolescent health and the pandemic and provided guidance on messaging related to family stressors and coping, child abuse and neglect, domestic violence, mental health and suicide prevention, and health equity.

The Adolescent Health Unit started more intentional outreach to other divisions in the Health Department and to other

departments across the Agency of Human Services. These included to the Department of Mental Health, and Division of Substance Use Programs, and the Division of Health Promotion and Disease Prevention, namely the tobacco prevention team. These partnerships are critical to enhancing the coordination of our adolescent health efforts across our department and agency, especially related to mental health, suicide prevention, youth voice and engagement and substance use prevention. MCH also has representation on a vaping prevention workgroup that was established 2 years ago. While much of this has been paused due to COVID-19, there have still been several opportunities for collaboration related to proposal review processes for regional tobacco control coalitions and supporting linkages to community partners such as Outright VT and VT Afterschool to expand work related to tobacco prevention efforts.

Vermont MCH has actively worked within the realm of injury prevention to reduce Vermont's teen and young adult suicide rate. Analyses by the MCH/CDC Assignee Epidemiologist have enabled Vermont to further understand the influences behind its high suicide rate. MCH provides leadership to the statewide Suicide Prevention Coalition and works specifically with the Center for Health and Learning youth suicide prevention planning. MCH participates on the Suicide Prevention Data Workgroup and has assisted in the preparation of several suicide prevention grant applications. The Health Department and Department of Mental Health have a collaborative planning relationship for suicide prevention. DMH is working with two pilot communities to implement Collaborative Assessment and Management of Suicidality (CAMS) intervention and began planning for the statewide use of the elements in the Zero Suicide model. VDH is participating in the Suicide Prevention Child Safety Learning Collaborative in which Department of Mental Health Crisis Counselors will be supported via QI techniques to screen youth for suicidality. MCH also chairs the Child Fatality Review Team who review all youth suicide deaths in Vermont and make recommendations for systems changes that could prevent suicide deaths among Vermont's youth.

The Division of MCH's Personal Responsibility Education Program (PREP) works with high-risk youth ages 10 – 19 (20 and under if pregnant or parenting) on healthy relationships and life skills in an "upstream" approach to preventing pregnancy or delaying second pregnancies. MCH presently has 6 PREP subrecipients and the program is implemented across community-based youth serving sites, including Parent Child Centers, Boys and Girls Clubs, the Association of Africans Living in Vermont, and others. This work is overseen by the MCH Adolescent Health Program Manager, who also serves on several youth and young adult related statewide initiatives broadly related to youth development, including the *Youth Thrive* Statewide Coordination Team, and co-chairs the *Youth Services Advisory Council (YSAC)*. She is also a trainer in the *Youth Thrive* framework, which grew out of the Center for the Study of Social Policy's development of the Strengthening Families model. Youth Thrive utilizes the most current science on adolescent brain development, trauma, and resilience.

The Adolescent and Reproductive Health Program Director and Adolescent Health Program Manager worked closely with the Agency of Education on an interagency workgroup per the request of the state legislature to improve and standardize sexual health education in Vermont schools. Several meetings were held, two of which included community stakeholders, to gather input to assess the needs and gaps related to sex ed in the state. A series of recommendations were formulated and presented to the legislature and now efforts are under way to implement the recommendations. This work has been somewhat slowed due the state's COVID-19 response efforts, but it is ongoing.

For a fifth year, MCH partnered with Dr. Gibson, a pediatrician and adolescent medicine specialist to provide training and technical assistance to Vermont's PREP program to further enhance the training opportunities for program facilitators who implement evidence-based curriculum. Dr. Gibson has provided a wide variety of trainings to PREP staff over the past years and this work has expanded to include pediatricians, family practice physicians, afterschool staff, and school-based health educators. Trainings have been in person and via webinars on several different topics; Adolescents and LARC, Adolescents and STIs, and Adolescents and Emergency Contraception.
Dr. Gibson has also supported some new work related to eating disorders. Dr. Gibson is the medical director of an adolescent eating disorders clinic at UVMMC and played a key role in help to planning and lead a one-day training on multidisciplinary approaches to eating disorders. The MCH Director of Adolescent and Reproductive Health also served on this planning committee.

The PREP Program Manager/Adolescent Health Program Manager was fully deployed to our Health Operations Center as part of the COVID-19 response in late May of 2020.Duing this time, the Director of Adolescent and Reproductive Health covered many aspects of our MCH work, including PREP. The Adolescent Health Program Manager role as a health equity technical advisor was critical to our state's COVID-19 response, and in this role, she has managed a team of six. This experience has further enhanced future PREP activities. While PREP implementation has been very challenging due to COVID-19, some other work related to sexual health education in our state has been ongoing, with some important successes happening over the past several months.

The Division of Maternal and Child Health continues to collaborate with the Agency of Education, and several community partners through the Sexual Health Education Stakeholders Group on workforce development activities related to improving sexual health education in schools and community-based settings, as well as to support the implementation of the Condom Availability Law and share resources, guidance, and sample templates for procedures that were created to support schools with the implementation of the law. Efforts have included offering a webinar through the Vermont School Nurses Association on the new law and collaborating with community partners to offer educational sessions to Vermont health educators through the VT Higher Education Collaborative on Essential Topics in Sexual Health Education. We also continue to collaborate with Elevatus to support attendance in their 3-day Sexuality Educator training for people who work with people with Intellectual and Development Disabilities. By the end of January 2022 over 50 people had been trained in the Elevatus curriculum through support from the Division of Maternal and Child Health.

The Youth Services Advisory Council (YSAC) promotes shared responsibility across state and community stakeholders for achieving positive outcomes for youth and young adults in Vermont. The YSAC includes representation from the Health Department's Divisions of Maternal and Child Health and Alcohol and Drug Abuse Programs, as well as the Department of Mental Health, Department for Children and Families, Department of Vermont Health Access, Department of Labor, Agency of Education, Vermont Afterschool, and adolescent treatment providers, among others. The Council identified several core outcome measures which include improving health care access and having a medical home; successfully completing high school, preparing adults to work with youth, youth having employment or vocational training, stable housing, and at least one supportive relationship; youth being free from incarceration, and engaged in planning for their future. MCH's Adolescent Health Program Manager previously represented MCH on the Council and now serves as a Co-Chair.

The MCH collaboration with Vermont Afterschool Inc. continues and has expanded. Vermont Afterschool Inc. has a mission to: *support organizations in providing quality afterschool, summer, and expanded learning experiences so that Vermont's children and youth have the opportunities, skills, and resources they need to become healthy, productive members of society.* MCH staff provide guidance on best practice approaches to out of school programming, performance measurement and stakeholder engagement, positive youth development, and communications/messaging.

Vermont Afterschool's work under the CDC-funded Opioid Data to Action funding continues the work of the Youth and Community Health Coordinator and the Youth Voice Coordinator. MCH supports the Youth Voice Project, a data informed, community-led process of recognizing and building upon youth strengths and mitigating risk of substance use disorder and the work of Regional Youth Councils. Work for a Statewide Youth Council continues at the local level through which youth get to design, apply for, and manage their own wellness initiatives in their communities. The MCH Injury and Violence Prevention Program Manager served on a proposal review process led by VT Afterschool to fund summer programming expansion efforts focused on COVID recovery for children and youth. This was the second year these funds were made available for summer matters or all initiatives.

The MCH Adolescent Health Program Manager serves on the VT9to26 Coalition, which is an action-oriented coalition working in partnership to achieve positive outcomes for all youth in Vermont. The focus of this coalition is to ensure that all young people ages 9-26 are safe, healthy, supported, educated, and engaged. VT9to26 is Vermont's youth systems building effort that continues the work of Building Bright Futures and the early childhood system in Vermont for children ages 0-8.

Partnerships

The Primary Care and Public Health Integration meeting, which convenes monthly and includes pediatric, family practice, women's health/adult, and Ob providers is an important partner in identifying innovative strategies to increase access to, utilization of, and quality of adolescent well care; as well as other youth empowerment strategies.

The Vermont Pediatric Council (VPC) is based upon a national model developed by the AAP; its purpose is to foster enhanced communication among pediatricians, insurers, public health professionals and others committed to improving the health status of and health care for Vermont's children. VPC membership includes leaders from the following organizations and agencies: MCH; Vermont chapters of the AAP and the AAFP; the Department of Vermont Health Access (state Medicaid agency) and other Vermont insurers (e.g., Blue Cross Blue Shield of Vermont, CIGNA, MVP); VCHIP; and the Vermont Medical Society.

As described throughout this report, a key partner across all population domains is the Vermont Child Health Improvement Program (VCHIP). VCHIP is a population-based child and adolescent health services research and quality improvement program of the UVM.

In addition, partnerships as outlined above include the Youth Thrive Statewide Coordination Team, the Youth Services Advisory Council, Vermont After School Inc., and the VT 9 to 26 Coalition. Vermont Raise Awareness for Youth Services (VT RAYS) is our youth health advisory council as mentioned in sections above.

Other partners in our adolescent work include: Planned Parenthood of Northern New England, the Vermont Network Against Domestic and Sexual Violence, Outright VT, Vermont Medicaid, the Agency of Education, the Department of Mental Health, Vermont State School Nurses' Association, the Center for Health and Learning, local schools and school boards, and a broad range of youth serving organizations.

Adolescent Health - Application Year

Adolescent

Vermont continues to support a Vermont youth advisory council, VT Raise Awareness for Youth Services (VT RAYS). We will continue to look for opportunities to collaborate with VT RAYS to inform activities related to services or resources for the adolescent and young adult population. Additionally, we plan to work with VCHIP, VT RAYS, and Vermont Afterschool to:

- Build and sustain a combined (VT RAYS-VT Afterschool) youth-led advisory council to address statewide adolescent and young adult health issues, including improving access and utilization of high-quality prevention health services, including behavioral health.
- Expand diversity and membership within combined group
- Support youth leadership positions within the group, including trainings to build skills around youth leadership and/or specific public health priority areas [i.e., youth social emotional wellness].
- Access and utilize data to inform new initiatives, based on youth identified areas of concern
- Support youth lead activities and advise on priority areas that support increased access and utilization of preventive health services for all young people, with a focus on vulnerable and underrepresented youth
- Create opportunities with youth and medical community, public health officials and other stakeholders to share and promote youth voice and experience on COVID recovery efforts

Health Department School Liaisons and Maternal and Child Health Coordinators promote *Bright Futures* 4th edition with school and primary care providers. Liaisons will continue to look for opportunities to promote the concept of annual preventive care for all school-aged students with an emphasis on the adolescent population as measured by our annual School Nurse Report. Additionally, Liaisons will continue to promote strategies with school nurses to increase awareness and promoting annual well care visits (in partnership with VCHIP).

The Health Department will be continue working closely with schools this fall and monitor the current situation and evidence based practice recommendations related to COVID-19 pandemic response and recovery. There will be a strong emphasis on the importance of schools and provider offices strengthening relationships and communication to ensure the best outcomes for students and families. We hope that through these emphasized or renewed partnerships, schools and provider offices will continue to develop, maintain, or improve the way they communicate to ensure students and families are accessing preventive care, addressing chronic illness care, and coordinating on acute needs (like when students present with COVID-19 symptoms, or to promote COVID-19 vaccinations). We are also hoping providers will continue to support local level health related information needs for their communities (e.g. be available to present information or answer questions locally) in alignment with public health messaging. As part of school reopening processes in the fall and ongoing pandemic response and recovery efforts, the Health Department will continue to coordinate and collaborate with the Agency of Education for the 22-23 school year over the summer 2022.

Over the past three years, the VT Dept of Health has engaged in a robust body or work with the Agency of Education and a variety of community partners. As a result of some work with our state legislature, the Agency of Education (AOE) and the Health Department have been working collaboratively to improve sexual health education in Vermont, especially in Vermont schools, and to frame sexual health education within the broader context of comprehensive health and wellness education for sustainability.

A condom availability in schools' law was passed and went into effect on July 1, 2021. The law requires that all secondary schools in the state (grades 7-12) must make condoms available. The Health Dept and AOE will continue to work in conjunction with several community partners to create supportive materials and guidance for schools to help support this implementation.

Before COVID, the Health Department and Agency of Education staff conducted stakeholder meetings and developed state guidance in response to the legislature's request to focus on improving sex ed in schools. This group meets regularly to

review community and PreK-12 sexual health education activities across the state. This workgroup collaborated to develop the following publications:

- Implementing Comprehensive Health Education: Laws and Regulation (1/30/20) Agency of Education Memo, Secretary Daniel French
- Comprehensive Sexual Health Education and Condom Availability Programs (1/30/20) Joint Memo, Agency of Education, Secretary Daniel French and Dr. Mark Levine, Vermont Department of Health
- Sexual Health Education Resource Guide (1/30/20) Joint guidance developed by the Agency of Education and the Vermont Department of Health

The Sexual Health Education Advisory Group includes representation from several organizations that directly provide, or support organizations that provide, sexual health education to their constituents. Members represent AOE, the Health Department, Planned Parenthood of Northern New England (PPNNE), Outright VT, VT Cares, VT Network, PreK – 12 health educators, and a pediatrician who specializes in Adolescent Medicine and sexual and reproductive health. The group is dedicated to identifying priority topics in sexual health education and delivering professional learning and resources that support high-quality sexual health education. Many of these partners have supported PREP programs in a variety of ways over the years via training and TA. The stakeholder group played a central role in helping to develop the Essential Topics guide and developed and provided topical trainings through the VT Higher Education Collaborative. A webinar for school nurses on the condom availability legislation was also conducted by Planned Parenthood, a key member of the stakeholders' group, through the Vermont School Nurses Association.

In 2022-2023 MCH's Adolescent Health Unit will continue to inform the work outlined above. Due to several changes in staff, the adolescent health team will spend time in the fall of 2022 assessing priorities, opportunities for coordination and collaboration, and exploring new work that has arisen as the result of the impacts of COVID. The sexual and reproductive health work will continue, and this work will be further supported and enhanced by VT's participation in the Leadership Exchange for Adolescent Health Promotion (LEAHP). This is a learning collaborative aimed at building state education and health policymakers' capacity to improve sexual health education, sexual health services, and safe and supportive environments in schools. The Vermont LEAHP team includes representation from the Health Department, the Agency of Education, and community partner organizations, such as Planned Parenthood of Northern New England and Outright VT, and school- based health educators. Vermont has been part of the third LEAHP cohort since the spring of 2021. The VT Team has participated in trainings and TA opportunities, as well as action planning.

For a sixth year we are contracting with a pediatrician and adolescent medicine specialist, Dr. Erica Gibson, who has been providing training and TA to our PREP program staff, and the broader sexual health education stakeholder group efforts. This year, Dr. Gibson will also continue to provide training and TA to VT Afterschool Inc. In the plan year efforts will continue to be expanded to help support the professional development of sexual health educators across the state. These include health educators in Vermont's middle and high schools, school nurses, community based sexual health educators, and afterschool professionals. This will include offering professional development opportunities both in person (where possible) and remotely.

Another critical area of work that has emerged and will continue relates to eating disorders. Dr. Gibson is a leader in VT and oversees the Adolescent Eating Disorders Clinic at UVMMC. Early in 2022 MCH staff along with Dr. Gibson served on the planning committee for a one-day multidisciplinary training related to eating disorders. Over 400 people from across the state attended the training. The planning group will continue to meet and will follow-up on key lessons learned as a result of the training in order to identify ongoing supports and training opportunities for health care providers, mental health clinicians, school nurses and others. The MCH Director of Adolescent and Reproductive Health will serve on a legislatively enacted Eating Disorders Working Group tasked with assessing services in Vermont for individuals with eating disorders and making recommendations to the General Assembly on how access to care can be improved, including recommendations for expanding and improving existing services.

MCH will continue to have leadership engaged in various partner initiatives, including co-chairing the *Youth Services Advisory Council (YSAC),* which promotes shared responsibility across state and community stakeholders for achieving positive outcomes for youth and young adults in Vermont; and collaborating with the Agency of Education to conduct an assessment of the current landscape related to sexual health education, and following up on activities that were recommended to the state legislature in January of 2020 for improved standardization of sexual health education.

The Youth Services Advisory Council will play a critical role in ensuring the success of the Statewide Youth Council, which was enacted this past legislative session. With Vermont Afterschool and the Division of Maternal and Child Health, the YSAC will advise on recruitment, application, and training, and convening processes as this group coalesces.

MCH will continue to fund Vermont Afterschool's work around preventing risk behaviors and promoting strengths for youth. Vermont Afterschool will be entering its fifth year of funding from MCH, which continues to support the work of the Youth Voice Coordinator and the Youth and Community Health Coordinator, as well as many elements of the Vermont Youth Project and Youth Councils. VT Afterschool has become a recognized leader in our state for their collaborative work across many priority topics and with many partners, but especially for their commitment to youth voice and the establishment of youth councils. We also are planning to promote collaboration (through this grant relationship with VT Afterschool) between VCHIP's Youth Health Improvement Initiative and VT Afterschool to support the work of the VT RAYS, where VCHIP would continue to provide opportunities to promote youth voice and input with the medical and public health community, and VT Afterschool would support recruitment, logistics, facilitation, administrative oversight and managing youth incentives.

MCH Adolescent Health Program Manager will continue to participate in the Vermont 9to26 Coalition in the year ahead. The focus of this coalition is to ensure that all young people ages 9-26 are safe, healthy, supported, educated, and engaged. MCH staff are able to provide guidance on best practice approaches to out of school programming, performance measurement and stakeholder engagement.

We hope to explore leverage points with Vermont's health reform system given that adolescent well care visits are an ACO measure. Health Department leadership sit on several ACO subcommittees. Vermont MCH has developed supporting materials on *Clinical & Community Strategies to Improve Adolescent Well Care Rates* that have been and will continue to be distributed widely to ACOs and Unified Community Collaboratives.

VDH School Liaisons and the Vermont Child Health Improvement Program (VCHIP) will provide ongoing TA to school nurses to facilitate connections between schools and medical homes. Work will be ongoing to maintain and strengthen partnerships between schools and medical providers locally. These partnerships may continue to address the planning for school response and recovery efforts during the current COVID-19 pandemic, be a local resource for schools for COVID-19 related questions by using the most current public health information, and address acute needs related to chronic health conditions care plans, promote COVID-19 vaccination for eligible youth, or illness that may reflect COVID-19 symptoms.

MCH previously worked with VCHIP through the youth health improvement initiative on finishing an updated sports clearance form that highlights the importance of annual well care. This form had been reviewed by the Vermont chapter of the American Academy of Pediatrics and Vermont Academy of Family Physicians. It was shared with the Vermont Principals Association's Sports Medicine Advisory Council. We planned to roll it out during the previous two school years, but there were some delays, and this activity was later put on hold due to the early closure of schools due to the COVID-19 pandemic. COVID-19 response also took priority during the previous school year. We plan to review the current iteration of this document to update it using this plain language lens to ensure a product that is easily understandable and continues to highlight the importance of an annual well care visit (especially for the adolescent population). We hope to do this in partnership with VCHIP and the Primary Care Public Health Integration work group.

Vermont MCH will continue to participate on the Vermont Suicide Prevention Coalition. Additionally, the Department of Health has increased its capacity to address suicide prevention in Vermont by receiving a comprehensive suicide prevention grant from the CDC. Vermont MCH sits on the advisory committee for this grant as well as the suicide data subcommittee. We

have increased data capacity from the NVDRS (violent death analysis) and the ED-SNSRO (suicide surveillance in emergency departments) grants that is informing our programs. In partnership with the Vermont Child Health Improvement Program (VCHIP), MCH will collect and report on quality improvement data from pediatric practices on depression screening and will promote suicide screening in primary care using the nationally recognized *Zero Suicide* approach. MCH continues to build upon its partnership with DMH by ensuring that leadership from both departments meets bimonthly to support enhanced coordination and collaboration around shared priorities. We are exploring how QI projects can be used to support youth under stress from the significant disruptions of the COVID-19 pandemic. MCH holds a lead role in the VT Child Fatality Review Team and will assist with review of deaths by suicide and formation of relevant recommendations. MCH funds Umatter Youth and Young Adults, a leadership and training program that trains youth on personal skills, coping, and stress management as part of upstream suicide prevention. While this work was somewhat interrupted due to COVID-19, there have also been important developments related to adapting materials for online learning and offering more options which increases the reach of this program.

MCH will continue to identify and work with key community partners that serve Vermont's New American population to identify outreach and engagement strategies to promote messaging around adolescent health issues, such as injury, suicide, well-visits, and other preventive health measures. More specifically as part of the state's COVID-19 response, the MCH Adolescent Health Program Manager was assigned to serve as the Equity Technical Advisor based on her leadership as a member of the Health Department's Health Equity Action Team (HEAT). This role in the Health Operations Center has been critical to identifying needs and gaps related to health equity, and planning activities to respond to and address barriers facing specific populations in our state. The primary role of this position has been to work with a Health Equity and Community Engagement Team to engage partners across the state in targeted educational outreach, prevention and outbreak response plans unique to each setting and population. This work has included, and will continue to focus on New American communities, BIPOC communities and other vulnerable populations. This work has evolved significantly and with the support of a CDC Health Disparities grant the Health Dept has built out a new cross department team dedicated to supporting and advancing health equity. This includes division level Health Equity Team Leads. The former Adolescent Health Program Manager has transitioned into the role of the MCH Health Equity Team Lead. MCH recently hired a new Adolescent Health Program Manager. These two positions will collaborate closely to enhance health equity efforts related to adolescent health.

MCH plans to continue an effort to partner with VCHIP's, Youth Health Improvement Initiative and the Wisconsin-based, PATCH (Providers and Teens Communicating for Health) program to promote the use of, PATCH for Teens Toolkit. This program provides school health educators, health-related professionals, youth workers, and other adults the materials and resources needed to teach young people about their rights and responsibilities in health care settings. Our hope is that this curriculum that can be delivered in a health class will help to empower youth to access their primary care provider and develop skills that will help them to access recommended preventive care and care as needed. Recruitment for this activity was delayed the last three school years. We reconnected with the program in Wisconsin and planned to recruit in the winter/spring of 2019/20. Due to the closure of schools in 2020, this was not accomplished. Additionally, COVID-19 pandemic response efforts continued to take priority over implementation of this program during the previous two school years. The PATCH program had previously confirmed we are still able to access the kits, so we plan to revisit recruitment in the fall/winter after reconnecting with the PATCH Program. We hope to identify schools willing to try this curriculum and report back on reactions. We also plan to share information about PATCH through other electronic communications with schools, and through the Health Department School Liaisons.

MCH will continue to promote healthy behaviors among youth through an empowerment model through promoting of UP for Learning's *Getting to 'Y'* program. *Getting to 'Y'* is an opportunity for students to take a lead in bringing meaning to their own Youth Risk Behavior Survey data and taking steps to strengthen their school and community based on their findings by addressing risks and promoting strengths. MCH is also continuing to support, Personal Power and Community Connections described elsewhere in the report. UP for Learning is planning to adjust program delivery strategies as needed relative to public and school health needs during the next school year. P2C2 (formerly M3) has been continuously improved and adapted to have a deep and more sustained impact by consistently refining it to be more relevant, engaging, and

responsive. For the coming year, the P2C2 concepts will move out of a siloed P2C2 program to be integrated into all of UP's youth empowerment programs to fully align with the Whole School/Whole Community/Whole Child national initiative, which takes a holistic approach to the well-being of children and their community. All GTY and P2C2 resources and materials are adapted for remote, hybrid, or in-person educational settings.

MCH plans to continue its work to engage providers and school partners regarding school-based health centers (SBHC). MCH will continue to identify its roll regarding providing infrastructure and convening support to school-based health centers. We will continue to attempt to complete & build upon our assessment of SBHC across the state, examine opportunities to establish connections to primary care medical homes, and opportunities for common indicators and measures across centers. MCH has reached out to existing SBHCs to form what we're calling, Vermont's SBHC Peer Collaborative. We plan to build upon information gathered during collaborative calls to help direct the future of our MCH support related to this work. We will use these opportunities to highlight MCH Title V and EPSDT priorities and explore opportunities to encourage participants to consider objectives and measures that align with MCH priorities (such as adolescent well care). Additionally, we will continue to explore opportunities to engage the School Based Health Alliance, and continue to use this national resource to learn more about SBHCs and begin to network with national partners and build relationships for possible technical assistance and resource sharing. One of Vermont's adolescent health leaders was invited to participate in the School Based Health Alliance State Leader's monthly call, an opportunity to hear about issues happening nationally, and opportunities to learn from this leadership community and share resources. Thanks to steps taken over the last two years to implement telemedicine opportunities in primary care (during the pandemic), we are interested in exploring what types of school linkages could be continued, made, or sustained to continue to increase access and connection to primary care in the school setting. MCH will be partnering with the Youth Health Improvement Initiative at VCHIP to continue develop and implement an assessment tool for our existing SBHCs, identify common assessment measures of SBHC implementation and desired outcomes, consider training and development opportunities with SBHCs, and gather youth perspectives on SBHCs. YHII will be continue supporting surveying of our SBHC peer collaborative members. They will then be sharing findings with MCH and other stakeholders when available. Competing priorities for schools and providers at these sites has impacted participating in surveying opportunities, but we plan to continue to our assessment and identify new partners as more schools consider SBHC's. MCH also partners with the Office of Oral Health at the Health Department in relation to their 802 Smiles program which supports school-based oral health access.

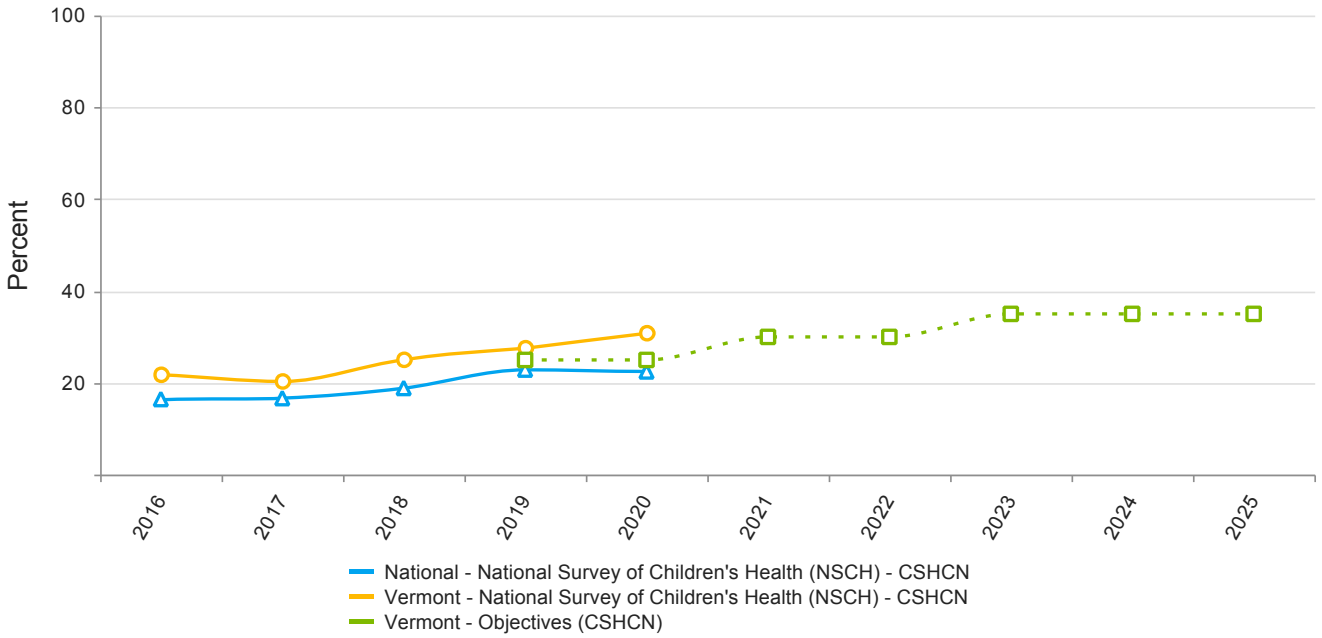
MCH will continue to fund travel and work stipends for school nurse's participating in Vermont's School Nurse Advisory Committee. The primary role of the School Nurse Advisory Committee is to review and update the *Standard of Practice: School Health Services Manual*, maintain and update the new school nurse orientation, and to strengthen the school nurse workforce development. In the upcoming year, the State School Nurse Consultant and the School Nurse Advisory Committee plan to revise the format of the Stands of Practice: School Health Services Manual and create documents that support student, family, and school community physical and mental health and resilience during and after the COVID-19 pandemic. The SSNC and the School Nurse Advisory Committee will also evaluate and revise the current new school nurse orientation content, and potentially create continued training and support opportunities for school nurses statewide. The SSNC will also be working with a vendor to support School Nurse Leadership training & and LEA grantees who will receive CDC Public Health Crisis Response funding through the Health Department to support implementation of their School Nurse leadership vision.

Please note: Only those strategies that link with national and state performance measures are identified in the Action Plan Table for this section.

Children with Special Health Care Needs

National Performance Measures

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care
Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			25	25	30
Annual Indicator	21.8	20.4	25.1	27.6	30.8
Numerator	2,189	1,808	2,162	3,016	3,811
Denominator	10,050	8,853	8,632	10,947	12,391
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	30.0	35.0	35.0	35.0

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - % of CYSHN that have had a transition planning meeting by their 18th birthday

Measure Status:	Inactive - Replaced				
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			30	50	70
Annual Indicator			38	38	38
Numerator					
Denominator					
Data Source			Program Data	Program Data	Program Data
Data Source Year			2019	2019	2019
Provisional or Final ?			Final	Final	Provisional

ESM 12.2 - # of families, transition-aged youth, and providers who participated in transition-focused trainings using established/high-quality/best- practice transition resources

Measure Status:	Active		
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	175.0	175.0	175.0

State Action Plan Table

State Action Plan Table (Vermont) - Children with Special Health Care Needs - Entry 1

Priority Need

Achieve a comprehensive, coordinated, and integrated state and community system of services for children

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Objectives

Increase by 20% the percentage of children and youth with special health care needs receiving coordinated care

By 2024, increase by 20% the percentage of primary care practices that use the comprehensive, universal plan of care to share information and coordinate care with specialists and the entire care team

By 2024, increase by 20% the percentage of primary care providers with proficiency to facilitate transitions from pediatric to adult care

Strategies

1. Lead efforts to improve and align delivery of care coordination for CYSHN in an evolving landscape with multiple sources of care coordination exist. Includes widespread stakeholder involvement, systems assessments, and presentation of findings to partners including leadership in VT Medicaid, OneCare VT, the Blueprint for Health.

2. Strengthen statewide efforts to improve collaborative approach to transitions through partnership with HireAbility VT, Vermont Family Network, and education partners. Includes supporting Transition Core Teams as well as organizing and funding trainings, conferences, and youth engagement activities, including a youth summit.

3. Expand use of homegrown Family Engagement toolkit to create authentic family partnerships with our programs to inform our work.

4. Partner with advocacy organizations and other state programs to address workforce issues, including the availability of nurses for technology dependent/medically complex and palliative care children, and direct care providers such as Personal Care Attendants. Includes working with Vermont Medicaid to implement innovative payment models and to identify policy opportunities, as well as work with various state partners to identify infrastructure investment opportunities, such as for workforce recruitment, retention, and training programs.

5. CSHN will maintain leadership role in new statewide Care Coordination Collaborative. Work will build on established relationships with medical homes, specialty clinics, hospitals, human services agencies, home health, early childhood providers, and families, to identify shared priority areas and promote high-quality service models, and shared improvement and evaluation strategies. CSHN will adapt and expand resources with consideration for regional differences, including rurality, cultural and linguistic differences, and other social determinants of health.

6. In consultative model with minimal instances of direct service care coordination, CSHN will provide resources, referrals, and provider education concerning the CYSCHN population, focused on anticipatory planning for adolescents: a) Collaboration with the Blueprint for Health (Vermont's medical home/ health reform initiative) to enhance care coordination in primary care; b) Represent CYSHN on regional Transition Core Teams that specialize in supporting youth in the area prepare and transition into adulthood; c) Provide leadership to Vermont pediatric practices through a care collaborative and train on strategies and tools for comprehensive and integrated care planning – using best practice; d) Promote the use of Bright Futures as Vermont's EPSDT periodicity schedule; e) Integrate use of new database and begin to map out reporting capabilities for a future release

7. Fund Vermont Family Network (VFN) to take the lead in the development and implementation of a multi-part webinar series addressing state-specific transition supports

8. Participate in division-wide assessment of cultural and linguistic competency and implement improvement recommendations.

ESMs	Status
ESM 12.1 - % of CYSHN that have had a transition planning meeting by their 18th birthday	Inactive
ESM 12.2 - # of families, transition-aged youth, and providers who participated in transition-focused trainings using established/high-quality/best- practice transition resources	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Report: CSHN

Even more so than the previous grant year, the majority of CSHN staff were deployed full time to the Health Department's COVID-19 response team over the course of this reporting period. Similarly, a small team continued with key program functions, focused on maintaining essential support services such as eligibility reviews and service authorizations, newborn screening functions, and consultation/technical assistance to families and providers. While many of the projects and collaborations directed/supported by CSHN continued, the impact of the pandemic and the Health Department's COVID-19 response on our overall capacity was undeniably significant.

The CSHN staff deployed to the COVID-19 response applied their expertise with family-centered care coordination, pediatric nursing, and systems-thinking in support of Vermonters experiencing the myriad hardships of the pandemic. In several cases, CSHN staff assumed leadership roles in the department's COVID-19 response, operating in an Incident Command Structure during long stretches of case surges, often 7-days a week, across the entirety of this reporting period. Several CSHN staff were core members of the case investigation/contact tracing unit; others led the development of a care coordination model implemented to assist Vermonters in isolation/quarantine with access to essential resources, such as food, financial assistance, and various non-COVID support services.

Operating within the restricted capacity of staff deployments, Vermont's CSHN program continued to shift towards population-based approaches, focused on systems and infrastructure development, while supporting and supplementing the direct care coordination needs of children with special healthcare needs and their families. In regions where there are gaps in the system of care, CSHN maintains direct engagement with certain children and families. The network of services we oversee supports children and youth from infancy into adulthood. Our relationship-building and partnerships with medical homes, pediatrician's offices, and specialty clinics across the state allow us to focus staffing resources on the most medically fragile children in the state.

CSHN consistently leverages its position within the State of Vermont's Agency of Human Services, as well as within the larger system of care, to collaborate with human services agencies (mental health and developmental services), Children's Integrated Services and Early Intervention providers, regional hospitals, larger health networks, the state's Accountable Care Organization (OneCare VT), and the home health system. Additionally, both the Newborn Screening and Early Hearing Detection and Intervention programs are housed within CSHN and are discussed elsewhere in this report. These programs highlight CSHN and the Maternal Child Health Division's commitment to the full life course supports.

Through an intergovernmental agreement with the Department for Vermont Health Access (i.e. Vermont's Medicaid entity), CSHN administers the state's Children's Personal Care Services (CPCS) benefit, the Pediatric High-Tech Nursing (HTN) Program, and the Pediatric Palliative Care Program (PPCP). This arrangement allows CSHN to make policy recommendations that balance Medicaid regulatory requirements with population health needs gathered through qualitative and quantitative methods. Efforts to de-silo and align work both within state government and across community partners are ongoing. Combined, these programs serve over 1200 children and families per year.

CSHN has long been committed to the nutritional health of Vermont's CYSCHN population. The current reporting period includes the first full year after payments for nutrition services were transitioned from the CSHN program at VDH, to Vermont Medicaid and private insurers. Nutritional services for Vermont's CYSHCN population are medically necessary and fit within the scope of the Medicaid Act and fall under the EPSDT statute. Registered dietitians were an existing Medicaid provider type and the code and fee structure were already established. The transition was seamless, thanks to years of establishing a strong understanding within Medicaid about EPSDT.

The Registered Dietitians partnered with CSHN provide an array of essential services to CYSHCN, both directly and in consultative models. Participation on care teams and in care conferences supports the delivery of comprehensive family-centered care. Further, all dieticians or care teams providing services for CYSHCN have access to consultation and

technical assistance through two Registered Dietitians under direct contract with CSHN. These partners have training and expertise in addressing the nutritional and dietetic needs of children and youth with a variety of diagnoses, including those with complex medical conditions and developmental delays. Through consultation and technical assistance, they promote best practice techniques and help sustain up-to-date subject-matter expertise across a wide network. While being forced to develop approaches to this work via online platforms has opened new opportunities for collaboration with certain partners, the team noted some challenges engaging directly with families.

From October 2020 to September 2021, 107 children, birth to 21 years old, received services provided by this network of registered dietitians. Of the 107 children, 93% had Medicaid coverage (85% of the total had Medicaid as primary; 4% had Medicaid as secondary). For children and families who encounter difficulty accessing nutrition services, CSHN will provide financial technical assistance, including referrals to a medical necessity supplemental fund, to bridge access to services until adequate insurance coverage can be established. Every Registered Dietitian who had previously been contracted with CSHN was successfully enrolled as a Medicaid provider in advance of the transition. In the first 6-mo reporting period since the transition, 171 separate direct service contacts were billed to Medicaid. In the final quarter of this grant reporting period (7/1/21 – 9/30/21), 39 hours of technical assistance was provided to providers and teams. Longitudinal tracking of service provision in this payment model, combined with qualitative reporting, will enable ongoing assessment of the impact on Vermont's CYSCHN population.

The CSHN program continued to support changes in the care coordination system for CYSCHN, albeit in a limited capacity due to staff time commitments with the COVID-19 response. Previously established partnerships with various state entities, as well as medical homes, the Blueprint for Health, and the state's sole Accountable Care Organization (OneCare VT), allowed this work to continue towards the goal of supporting families and their children's service providers in the coordination of family-centered care. This groundwork meant that efforts continued throughout the reporting period, while relying less and less on the direct service of CSHN staff, fee-for-service financial assistance, or State-run condition-specific clinics.

Previous block grant reports described efforts to both increase access to care coordination and to streamline care coordination for families connected with multiple care coordination providers (i.e. mental health, behavioral health, developmental services, specialty care clinics, primary care, etc.). Stakeholder input, especially feedback received from families, facilitated by CSHN's Family Engagement Coordinator, showed these circumstances to be burdensome and chaotic, not to mention counter the trifold aim of high-quality care coordination (viz., improved family experience, improved health outcomes, and reduced costs). By leveraging increasing pediatric ACO attribution and establishing a payment structure in support of a "lead care coordinator," CYSCHN families should be able to access supports from the single care coordination entity of their preference. National best practice standards for care coordination are reflected in the ACO's model, as well as consideration for the generalizable skillset needed to provide high quality coordination across diverse patient populations. CSHN continued to assist with these efforts, for example by embedding social work staff within medical homes to test the viability of this model within a fully staffed practice. Early impressions were positive. However, even as providers attempt to increase staffing to meet patient and family care coordination needs, workforce challenges related to the pandemic, ongoing shifts in the care coordination landscape, and the heterogenous nature of this landscape, mean that comprehensive systems change continues to be a work in progress. Integrating various Electronic Medical Records systems in support of shared plans of care is one example of an evidence-based care coordination strategy that remains elusive.

As part of CSHN's partnership with the Children's Chronic Care Initiative (CCCI) through the VCHIP grant, efforts are underway to build upon previous care coordination improvement projects. The CCCI team has conceptualized an approach that brings together healthcare professionals, organizations, patients, families, and other stakeholders, to develop a shared vision for further aligning care coordination services across the aforementioned heterogenous field. This project is informed by the findings of a family survey and focus group series, conducted by CSHN's Family Engagement Coordinator in 2019-2020. The CCCI team identified the Pediatric Medical Complexity Algorithm, the Rural Policy Research Institute's "Care Coordination: A Self-Assessment for Rural Health Providers and Organizations," and the Institute for Healthcare

Improvement's Compass Assessment Tool, as standardized metrics to evaluate the project.

Home-based nursing services for children with considerable medical complexity and fragility continues to be a priority area for CSHN, our AHS partners, and multiple stakeholders in Vermont. Previous improvements in high-tech nursing utilization percentages (nursing hours authorized as medically necessary/nursing hours provided) have since stalled, especially with the onset of the COVID-19 pandemic. This reporting cycle saw development of an innovative payment model, which blends a typical fee-for-service approach with a special monthly payment based on a percentage of the child's monthly allocation of nursing hours. This model was created by the Payment Reform team at DVHA, as part of a collaborative endeavor with CSHN, and adult High-Tech Nursing Program at the Department for Disabilities, Aging, and Independent Living (DAIL). Stakeholder input from family and legal advocates, as well as the statewide network of home health agencies, is reflected in the payment model. It will go-live 1/1/2022.

CSHN leadership participated with cross-agency partners to identify priority investment areas for the enhanced Home and Community Based Services (HCBS) FMAP funding made available to states. This was an opportunity to consider the CYSCHN population's needs, beyond the CSHN program's immediate sphere of influence and offer input into how to commit this one-time funding to projects and opportunities to sustainably strengthen our services across many populations and age ranges. Our longstanding partnerships with other AHS departments and programs was reflected in the thematic alignment with proposals, especially related to workforce development and retention. Additionally, the Pediatric Palliative Care Program secured funding to provide the home health agencies who deliver services with goods and materials for "comfort carts." These are items not otherwise obtainable within the program's payment model that will enhance the quality of palliative care service provided.

CSHN continues to leverage special Medicaid waiver authorities to administer the Children's Personal Care Services program with the utmost flexibility and responsiveness towards participant needs during the COVID-19 public health emergency. Key program modifications were made so that new applications receive a comprehensive review, as well as to minimize service disruptions for families actively enrolled based on a previous eligibility determination. Most significantly, the program continued to offer the special "COVID Payments" to parents and legally responsible caregivers. To date, over 700 individual parents and primary caregivers have opted to access payments for providing medically necessary personal care services to their child in the absence of a Personal Care Attendant. In January 2021, CSHN began work with Medicaid Policy on a proposal to allow parent payments on a permanent basis, beyond the end of the Public Health Emergency COVID-19 waivers. This will amount to a paradigmatic change in program operations, as well as an opportunity to address the disproportionate financial hardship experienced by CYSCHN families, who often rely on unpaid family caregivers. CSHN anticipates a robust stakeholder engagement process to operationalize this option in a way that balances family-centered service with Medicaid regulations.

MCH/CSHN continued its contract with a Family Engagement Coordinator and built upon a division-wide assessment to understand the current state of family engagement and identify opportunities for new or further engagement. These preliminary efforts led to the creation and implementation of a Family Engagement Toolkit, which is now in use by programs across MCH to engage family partners in all aspects of work moving forward. Within the division, the WIC program and the Early Hearing Detection and Intervention (EHDI) program are earlier adopters of this practice. Finally, as mentioned above, the Family Engagement Coordinator's efforts have been instrumental planning the next phase of care coordination systems work by identifying and engaging family partners.

Best practice approaches to support transitions for CYSHCN into adulthood health care systems continues to be a priority area and has been identified as one of Vermont's NPMs. Through the VCHIP grant, our partners in the Children's Chronic Care Initiative (CCCI) have led quality improvement initiatives to improve successful transitions from pediatric care to adult focused care in engaged specialty care and primary care practices [Pediatric and Adult Rheumatology, Pediatric and Adult Endocrinology, Pediatric and Adult Pulmonology, pediatric primary care site, Family Medicine site]. Collaborative work has focused on strengthening partnerships between pediatric and adult care teams to facilitate positive patient and family experiences throughout the transition journey, including transition preparation, planning, transfer of care, and integration to

adult focused care. Through continued engagement with recruited pediatric and adult specialty and primary care practices, VCHIP continues to provide quality improvement coaching to support clinical teams as they implement the Six Core Elements of Got Transitions, a nationally recognized, evidenced based framework for supporting successful transitions.

Other efforts to support Transitions to Adulthood have included statewide engagement in the regional Transition Teams. Based out of the HireAbility (formerly VocRehab) division of the Department of Disabilities, Aging, and Independent Living (DAIL), these transitions teams have historically focused on education and employment. With the integration of CSHN as a regular partner at the regional and leadership level, there's been opportunity to grow necessary transition planning more holistically, while de-duplicating efforts that may be happening within the Medical Home. There is now an annual statewide transition summit for each regional team to attend together for the purposes of learning and improvement, and youth engagement has been such a priority area, that this year a Youth Summit specific to transition was planned and lead by and for transitioning youth.

CSHN continues to partner with the VT Family Network (VFN) to support families of CYSHN. VFN offers an array of services and resources, often provided by individuals with lived experience in a family-to-family model. Through a combination of informational and educational materials, a telephonic support line, parent support groups, "SibShops" for siblings of CYSHN, and training and educational events, VFN maintains an important presence across the state. Their Family Leadership Series seeks to empower families and caregivers to engage in system of care improvement projects. They facilitate family engagement with the Medicaid Exchange Advisory Committee and the interagency Autism Work Group. Annual VFN conferences continue to bring several hundred VT families, providers, and policy makers together, although the pandemic has created challenges and opportunities to convene such events.

Using Title V funding, CSHN provides a small grant to VFN to provide oversight and administration of the Supplemental Assistance Fund; awards are made to families when there are no other financing options. In addition, small allocations for respite care are made to families based on need, as determined by CSHN policy. Starting in July 2021, CSHN shifted additional oversight and administrative duties of these respite funds to VFN, to be integrated with the Supplemental Assistance funding stream, so that families can access supports in a more holistic model that better meets their overall needs. Over the course of the COVID-19 Public Health Emergency, CSHN and VFN have partnered closely to bring information to families about changes in service models and regulations, related to the pandemic. Examples include townhall-style forums and leveraging of VFN's social media presence to distribute materials. We expect this will continue throughout the pandemic response.

VT is committed to cultural sensitivity and outreach strategies to New American, non-English speaking, and immigrant communities. CSHN continues to include measures in our annual grant to the VT Family Network to focus efforts with their VT Leadership Series towards the goal of growing and sustaining a strong group of passionate family leaders from these communities. The Leadership Series trainee groups continue to be culturally, linguistically, and geographically diverse, rich in perspective and knowledge, supported by a grant performance measure demonstrating at least 10% racially diverse participants.

Vermont's Birth Information Network was established by enabling legislation in 2002 and began with births occurring in 2006. CSHN continues to work closely with Division of Health Statistics and Informatics to follow up with families whose newborns have been born with any of the more than 40 specified health or developmental needs, contacting every identified family, ensuring connection to services and coordination.

For many years, CSHN has been the recipient of two newborn hearing screening grants, an MCHB EHDI grant, and a CDC EHDI cooperative agreement. These funding streams support the stability, quality, and effectiveness of the VT EHDI system, including universal in-hospital newborn hearing screening; universal outpatient follow-up through the hospitals for babies who were missed or need a repeat screen; accessible, in-state, non-sedated auditory brainstem response (ABR) for diagnosis of infants by the age of 3 months; mutual cross-border collaboration with EHDI programs in neighboring states; individual case management to assure completion of screening, diagnosis, and entry into early intervention; integration of

EHDI program management and processes with Newborn Bloodspot Screening through their co-location in CSHN; and, electronic data integration through the VT Child Health Profile—accessible to Medical Homes. In addition, an expanding number of medical homes are now providing in-office Otoacoustic Emissions (OAE) screenings, with training and instruments provided by the EHDI team. Lay midwife practices have also received placement of and training in the use of OAE screening instruments; lay midwife practices deliver most of the about 200 VT babies born at home who previously did not receive hearing screening as newborns. As these non-hospital providers screen babies and children, the screening results are recorded in the statewide Child Health Profile, along with the data from birth hospitals.

During this reporting period, CSHN's key partners with EHDI grants presented at a CDC sponsored meeting and the National EHDI meeting, titled "Partnering with Primary Care Providers and Midwives to Provide Newborn Hearing Screening and Re-Screening during COVID-19." Most importantly, VTEHDI's established partnerships with primary care providers and home birth midwives were instrumental in ensuring hearing screenings and outpatient re-screenings for newborns from the onset of the COVID-19 Public Health Emergency, as well as during the ransomware cyberattack suffered by the University of Vermont Medical Center.

Previous grant reports have described the multi-year process undertaken to transition the functions of VDH's Child Development Clinic to UVMMC. The process was highly collaborative, including the recruitment of a Developmental-Behavioral pediatrician, establishing a unified point of referral, triaging the intake process and integrating with the Title V/Medicaid-funded UVM Autism Assessment Clinic (AAC) in the Division of Child Psychiatry-Vermont Center for Children, Youth and Families (VCCYF), and attributing adequate staff time and expertise to provide management and care coordination to referred families. Since the onset of the pandemic, no additional referrals for the CDC have been accepted and only a "tail" of families that were already enrolled prior to March 2020 will receive assessments through the older model. At the onset of this grant reporting cycle, discussions are underway to address wait times for assessments through the UVMMC Developmental-Behavioral Pediatrics and VCCYF clinics. CSHN's longstanding participation with the interagency Autism Workgroup - comprised of state staff, families, and providers - means we are well positioned to influence and support various efforts related to screening, treatment, and support needs for children with developmental concerns.

CSHN continues to participate in the leadership of re-invigorating efforts towards improving the system of care for children with ASD (autism spectrum disorder) and other developmental disabilities. Although VT continues to improve in our screening and evaluation of children at risk, like many states, we are experiencing a lack of access and capacity in treatment services. In response, the state's Integrating Family Services leadership, in partnership with Children's Disability Services and CSHN, continues to energize the VT Autism Workgroup, comprised of a multidisciplinary cross-section of stakeholders from across the state, including parents of children with ASD. The group is revising the State Autism Plan.

Partnerships

As described above, the Vermont's CSHN program works in concert with a number of other state and community partners, including: VT Family Network; VT Federation for Families; Children's Integrated Services/Early Intervention; UVM Medical Center and VT Children's Hospital; children's divisions within the Departments of Mental Health (DMH), Children and Families (DCF), and Disabilities, Aging and Independent Living (DAIL); Agency of Education; VT Child Health Improvement Program, VT Leadership Education in Neurodevelopmental Disabilities, the VT Chapters of the American Academy of Pediatrics and Family Medicine. CSHN actively participates on the Medicaid Advisory Committee and adds an important voice for children with complex medical needs that must be fully understood when making insurance policies within the changing landscape of health care reform.

Children with Special Health Care Needs - Application Year

Action Plan: CSHN

CSHN is engaged in an array of ongoing projects and new initiatives. With the return of all CSHN staff to typical job duties following lengthy deployments to VDH's COVID-19 response, much of our work is aimed at reinvigorating areas of the system of care hit hardest by the pandemic, as well as the programs and services we directly oversee.

At the organizational level, CSHN is restructuring the medical social worker role into a more population- and systems-oriented model for supporting CYSCHN in Vermont. This shift builds upon several years of work prior to the COVID pandemic, including a series of stakeholder engagement projects where families and providers contributed significant input to identify areas of opportunity for improving the care coordination system in Vermont. Planning for this restructuring takes into account several key factors and trends in Vermont: increased availability of care coordination through medical homes and specialty clinics; increased ACO attribution (OneCare VT) for CYSCHN; the transition of all state-run specialty clinics to UVMMC; telehealth and communications strategies developed during the COVID response that support broader outreach efforts.

The CSHN team has worked since early 2022 to develop a "Care Consultation and Systems Health" model that blends macro-social work, episodic and consultative care coordination, and financial/technical assistance tools. In this model, individual family contacts and outreach to/from providers are documented and categorized in a centralized tracking system, and trends are reviewed against regional needs assessments to identify barriers, gaps, and improvement opportunities. The CSHN Care Consultant is intended to be positioned further "upstream" than the medical social worker role and will represent CSHN in a leadership capacity on statewide committees and workgroups. Finally, the Care Consultation and Systems Health model further integrates CSHN's financial technical assistance and training specialist to develop and disseminate educational resources based on population and provider needs.

A core aim of the Care Consultation and Systems Health model is to be flexible and responsive to changes in the system of care. The aforementioned increase in care coordination providers and funding available through the ACO have the potential to muddy the waters for families who have consistently expressed the need for a lead coordinator and clear roles on their care teams. Further, the seismic impact of the pandemic on the healthcare system continues to be felt, requiring projects in the works prior to COVID to adjust to the new normal.

In partnership with VCHIP, CSHN convened a broad, high-level group of stakeholders, including families, OneCare VT, UVMMC's Children's Specialty Center, the Vermont Family Network, and care coordinators from human services agencies and medical homes/primary care practices. The "Care Coordination Collaborative" intends to assess the landscape of care coordination for CYSHCN in Vermont, partner with stakeholders to gain consensus on priority areas, support shared learning and identify improvement strategies, and establish evaluation and measurements strategies. An initial two meeting summit series was held in March 2022, with follow up meetings in April and June. Based on an analysis of the input to date, the VCHIP team is working to implement and standardize Shared Plans of Care, as well as to present key findings to senior leadership at large organizations (OneCare VT, the Blueprint for Health, the UVM Health Network, and Vermont Medicaid). Going forward, as the VCHIP team reports on progress with implementation efforts and data from evaluation metrics, CSHN's Care Consultation and Systems Health team will disseminate project materials more broadly across the state, adapted according to different regional and sub-population needs.

In recent months, long-term work to transition CSHN's Child Development Clinic to our partners at UVMMC officially concluded. The CDC was the last remaining direct service clinic and was the most complex to transition, requiring a lengthy recruitment process for a Development-Behavioral Pediatrician and meticulous planning across multiple stakeholders. Now that the UVMMC clinic is fully operational, CSHN is working to reduce wait times and expand the system's overall capacity for developmental assessments through models that leverage partnerships with primary care practices and Early Childhood/Part C providers within the Children's Integrated Services network. To conduct this work, CSHN convened a

workgroup with representatives from other Agency of Human Services departments, solicited input from UVMMC clinicians and the interagency Autism Workgroup, and engaged a VCHIP project lead with connections to the Vermont Chapter of the American Academy of Pediatrics. Details for piloting a new assessment model are underway, with a planned January 2023 start date.

Parallel to this project, CSHN's Care Consultation and Systems Health team is developing an infographic and FAQ to assist families who are waiting for a development assessment. These resources have undergone extensive review by stakeholders and serve to communicate important information about the array supports available to children, even prior to receiving an official developmental or autism spectrum diagnosis.

Through our administration and oversight of three Vermont Medicaid programs, CSHN is working to leverage one-time investment opportunities and new policy opportunities to better serve CYSHCN and their families. For the Pediatric Palliative Care Program (PPCP), enhanced FMAP funds were earmarked to purchase goods and supplies for the home health agencies who deliver this suite of services. These supplies are not otherwise covered by the program's payment structure and will be used directly with the children and families enrolled to deepen the impact of palliative supports they receive. For over two years, the Pediatric High-Technology Nursing program (HTN) has been engaged in a project with Vermont Medicaid's payment reform team towards the goal of increasing service utilization rates for eligible members. HTN services are essential for keeping the most medically fragile children in the state at home with their families. Looking ahead, in addition to assessing the first full year of the new hybrid payment model implemented in January 2022, the project team will access enhanced FMAP funds to trial a value-based payment component as another pro-active measure to increase service provision to HTN families.

Children's Personal Care Services (CPCS) is the largest Medicaid program CSHN oversees. Since the beginning of the COVID-19 Public Health Emergency, CPCS has operated under temporary waiver authority to allow parents and legally responsible caregivers to be paid for providing personal care to their eligible child. Based on family input received throughout the pandemic, CSHN partnered with Vermont Medicaid to make this payment option permanent, as part of Vermont's recent Global Commitment to Health renewal. In the spring, CSHN conducted a comprehensive survey to obtain additional input on the impact of this payment option and set a baseline to monitor family experience going forward. Work is underway to develop policy/rule and additional guidance for parents who will access this option when there are barriers to receiving personal care services from an attendant hired by the family, as the typical service model intends. We anticipate several additional rounds of family and stakeholder engagement going forward.

CPCS is an EPSDT covered service; opening a parent/caregiver payment option removes a barrier to accessing the service, while simultaneously addressing the disproportionate financial hardship and unpaid family caregiving experienced by CYSCHN. At the same time, the intent of CPCS is for families to receive supplemental support with their child's needs, and the impact of the pandemic on the healthcare workforce has been significant. To this end, CSHN continues to participate on the interagency HCBS FMAP workgroup to inform ongoing spending and implementation planning. One early initiative pertains to workforce retention and recruitment strategies, focused on direct care providers, such as PCAs. CSHN will continue to use Title V funding to support family leadership and engagement programming. This will primarily occur through our sub-recipient partnership with the Vermont Family Network (VFN; one of Vermont's Family Voices/F2F organizations). VFN organizes a family leadership series, maintains a family support team, administers a supplemental assistance fund including an option for respite, hosts SibShops, and hosts an annual conference. Building on updates to the VFN grant last year, there are increased expectations to reflect racial, ethnic, and geographic diversity in their outreach efforts, as well as measures to ensure all of their programs, activities, and materials are accessible to those who are of limited English proficiency or non-English speaking.

Throughout the majority of the last grant cycle, MCH/CSHN contracted with the parent of a child with a special health need, who has professional expertise in the field, to coordinate programmatic and divisional family engagement initiatives, including an onboarding toolkit for family partners. Given the opportunity to take on a permanent position in the Health Department's new Health Equity and Community Engagement (HECE) team, MCH/CSHN's family engagement coordinator

will not continue in her contracted role for the next grant cycle. However, the family engagement toolkit she developed with MCH/CSHN partners is in use in several programs currently and will be implemented to onboard family partners in future projects as well. Further, MCH/CSHN will work with the new HECE team to identify strategies to continue with family engagement efforts through new partnerships.

Vermont's NPM is Transitions to Adulthood. Transition supports for CYSHCN to young adult health care services, both primary and specialty care, will also continue to be a focus of our efforts this coming year. Part of the shift from a direct-service model to population-based health is the opportunity to ensure transition tools are available and in use across the range of care coordination providers discussed above.
CSHN will continue to support specialty care transition improvement work through a VCHIP project with the Children's Chronic Care Initiative (CCCI). The CCCI team will continue to implement youth transition readiness assessments within condition-specific clinics at UVMMC and expand electronic health record functionality to track and report on transition efforts. The CCCI team is incorporating Got Transition's Six Core Elements at every opportunity, including with their primary care transition focused work, where they will build upon a new workflow previously piloted in collaboration with a local family medicine practice and UVM Children's Hospital's Pediatric Primary Care practice. An element of CSHN's grant with the Vermont Family Network involves transitions supports, with a focus on self-advocacy and supportive decision-making (SDM) for CYSHCN. CSHN will continue to work closely with HireAbility (formerly VocRehab) leadership to ensure the statewide system of transition counselors are well-informed and supported on the unique needs of CYSHCN.

Please note: Only those strategies the link with national and state performance measures are identified in the Action Plan Table for this section.

Cross-Cutting/Systems Building

State Performance Measures

SPM 5 - Percent of MCH programs that partner with family members, youth, and/or community members

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective			75	75	90
Annual Indicator		66.7	77.8	88.9	88.9
Numerator		6	7	8	8
Denominator		9	9	9	9
Data Source		Program Data	Program Data	Program Data	Program Data
Data Source Year		2018	2019	2020	2020
Provisional or Final ?		Final	Final	Final	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	90.0	100.0	100.0	100.0

State Action Plan Table

State Action Plan Table (Vermont) - Cross-Cutting/Systems Building - Entry 1
Priority Need
Achieve a comprehensive, coordinated, and integrated state and community system of services for children
SPM
SPM 5 - Percent of MCH programs that partner with family members, youth, and/or community members
Objectives
By 2024, 100% of MCH programs have family partnership across all levels of engagement
By 2024, 75% of families in MCH programs who are satisfied with the services and programming
Strategies
1. Continue long-standing partnership with Vermont Family Network
2. Assess needs and develop a new plan for family engagement work (due to contractor taking new position)
3. Convene advisory councils, including: CSHN, Hearing and Newborn Screening Advisory, ASD, mental health integration, and other state and local committees
4. Continue implementation of Family Leadership Series to successfully engage and sustain a strong group of passionate family leaders who are engaged in a variety of state boards and councils within the system of care for CYSHN
5. Support and partner with patient/family advisors and family partnership program at UVM Medical Center
6. Convene the Youth Health Advisory Council (YHAC)
7. Provide leadership to the Youth Services Advisory Council (YSAC)
8. Include parent- and family-voice in all communications campaigns and outreach strategies

Cross-Cutting/Systems Builiding - Annual Report

Cross-cutting: Family Partnership:

VT has a long tradition of promoting family-centered care and involving families in all levels of decision making. Our MCH Division values family input across programming and planning and works to do this in an authentic and meaningful manner. Vermont is advancing a new state performance measure on family partnership which aims to ensure that MCH programming partners with families across all levels of engagement:

1. Families are in leadership roles to partner with other program staff in decisions related to program planning and policymaking
2. Families serve as representatives more broadly and in a general advisory capacity, beyond
3. Families serve as representatives on select advisory committees and taskforces related to specific issues, conditions or MCH populations
4. Input from families through general surveys or satisfaction surveys

In addition to the ongoing activities described in the “Family Partnership” section of this annual report/application.

In recent years the MCH/Title V and MIECHV Needs assessments included family and consumer voice, including focus groups and a survey.

Vermont Title V grants to the Medical Center include performance measures of family/patient satisfaction. In addition, the University of Vermont Children’s Hospital created a ‘Patient/Family Advisory Council’ (PFAC) approximately eight years ago, including patient/family advisors (PFA). In 2014, the University of Vermont Medical Center made implementing a culture of Patient and Family-Centered Care a strategic priority and in 2015, the University of Vermont Children’s Hospital (UVMCH) hired a part-time Patient and Family-Centered Care Coordinator position to continue the growth of the program within pediatric settings. As of April 2018, The Patient and Family-Centered Care Program at UVMCH now includes 50+ PFAs engaged in work across five monthly advisory committees in addition to inclusion on quality improvement projects, workgroups, and sub-committees. Vermont Title V continues to collaborate in the funding of a family engagement coordinator who works with both MCH and UVMCH to meet joint goals: amplifying and diversifying patient/family voice in pediatric settings across the state and exploring new ways to capture and include patient/family voice in pediatric settings across the state; and measuring the impact of having authentic patient/family engagement from both the patient/family and provider perspective.

The UVM Leadership Education in Neurodevelopmental and Related Disabilities (LEND) program provides a 9-month graduate level interdisciplinary training to health professionals focused on the following competencies: family-centered care, interdisciplinary collaborative teaming, cultural competence, knowledge and skill development in neurodevelopmental disabilities, and leadership. VT CSHN works closely and collaboratively with LEND. VT-LEND faculty and staff strive to promote awareness of, accessibility to, and participation in all components of the LEND program for individuals from diverse ethno-cultural backgrounds and underrepresented groups, including those with disabilities.

Vermont MCH/CSHN contracts with a parent of a child with a special health need who has professional family engagement expertise and an early childhood background to provide consultation to our entire division around building and maintaining authentic culturally responsive family engagement. A committee worked together to assist in the development of a Family Engagement Toolkit, which is used by programs across MCH to engage family partners in all aspects of work moving forward.

As part of VDH’s COVID-19 response, several MCH staff members have emerged as leaders in our work around family engagement and health equity. The Health Equity and Community Engagement (HECE) team aims to:

- Facilitate proactive and specialized outreach to priority populations, in conjunction with community partners, to identify and address local COVID-19 outreach gaps, reduce COVID-19 stigma, and promote prevention behaviors
- Support culturally sensitive and trauma informed messaging, testing, contact tracing, case follow-up, resource referrals, and other COVID-19--related services as needed
- Partner with and fund community-based organizations for assistance in reaching priority populations

- Advocate that health supports and services offered to the public are: available, accessible, affordable, coordinated, culturally appropriate, and offered with cultural humility
- Support public health communications response efforts by creating and disseminating prevention and containment information in plain language, taking into account the first languages and social-cultural norms of the audience
- Use performance and evaluation data to continually improve the work of the team and understand our impact
- Support data collection, analysis, and reporting that is transparent, credible, and brings attention to health disparities
- Support District Offices in building and maintaining relationships with key stakeholders from each community

Over the last year, Help Me Grow with its partner, Building Bright Futures, successfully engaged parents in leadership roles in Vermont's early childhood system. These efforts included the hiring of parent ambassadors, hosting regional and statewide forums to support family mental health during the COVID-19 pandemic, and hosting virtual training and events to promote family resilience. BBF and HMG seek to continue empowering families, provide opportunities for them to take a leadership role and recognize the value and importance of compensating them for their time.

MCH staff sit on the VT9to26 Coalition. This coalition is an action-oriented coalition of youth and adults working in partnership to achieve positive outcomes for all youth in Vermont. It takes collaborative action to ensure that all young people ages 9-26 are safe, healthy, supported, educated, and engaged. Drawing inspiration from the Vermont Youth Declaration of Rights, this group is committed to helping youth find what they need to be the best versions of themselves. As a coalition, we support partners of youth in strengthening opportunities, programs, and support in the third space that recognize the rights of youth and increase positive youth outcomes.

MCH, in partnership with VCHIP, convenes the Youth Health Advisory Council called, Vermont Raise Awareness for Youth Services (VT RAYS). The Vermont RAYS is a diverse group of young leaders committed to elevating and empowering youth voice across health care and community settings to improve the quality, safety, and effectiveness of youth services. The VT RAYS seeks to enable meaningful adolescent and young adult involvement in improving adolescent health care in Vermont. The VT RAYS have begun meeting twice a month during the school year. Their meetings have included several subject matter experts visiting to inform them on a variety of topics that impact adolescent and young adult health (e.g. marijuana effects on the brain). These presentations help to inform the members so they can provide meaningful input and apply learned information to future activities. Additionally, the VT RAYS presented at the University of Vermont Medical Center's weekly pediatric grand rounds. It was an engaging and informative panel discussion with these impressive youth. The VT RAYS also provide youth led clinical assessments where they work with primary care practices, specialty care centers, and other community organizations to provide input on improving youth friendliness and overcoming barriers for youth to access care.

The School Nurse Advisory Committee includes school nurses, an appointed professional from the Agency of Education, and the State School Nurse consultant. MCH is currently in the process of recruiting a parent to join the committee. VFN is assisting us with recruiting among a cohort of individuals that have received training support around self-advocacy.

Cross-Cutting/Systems Building - Application Year

Cross Cutting: Family Partnership:

In addition to the ongoing activities described in the "Family Partnership" section of this report/annual report and the Crosscutting Annual Report, Vermont MCH is planning the following activities in the coming year:

1. Continue long-standing partnership with Vermont Family Network in support of their Family Support Consultants, Family Leadership Series, as well as participation on state and local committees, advisory groups, and other opportunities to represent the family voice.
2. Our contractor who provided consultation around building and maintaining authentic culturally responsive family engagement recently took on a new role, so efforts are underway to assess needs and develop a new plan for family engagement work.
3. Continue to implement the Family Engagement Toolkit, which will assist MCH and CSHN to partner more intentionally with families and stakeholders across programs in each phase of our work.
4. Convene advisory councils, including: CSHN, Hearing and Newborn Screening Advisory, ASD, mental health integration, and other state and local committees.
5. Continue implementation of Family Leadership Series to successfully engage and sustain a strong group of passionate family leaders who are engaged in a variety of state boards and councils within the system of care for CYSHN.
6. Support and partner with patient/family advisors and family partnership program at UVM Medical Center.
7. Leverage HRSA's Early Childhood Comprehensive Systems: Health Integration Prenatal To Three Program (ECCS) grant opportunity to provide leadership, advisory and decision-making opportunities to increase diverse family representation on key early childhood committees and workgroups using innovative and non-traditional engagement strategies and disseminate findings. Partner with the ECCS Family Leader and contracted cultural brokers to conduct the following activities:
    - Engage, train, and expand family leadership to promote a culturally and linguistically responsive approach and build resiliency.
    - Cultivate family representation on key committees and workgroups.
    - Conduct regular family engagement assessments.
    - Promote a two-generation approach by identifying and sharing best practices from partners such as Head Start and Early Head Start Policy Councils with strong systems for family engagement and decision making.
8. Continue to convene the Youth Health Advisory Council called, Vermont Raise Awareness for Youth Services (VT RAYS). The Vermont RAYS is a diverse group of young leaders committed to elevating and empowering youth voice across health care and community settings to improve the quality, safety, and effectiveness of youth services. The VT RAYS seeks to enable meaningful adolescent and young adult involvement in improving adolescent health care in Vermont. The VT RAYS have begun meeting twice a month during the school year.
9. Provide leadership to the Youth Service Systems Enhancement Council. The Youth Service Systems Enhancement Council promotes shared responsibility across state and community stakeholders for achieving positive outcomes for youth and young adults. The Council promotes, advocates for, and monitors the continued evolution of culturally competent, holistic, strengths-based service systems for young people, advocates for improved quality of and access to these services, organizes policy responses to remove barriers to achieving these goals, and, importantly, involves youth, parents and communities in the design of these services.
10. Fund and support the new Governor's Youth Council which was established through H.293, signed into law by Governor Scott in 2022. The law created a State Youth Council to collect input from youth across Vermont and help inform the development of policies that affect young people.
11. Include parent- and family-voice in all communications campaigns and outreach strategies.

12. Through new CDC Health Disparities grant the Department of Health will be significantly expanding our capacity to address health equity in response to COVID, as well as across public health. This includes additional staffing for health equity and community engagement, and a new position in the Division of Maternal and Child Health who will work across MCH to support MCH and Health Department workforce development and health equity training; participate in departmental and division-level planning, including development of the MCH Strategic Plan and selection of Title V measures; work with managers to assess MCH programming, identify gaps, develop recommendations and implement health equity plans; and advise on funding decisions, grantmaking processes, and business processes.

13. MCH is actively working to define a health equity performance measure for future Title V applications.

Please note: Only those strategies the link with national and state performance measures are identified in the Action Plan Table for this section.

III.F. Public Input

Public Input

Ongoing public input for Title V programs takes a variety of forms that allows direct and indirect input into Title V as well as input into general MCH programs of the Health Department. The public budget process is one opportunity, as the Health Department budget is publicly available. MCH uses its website to highlight aspects of programming, as well as features our recent Title V application, needs assessment, state action plan, data briefs, and other accompanying documents. For more, visit: healthvermont.gov.

In Vermont, the 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 recent 2020 five-year needs assessment process, and are regular members of VDH advisory committees and collaborative efforts (School Health, Birth Registry, Early Childhood Comprehensive Systems, Department for Children and Families, Newborn Screening, Children's Integrated Services, Agency of Education, Department of Mental Health, Home Visiting Alliance, etc.) Historically, the MCH Director presents the Title V application to the Health Department leadership annually (on pause the last couple of years due to COVID), which includes representation from our Divisions of Health Promotion and Disease Prevention, Environmental Health, Substance Use Programs, Health Statistics and Informatics, Laboratory Science and Infectious Disease, Emergency Preparedness, and Local Health.

Starting in the 1980s, the Agency of Human Services (of which the Health Department is part) holds an annual public hearing for all the Block Grants (Social Services, Title V, Preventative Health and Health Care Services, Community Mental Health Services, Substance Abuse Prevention and Treatment, Community Services, and Low-Income Energy Assistance). This hearing is formally publicized in a display ad (not in the legal column) of all the major daily newspapers in the state. Legislators are invited. State staff are present at the Public Hearing to provide informed responses to any questions posed at the Hearing. The Hearing is recorded, and a written transcription is available afterward to the public. Beginning last year, drafts of each block grant application were made available to attendees. Due to COVID-19, this year's hearing, which was held on July 19, 2022, was hybrid.

The State Health Assessment and State Health Improvement Plan (SHIP) include a broad stakeholder process. With guidance from the steering committee of state and non-state partners, the Health Department put together an Advisory Committee with a wide variety of community partners, informed by programs. The SHA/SHIP leadership coordinated "out" engagement where they went and met with people in the community, focusing on populations who experience or may be at risk of experiencing health inequity.

State of Vermont legislative rules, such as those around Children with Special Health Needs, Newborn Screening, WIC, child fatality and maternal mortality review panels, home visiting, also require public input. Proposed rules must go through a public hearing process before they become final proposed rules reviewed by the Legislative Committee on Administrative Rules (LCAR).

MCH leadership promote Title V at meetings of all levels. The MCH strategic plan (corresponds to Title V priority areas and performance measures) is shared with leadership of the Agency of Human Services and in the Governor's Office. MCH Coordinators and school liaisons at the local district offices are charged with sharing MCH priorities with local level leadership and community agencies. Briefs that highlight data and Vermont MCH initiatives are shared broadly at the state and local levels.

The MCH/EPSDT program elicits partners' input on a monthly basis from representatives of the Vermont Chapters of the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, the American College of Internal Medicine, and the Vermont Nurse Practitioner Association. MCH staff

facilitate regular meetings of the VDH Office of Local Health MCH Coordinators and School Liaisons who provide input on the latest MCH-related issues from the communities in which they work.

Focus groups and surveys with home visiting, WIC, CSHN, EPSDT programs are conducted to assess satisfaction with services and to solicit input for suggested improvements as well as additional services. The VDH/VCHIP Program for Opioid-exposed Newborns uses mothers who have experienced addiction as advisors for their program. The VDH Newborn Screening Advisory Committee has several parents of children with metabolic conditions as members. Vermont's Adolescent Health program is informed by a youth advisory committee. The Screening, Access, and Treatment for Mothers and Perinatal Partners (STAMPP) cooperative agreement held several stakeholder sessions during the development of the perinatal mood and anxiety disorder communications campaign, and the STAMPP women with lived experience interviews solicited information on the system of care for the perinatal population in Vermont.

The Division of MCH relies on the Vermont Family Network (VFN) for knowledge and awareness of issues regard family needs. VFN is committed to a mission that promotes better health, education and well-being for all children and families, with a focus on children and young adults with special needs. Vermont's CSHN program has a longstanding history of supporting the ongoing work of VFN through a series of subrecipient grants. VFN presents regularly to Vermont's Title V/Division of MCH's leadership team to bring the family voice and family advocate view to the strategic direction, action planning, and workforce development around MCH content (including Title V performance measures) and MCH competencies. In the past (pre-pandemic), VFN regularly participated in the preparation of the annual Title V submission, the five-year needs assessment, and attends the state block grant federal review when able—we hope to reinstitute this soon.

Vermont's MCH Director is a member of the Building Bright Futures State Advisory Council which includes stakeholders from public and private entities in Vermont, including families. The Title V strategic priorities are shared with this group as well as the Early Childhood Interagency Coordinating Team (ECICT).

III.G. Technical Assistance

Technical Assistance

Vermont Title V would benefit from technical assistance in the following areas. Although many of these items appeared on last year's TA list, due to the COVID pandemic and the deployment of most of our staff, Vermont was able to make little headway on many priority areas.

- Health Equity
  As described elsewhere in this application, Vermont used a health equity lens in the development of the State Health Assessment and State Health Improvement Plan (SHA/SHIP). Health equity was considered in each step of the process, including: who is engaged in the planning and priority setting; how individuals affected by inequity are engaged; what data is considered and how it is analyzed, how decisions are made; who is involved in decision-making, how data is reported; how decisions are made; and who is involved in decision-making. The Health Department identified four populations to focus health equity efforts as it relates to the SHA/SHIP: racial and ethnic minorities, LGBTQ identity, people living with disabilities, and Vermonters living in poverty. Vermont Title V would benefit from learning from other states (particularly rural states) regarding MCH approaches to health equity. Vermont's MCH Team recently welcomed a Health Equity and Family Engagement Lead who will provide organizing strategies around health equity.

- Gender inclusive language
  Vermont MCH recently received feedback that the use of some of our language such as "maternal" and "women" was not meeting expectations of inclusivity and equity. In response, we recently provided training to all our staff on gender inclusive language and program-specific intensive workshops to identify strategies and communication materials that could be modified and improved. We believe this is a very important conversation that Title V should be engaging in on a national basis.

- Social Marketing
  Vermont would appreciate the opportunity to learn more from other states and experts in how to communicate essential MCH public health messaging to the public, particularly in a rural state. Although, MCH benefits from a division-level Information Director and centralized Communication Office, the department's priorities often diverge from those of Title V.

- Two-Generation Approach
  Vermont MCH continues to articulate our work within the context of the two-generation approach, which has been a successful strategy to elevate maternal and child health priorities into statewide discussions of health reform, economic development, and other key policy and systems-level decisions. We would welcome any technical assistance or guidance on successfully implementing and funding two-generation approaches. Additionally, we would benefit from TA on the following two specific two-generation issues: maternal depression and toxic stress/ACES.

- School-based Health Centers
  As Vermont expands our focus on SBHCs, we would welcome any assistance regarding the funding, adoption, and implementation of SBHCs, particularly in rural communities, and with regard to coordination between SBHCs and medical homes.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - DVHA-VDH IGA 2017_signed.pdf

V. Supporting Documents

No Supporting documents were provided by the state.

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - Vermont Org Chart.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Vermont

	FY 23 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 1,656,553	
A. Preventive and Primary Care for Children	$ 849,812	(51.3%)
B. Children with Special Health Care Needs	$ 498,622	(30%)
C. Title V Administrative Costs	$ 71,232	(4.4%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,419,666	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 1,242,415	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 1,242,415	
A. Your State's FY 1989 Maintenance of Effort Amount $ 167,093		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 2,898,968	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 23,615,428	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 26,514,396	

OTHER FEDERAL FUNDS	FY 23 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Social Services Block Grant (SSBG)	$ 308,828
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 175,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 136,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Injury Prevention and Control	$ 350,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 30,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 240,000
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Early and Periodic Screening, Diagnosis & Treatment (EPSDT)	$ 9,900,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	$ 255,600
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 1,355,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) American Rescue Plan (ARP)	$ 175,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program	$ 625,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Newborn Screening State Evaluation Program	$ 235,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 8,600,000
Department of Health and Human Services (DHHS) > Other > Vermont's Title X Family Planning Services Program	$ 830,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > National Initiative to Address COVID-19 Health Disparities	$ 400,000

	FY 21 Annual Report Budgeted		FY 21 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 1,633,060 (FY 21 Federal Award: $ 1,656,553)		$ 1,085,287	
A. Preventive and Primary Care for Children	$ 902,832	(55.3%)	$ 509,666	(46.9%)
B. Children with Special Health Care Needs	$ 493,184	(30.2%)	$ 318,518	(29.3%)
C. Title V Administrative Costs	$ 68,589	(4.2%)	$ 36,472	(3.4%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,464,605		$ 864,656	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 1,224,795		$ 786,612	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 900,000		$ 312,605	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 2,124,795		$ 1,099,217	
A. Your State's FY 1989 Maintenance of Effort Amount $ 167,093				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 3,757,855		$ 2,184,504	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 23,183,762		$ 19,297,132	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 26,941,617		$ 21,481,636	

OTHER FEDERAL FUNDS	FY 21 Annual Report Budgeted	FY 21 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 225,000	$ 134,070
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 140,000	$ 130,424
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 240,000	$ 230,298
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Social Services Block Grant (SSBG)	$ 286,668	$ 254,614
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 40,000	$ 29,558
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Injury Prevention and Control	$ 100,000	$ 320,468
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000	$ 207,241
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program	$ 608,967	$ 724,703
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 8,500,000	$ 6,996,322
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 1,800,000	$ 1,543,042
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Early and Periodic Screening, Diagnosis & Treatment (EPSDT)	$ 10,993,127	$ 8,149,632
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Epidemiology and Laboratory Capacity (ELC)		$ 351,238

OTHER FEDERAL FUNDS	FY 21 Annual Report Budgeted	FY 21 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Immunization Cooperative Agreements		$ 26,769
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems		$ 181,870
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) American Rescue Plan (ARP)		$ 16,883

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Vermont anticipates this award will be fully obligated by the end of the FY21 project period and drawn by the end of the liquidation period	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Vermont anticipates this award will be fully obligated by the end of the FY21 project period and drawn by the end of the liquidation period	
3.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Vermont anticipates this award will be fully obligated by the end of the FY21 project period and drawn by the end of the liquidation period. At that time we will have met the 30% requirement	
4.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: The FY21 Administrative costs are slightly lower than budgeted due to the continued public health response to COVID-19. Administrative costs are allocated on the basis of a program's direct salary costs. Our FY23 budget assumes the resumption of direct and administrative costs to the pre-emergency levels.	
5.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**

	Field Note: Vermont anticipates this award will be fully obligated by the end of the FY21 project period and the state match will be within 10% of budget.	
6.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: We anticipate no revenue from Medicaid billing due to the transition of the Child Development Clinic from the health department to the UVM Medical Center.	

Data Alerts:

- The value in Line 1B, Children with Special Health Care Needs, Annual Report Expended is less than 30% of the Federal Allocation, Annual Report Expended. A field-level note indicating the reason for the discrepancy was provided.

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Vermont

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	$ 86,064	$ 80,158
2. Infants < 1 year	$ 150,823	$ 140,473
3. Children 1 through 21 Years	$ 849,812	$ 509,666
4. CSHCN	$ 498,622	$ 318,518
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 1,585,321	$ 1,048,815

IB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	$ 61,818	$ 86,340
2. Infants < 1 year	$ 127,623	$ 151,305
3. Children 1 through 21 Years	$ 929,211	$ 548,967
4. CSHCN	$ 70,338	$ 0
5. All Others	$ 0	$ 0
Non-Federal Total of Individuals Served	$ 1,188,990	$ 786,612
Federal State MCH Block Grant Partnership Total	$ 2,774,311	$ 1,835,427

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Vermont

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 692,093	$ 453,423
3. Public Health Services and Systems	$ 964,460	$ 631,864
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Federal Total	$ 1,656,553	$ 1,085,287

IIB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Direct Services	$ 46,456	$ 31,494
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 46,456	$ 31,494
2. Enabling Services	$ 569,433	$ 385,291
3. Public Health Services and Systems	$ 793,528	$ 536,919
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Other		
Cystic Fibrosis and Nutrition Network		$ 31,494
Direct Services Line 4 Expended Total		$ 31,494
Non-Federal Total	$ 1,409,417	$ 953,704

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Vermont

Total Births by Occurrence: 4,947 **Data Source Year: 2020**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	4,930 (99.7%)	330	29	29 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Holocarboxylase Synthase Deficiency	Homocystinuria
Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Methylmalonic Acidemia (Cobalamin Disorders)
Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Mucopolysaccharidosis Type 1	Primary Congenital Hypothyroidism	Propionic Acidemia	S, ßeta-Thalassemia
S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1	ß-Ketothiolase Deficiency
Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy	

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Newborn Hearing Screening	4,856 (98.2%)	39	6	6 (100.0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Newborn Hearing Screening: the VTEHDI (Vermont Early Detection and Intervention) program receives annual reports on all infants born in Vermont and diagnosed with permanent hearing loss. Additionally, VTEHDI recommends annual follow-up for infants who have high risk factors for developing hearing loss. Our program sends reminders to families and primary care providers annually between birth and three years of age for this cohort.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2021**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: 2021 metabolic data is not yet available for infants born in Vermont but screened in other states so 2020 calendar year data is reported here/ In 2020, there were 4,953 births in Vermont but 6 died before bloodspot screening could be performed and are not included here.	
2.	**Field Name:**	**Core RUSP Conditions - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2021**
	Column Name:	**Core RUSP Conditions**
	Field Note: Vermont screened for 33 conditions by dried bloodspot screening plus critical congenital heart disease (CCHD) and hearing loss. Since hearing loss data is derived from a separate program, we have chosen to report it separately under the "Other Newborn" section of this form. 4,875 infants were screened in VT, and a further 55 in other states. All 17 cases confirmed as not screened are also confirmed parental refusals. No infants have been lost to follow-up.	
3.	**Field Name:**	**Core RUSP Conditions - Total Number of Out-of-Range Results**
	Fiscal Year:	**2021**
	Column Name:	**Core RUSP Conditions**
	Field Note: Some infants may have received more than one positive screen.	
4.	**Field Name:**	**Core RUSP Conditions - Total Number Confirmed Cases**
	Fiscal Year:	**2021**
	Column Name:	**Core RUSP Conditions**
	Field Note: All confirmed cases are in separate individuals. Screening conditions reported 22 Congenital Hypothyroidism (8 definite, 14 probable – milder TSH elevation requiring treatment) and 7 others with <5 cases per condition (suppressed by state confidentiality policy.)	
5.	**Field Name:**	**Core RUSP Conditions - Total Number Referred For Treatment**
	Fiscal Year:	**2021**

	Column Name:	**Core RUSP Conditions**
	Field Note: One family declined additional testing despite referral.	
6.	**Field Name:**	**Newborn Hearing Screening - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2021**
	Column Name:	**Other Newborn**
	Field Note: We have chosen to report our Newborn Hearing Screening data separately because it comes form a different program. There were 9 deaths before screening could be performed, so 98.2% (4,856/4,944) would also be an appropriate rate for this measure. In addition to the 9 deaths, there were 88 infants who were not screened. Of these, 36 were parental/family refusals, 51 were home births that did not respond to requests, and 1 family was non-resident or moved out of the jurisdiction. No infants were lost to follow-up.	
7.	**Field Name:**	**Newborn Hearing Screening - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2021**
	Column Name:	**Other Newborn**
	Field Note: Of the 39 presumptive positive screens, 33 had normal hearing results on referral and 6 had confirmed hearing loss. All 6 were referred for treatment.	

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Vermont

Annual Report Year 2021

Form 5a – Count of Individuals Served by Title V (Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	0					
2. Infants < 1 Year of Age	0					
3. Children 1 through 21 Years of Age	2,435	40.0	0.0	58.0	2.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	2,289	56.0	0.0	42.0	2.0	0.0
4. Others	0					
Total	2,435					

Form 5b – Total Percentage of Populations Served by Title V (Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	5,133	Yes	5,133	83.1	4,266	0
2. Infants < 1 Year of Age	4,953	No	5,529	89.5	4,948	0
3. Children 1 through 21 Years of Age	148,338	Yes	148,338	98.0	145,371	2,435
3a. Children with Special Health Care Needs 0 through 21 years of age^	33,653	Yes	33,653	98.0	32,980	2,289
4. Others	469,679	No	464,546	2.9	13,472	0

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2021**
	Field Note: No direct services provided.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2021**
	Field Note: No direct services provided.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2021**
	Field Note: Numerator: There were 146 unduplicated patients served by the Child Development Clinic (CDC); including services by UVMMC Developmental Pediatrics and Vermont Center for Children, Youth and Families (both supported by Title V) between 10/1/20 and 9/30/21, plus the CSHCN listed below. Denominator: American Community Survey – Children 1-21, 2019 (from MCHB)	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2021**
	Field Note: Numerator: In 2021, 2,289 CSHCN cases were reported: 590 Genetics consults (State FY), 107 Nutrition consults (FFY), 133 Care Coordination Program (FFY: Note COVID disruption and model change), 20 High Tech (State FY), 63 Palliative Care (State FY), and 1,376 Children's Personal Care (State FY). Unfortunately, there is some duplication across programs that we have no simple way to account for. Denominator: National Survey of Children’s Health – CSHCN, 2019-2020 (from MCHB)	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2021**
	Field Note: No direct services provided.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2021**

	Field Note: Vermont-resident pregnant women with first trimester prenatal care receive public health messaging through MCH coordinators, Numerator: VT resident women receiving 1st trimester care. Denominator: VT resident women giving birth. Source: 2020 VT Vital Statistics/NVSS	
2.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2021**
	Field Note: Denominator: 2020 Census population estimate (5,529) for those aged less than 1 year. Data Sources: 2020 VT Vitals/ 2020 Census population estimates.	
3.	**Field Name:**	**Infants Less Than One Year Denominator**
	Fiscal Year:	**2021**
	Field Note: Population numerator is the 4,947 Vermont-occurrent births surviving for more than one day who received services from our Newborn Metabolic Screening Program in 2020. Denominator: 2020 Census population estimate for those less than 1 year. Source: 2020 VT Vitals/2020 Census Population Estimates	
4.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2021**
	Field Note: EPSDT Outreach and Informing/ School Health. Numerator: Assumed 98% reach. Denominator: 2020 Census Population estimates	
5.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2021**
	Field Note: EPSDT Outreach and Informing/ School Health. Numerator: Assumed 98% reach. Denominator: National Survey of Children's Health CSHCN Prevalence Estimates 0-17 (2019-2020) multiplied by US Census Bureau Population Estimates 0-21, 2020	
6.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2021**
	Field Note: Numerator: 13,474 Women’s Health Initiative (WHI) patients attributed to WHI Specialty (WM) providers based on our Blueprint patient attributions used for CHT payments (for 2021-Q3 CHT payments).	

7.	**Field Name:**	**Others Denominator**
	Fiscal Year:	**2021**
	Field Note: Denominator: Number of people ages 22+, 2020 Census estimates, minus pregnant women to prevent double-counting. Source: 2020 Census, 2020 VT Vitals	

Data Alerts:

1.	Infants Less Than One Year Denominator is greater than or equal to 110 % of the Infants Less Than One Year Reference Data.Please double check and justify with a field note.

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Vermont

Annual Report Year 2021

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	4,953	3,936	167	238	23	133	2	121	333
Title V Served	4,947	3,931	166	238	23	133	2	121	333
Eligible for Title XIX	1,889	1,336	108	94	16	43	1	38	253
2. Total Infants in State	5,529	4,900	88	22	153	121	0	245	0
Title V Served	5,136	4,552	82	20	143	112	0	227	0
Eligible for Title XIX	2,838	978	41	6	5	15	0	0	1,793

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2021**
	Column Name:	**Total**
	Field Note: Data source is 2020 VT Vital Statistics births file.	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2021**
	Column Name:	**Total**
	Field Note: All live births that survive for more than one day are considered to be Title V served because of our Newborn Screening Programs.	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2021**
	Column Name:	**Total**
	Field Note: Data source is the 'Payer' field from the 2020 VT Vital Statistics Births file.	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2021**
	Column Name:	**Total**
	Field Note: Due to delays in analyzing data from the Census population files - the race-specific estimates use the 2020 total population estimate of 5,529 multiplied by the race specific population rates from the 2019 Census data. This will be updated if time permits.	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2021**
	Column Name:	**Total**
	Field Note: Assuming 92.9% Title V served due to newborn screening programs that serve Vermont occurrent births. (see Form 5 text for estimation method of the rate) Since this number depends upon the row above it, it will also be updated time permitting.	

6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2021**
	Column Name:	**Total**

Field Note:
Data source is 2020 Medicaid claims data. 63.2% of unique IDs are missing race/ethnicity data. In addition, Asian race and Hispanic ethnicity are not well tracked and underestimate the true rates. "Hawaiian/Pacific Islander" and "Multiple Race" categories are not tracked in VT Medicaid claims data.

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Vermont

A. State MCH Toll-Free Telephone Lines	2023 Application Year	2021 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 649-4357	(800) 649-4357
2. State MCH Toll-Free "Hotline" Name	Vermont MCH	Vermont MCH
3. Name of Contact Person for State MCH "Hotline"	Kim Bean	Kim Bean
4. Contact Person's Telephone Number	(802) 865-1318	(802) 865-1318
5. Number of Calls Received on the State MCH "Hotline"		0

B. Other Appropriate Methods	2023 Application Year	2021 Annual Report Year
1. Other Toll-Free "Hotline" Names	Help Me Grow 211	Help Me Grow 211
2. Number of Calls on Other Toll-Free "Hotlines"		1,343
3. State Title V Program Website Address	https://www.healthvermont.gov/family	https://www.healthvermont.gov/family
4. Number of Hits to the State Title V Program Website		54,771
5. State Title V Social Media Websites	https://twitter.com/healthvermont; htpps://www.facebook.com/HealthVermont; https://www.youtube.com/user/HealthVermont	https://twitter.com/healthvermont; htpps://www.facebook.com/HealthVermont; https://www.youtube.com/user/HealthVermont
6. Number of Hits to the State Title V Program Social Media Websites		0

Form Notes for Form 7:

Social media sites are not specific to MCH. Counts would be artificially inflated due to large volume of traffic to the health department related to COVID and other public health priorities.

Form 8
State MCH and CSHCN Directors Contact Information

State: Vermont

1. Title V Maternal and Child Health (MCH) Director	
Name	Ilisa Stalberg
Title	Director, Maternal and Child Health
Address 1	108 Cherry St
Address 2	Suite 301
City/State/Zip	Burlington / VT / 05402
Telephone	(802) 863-7200
Extension	
Email	ilisa.stalberg@vermont.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Adam Poulin
Title	CSHN Program Administrator
Address 1	108 Cherry St
Address 2	Suite 101
City/State/Zip	Burlington / VT / 05401
Telephone	(802) 865-1385
Extension	
Email	adam.poulin@vermont.gov

3. State Family or Youth Leader (Optional)	
Name	Charlotte Safran
Title	Family Engagement Coordinator
Address 1	108 Cherry St
Address 2	Suite 101
City/State/Zip	Burlington / VT / 05402
Telephone	(802) 497-8024
Extension	
Email	Charlotte.Safran@vermont.gov

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Vermont

Application Year 2023

No.	Priority Need
1.	Ensure optimal health prior to pregnancy
2.	Promote optimal infant health and development
3.	Achieve a comprehensive, coordinated, and integrated state and community system of services for children
4.	Children live in safe and supported communities
5.	Youth choose healthy behaviors and thrive
6.	Reduce the risk of chronic disease across the lifespan
7.	Promote protective factors and resiliency among Vermont’s families

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Ensure optimal health prior to pregnancy	Continued
2.	Promote optimal infant health and development	Continued
3.	Achieve a comprehensive, coordinated, and integrated state and community system of services for children	Continued
4.	Children live in safe and supported communities	Continued
5.	Youth choose healthy behaviors and thrive	Continued
6.	Reduce the risk of chronic disease across the lifespan	Continued
7.	Promote protective factors and resiliency among Vermont’s families	Continued

Form 10
National Outcome Measures (NOMs)

State: Vermont

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	88.1 %	0.5 %	4,495	5,105
2019	89.1 %	0.4 %	4,760	5,345
2018	89.2 %	0.4 %	4,827	5,409
2017	90.1 %	0.4 %	5,077	5,635
2016	89.5 %	0.4 %	5,144	5,745
2015	87.4 %	0.4 %	5,126	5,862
2014	88.0 %	0.4 %	5,375	6,110
2013	84.3 %	0.5 %	5,025	5,962
2012	83.8 %	0.5 %	5,016	5,984
2011	83.0 %	0.5 %	5,000	6,025
2010	83.2 %	0.5 %	5,118	6,149
2009	83.5 %	0.5 %	5,037	6,030

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	76.6	12.3	39	5,090
2018	60.4	11.4	28	4,639
2017	62.7	11.5	30	4,781
2016	65.8	11.7	32	4,863
2015	65.6	13.2	25	3,810
2014	72.3	11.9	37	5,116
2013	62.7	11.3	31	4,943
2012	71.8	12.0	36	5,014
2011	43.9	9.4	22	5,008
2010	47.8	9.6	25	5,228
2009	52.5	9.5	31	5,901
2008	44.1	8.5	27	6,128

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2020	NR	NR	NR	NR
2015_2019	NR	NR	NR	NR
2014_2018	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	7.0 %	0.4 %	357	5,123
2019	6.6 %	0.3 %	351	5,357
2018	7.0 %	0.4 %	381	5,428
2017	6.7 %	0.3 %	380	5,649
2016	6.9 %	0.3 %	394	5,750
2015	6.6 %	0.3 %	390	5,898
2014	7.1 %	0.3 %	432	6,126
2013	6.7 %	0.3 %	401	5,968
2012	6.2 %	0.3 %	370	6,006
2011	6.7 %	0.3 %	404	6,073
2010	6.1 %	0.3 %	382	6,221
2009	6.7 %	0.3 %	411	6,103

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	7.6 %	0.4 %	391	5,130
2019	8.4 %	0.4 %	452	5,357
2018	8.5 %	0.4 %	462	5,427
2017	7.5 %	0.4 %	425	5,649
2016	8.0 %	0.4 %	457	5,746
2015	7.3 %	0.3 %	429	5,895
2014	7.9 %	0.4 %	486	6,126
2013	7.6 %	0.3 %	456	5,971
2012	7.6 %	0.3 %	454	6,006
2011	7.6 %	0.3 %	460	6,071
2010	7.2 %	0.3 %	446	6,218
2009	8.2 %	0.4 %	501	6,099

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	24.2 %	0.6 %	1,243	5,130
2019	22.9 %	0.6 %	1,228	5,357
2018	22.5 %	0.6 %	1,221	5,427
2017	21.6 %	0.6 %	1,223	5,649
2016	21.2 %	0.5 %	1,216	5,746
2015	19.9 %	0.5 %	1,175	5,895
2014	21.1 %	0.5 %	1,290	6,126
2013	19.3 %	0.5 %	1,153	5,971
2012	19.7 %	0.5 %	1,185	6,006
2011	19.3 %	0.5 %	1,172	6,071
2010	20.1 %	0.5 %	1,247	6,218
2009	19.7 %	0.5 %	1,199	6,099

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020/Q3-2021/Q2	11.0 %			
2019/Q4-2020/Q3	5.0 %			
2019/Q1-2019/Q4	1.0 %			
2018/Q4-2019/Q3	3.0 %			
2018/Q3-2019/Q2	2.0 %			
2018/Q2-2019/Q1	1.0 %			
2018/Q1-2018/Q4	1.0 %			
2017/Q4-2018/Q3	0 %			
2017/Q3-2018/Q2	1.0 %			
2017/Q2-2018/Q1	0 %			
2017/Q1-2017/Q4	1.0 %			
2016/Q4-2017/Q3	1.0 %			
2016/Q3-2017/Q2	2.0 %			
2016/Q2-2017/Q1	3.0 %			
2016/Q1-2016/Q4	2.0 %			
2015/Q4-2016/Q3	2.0 %			
2015/Q3-2016/Q2	1.0 %			
2015/Q2-2016/Q1	1.0 %			
2015/Q1-2015/Q4	1.0 %			
2014/Q4-2015/Q3	3.0 %			
2014/Q3-2015/Q2	3.0 %			
2014/Q2-2015/Q1	5.0 %			
2014/Q1-2014/Q4	4.0 %			
2013/Q4-2014/Q3	4.0 %			
2013/Q3-2014/Q2	4.0 %			
2013/Q2-2014/Q1	4.0 %			

Legends:

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	4.6	0.9	25	5,377
2018	4.2	0.9	23	5,443
2017	5.6	1.0	32	5,670
2016	3.1	0.7	18	5,766
2015	4.7	0.9	28	5,919
2014	5.0	0.9	31	6,144
2013	5.3	1.0	32	5,992
2012	5.0	0.9	30	6,028
2011	4.3	0.8	26	6,090
2010	3.0	0.7	19	6,233
2009	5.7	1.0	35	6,123

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	2.8	0.7	15	5,361
2018	6.4	1.1	35	5,432
2017	4.8	0.9	27	5,655
2016	3.5	0.8	20	5,756
2015	4.6	0.9	27	5,903
2014	4.6	0.9	28	6,130
2013	4.4	0.9	26	5,975
2012	4.3	0.9	26	6,009
2011	4.9	0.9	30	6,078
2010	4.2	0.8	26	6,223
2009	6.2	1.0	38	6,110

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	NR	NR	NR	NR
2018	3.1	0.8	17	5,432
2017	3.5	0.8	20	5,655
2016	1.9	0.6	11	5,756
2015	3.0	0.7	18	5,903
2014	3.4	0.8	21	6,130
2013	3.2	0.7	19	5,975
2012	2.5	0.7	15	6,009
2011	3.5	0.8	21	6,078
2010	2.2	0.6	14	6,223
2009	4.4	0.9	27	6,110

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	NR	NR	NR	NR
2018	3.3	0.8	18	5,432
2017	NR	NR	NR	NR
2016	NR	NR	NR	NR
2015	NR	NR	NR	NR
2014	NR	NR	NR	NR
2013	NR	NR	NR	NR
2012	1.8	0.6	11	6,009
2011	NR	NR	NR	NR
2010	1.9	0.6	12	6,223
2009	1.8	0.5	11	6,110

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	NR	NR	NR	NR
2018	NR	NR	NR	NR
2017	176.8	56.0	10	5,655
2016	NR	NR	NR	NR
2015	NR	NR	NR	NR
2014	163.1	51.6	10	6,130
2013	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	164.5	52.1	10	6,078
2010	NR	NR	NR	NR
2009	261.9	65.6	16	6,110

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	NR	NR	NR	NR
2018	NR	NR	NR	NR
2017	NR	NR	NR	NR
2016	NR	NR	NR	NR
2015	NR	NR	NR	NR
2014	NR	NR	NR	NR
2013	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	NR	NR	NR	NR
2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	11.5 %	1.1 %	568	4,944
2019	12.3 %	1.2 %	635	5,168
2018	10.8 %	1.1 %	568	5,242
2017	14.6 %	1.2 %	802	5,473
2016	17.0 %	1.2 %	943	5,555
2015	15.8 %	1.2 %	894	5,655
2014	15.0 %	1.1 %	882	5,863
2013	12.8 %	1.1 %	733	5,728
2012	13.7 %	1.1 %	799	5,827
2011	12.9 %	1.0 %	757	5,853
2010	12.9 %	1.0 %	761	5,922
2009	13.2 %	1.1 %	773	5,856
2008	12.1 %	1.0 %	734	6,056
2007	12.7 %	1.0 %	790	6,243

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	20.4	2.0	105	5,149
2018	23.7	2.3	111	4,690
2017	29.4	2.5	142	4,829
2016	28.2	2.4	140	4,963
2015	33.7	3.0	132	3,914
2014	35.0	2.6	185	5,283
2013	34.1	2.6	175	5,130
2012	31.6	2.5	164	5,192
2011	27.4	2.3	142	5,186
2010	26.4	2.3	140	5,297
2009	21.7	1.9	129	5,946
2008	16.8	1.7	105	6,238

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	9.1 %	1.1 %	9,872	108,033
2018_2019	10.3 %	1.3 %	11,293	109,234
2017_2018	9.7 %	1.3 %	10,528	108,194
2016_2017	9.3 %	1.1 %	10,231	110,165
2016	10.4 %	1.4 %	11,724	112,270

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	NR	NR	NR	NR
2019	22.0	6.4	12	54,562
2018	NR	NR	NR	NR
2017	NR	NR	NR	NR
2016	19.5	5.9	11	56,481
2015	NR	NR	NR	NR
2014	NR	NR	NR	NR
2013	20.7	6.0	12	57,928
2012	NR	NR	NR	NR
2011	16.9	5.3	10	59,212
2010	NR	NR	NR	NR
2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	29.8	6.4	22	73,714
2019	21.5	5.4	16	74,274
2018	23.7	5.6	18	76,046
2017	26.4	5.9	20	75,836
2016	27.4	6.0	21	76,634
2015	21.8	5.3	17	78,028
2014	31.5	6.3	25	79,461
2013	31.1	6.2	25	80,407
2012	25.8	5.6	21	81,502
2011	32.6	6.3	27	82,833
2010	22.7	5.2	19	83,649
2009	29.4	5.9	25	85,023

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2020	13.7	3.3	17	124,327
2017_2019	11.2	3.0	14	125,367
2016_2018	14.2	3.4	18	126,759
2015_2017	10.2	2.8	13	127,925
2014_2016	10.0	2.8	13	130,139
2013_2015	9.8	2.7	13	132,104
2012_2014	9.7	2.7	13	133,934
2011_2013	15.5	3.4	21	135,756
2010_2012	14.6	3.3	20	137,195
2009_2011	18.7	3.7	26	138,711
2008_2010	19.2	3.7	27	140,702
2007_2009	19.6	3.7	28	143,200

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2020	10.5	2.9	13	124,327
2017_2019	12.8	3.2	16	125,367
2016_2018	13.4	3.3	17	126,759
2015_2017	11.7	3.0	15	127,925
2014_2016	11.5	3.0	15	130,139
2013_2015	13.6	3.2	18	132,104
2012_2014	11.9	3.0	16	133,934
2011_2013	11.0	2.9	15	135,756
2010_2012	9.5	2.6	13	137,195
2009_2011	9.4	2.6	13	138,711
2008_2010	7.8	2.4	11	140,702
2007_2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	21.9 %	1.5 %	24,880	113,746
2018_2019	20.7 %	1.6 %	24,042	116,018
2017_2018	20.0 %	1.7 %	23,595	117,739
2016_2017	20.5 %	1.5 %	24,338	118,840
2016	21.1 %	1.7 %	25,195	119,440

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	22.0 %	3.4 %	5,466	24,880
2018_2019	23.5 %	3.9 %	5,656	24,042
2017_2018	19.1 %	3.3 %	4,506	23,595
2016_2017	19.3 %	2.7 %	4,702	24,338
2016	22.0 %	3.7 %	5,542	25,195

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	2.1 %	0.6 %	2,087	97,486
2018_2019	2.4 %	0.6 %	2,295	97,223
2017_2018	1.9 %	0.5 %	1,867	95,824
2016_2017	1.8 %	0.5 %	1,831	99,217
2016	2.3 %	0.8 %	2,367	100,745

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	10.2 %	1.2 %	9,837	96,887
2018_2019	8.6 %	1.2 %	8,313	96,788
2017_2018	9.3 %	1.6 %	8,853	95,400
2016_2017	9.6 %	1.5 %	9,541	98,897
2016	8.5 %	1.4 %	8,538	100,510

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	46.7 %	4.3 %	9,391	20,112
2018_2019	49.2 %	4.9 %	9,010	18,320
2017_2018	56.5 %	5.8 %	8,596	15,224
2016_2017	61.6 %	5.2 %	8,915	14,481
2016	64.8 %	4.9 %	9,331	14,404

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	93.2 %	0.9 %	105,772	113,548
2018_2019	94.7 %	0.8 %	109,755	115,902
2017_2018	95.0 %	0.8 %	111,385	117,206
2016_2017	93.7 %	0.8 %	110,513	117,938
2016	93.3 %	0.9 %	110,702	118,628

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	12.9 %	0.5 %	612	4,761
2016	14.5 %	0.5 %	760	5,254
2014	14.1 %	0.5 %	785	5,574
2012	13.7 %	0.4 %	831	6,070
2010	13.8 %	0.4 %	964	6,964
2008	13.7 %	0.4 %	890	6,491

Legends:

Indicator has a denominator <50 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	13.1 %	0.3 %	3,105	23,777
2017	12.6 %	0.3 %	3,097	24,495
2015	12.4 %	0.2 %	2,941	23,719
2013	13.2 %	1.0 %	3,303	25,042
2011	9.9 %	0.9 %	2,509	25,381
2009	12.2 %	0.7 %	3,441	28,259
2007	11.5 %	1.5 %	3,439	29,882
2005	9.5 %	1.1 %	2,846	29,956

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	14.0 %	1.8 %	7,696	54,906
2018_2019	14.0 %	2.0 %	7,370	52,719
2017_2018	15.1 %	2.2 %	7,310	48,453
2016_2017	13.0 %	1.8 %	6,549	50,385
2016	11.8 %	1.9 %	6,325	53,739

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	0.8 %	0.4 %	855	112,889
2018	2.8 %	1.0 %	3,138	113,412
2017	1.1 %	0.5 %	1,233	115,378
2016	1.1 %	0.4 %	1,337	119,999
2015	1.0 %	0.4 %	1,227	117,735
2014	1.0 %	0.4 %	1,226	122,074
2013	3.2 %	1.1 %	3,942	124,492
2012	3.0 %	0.8 %	3,647	122,488
2011	1.9 %	0.6 %	2,405	126,788
2010	2.7 %	0.7 %	3,459	130,034
2009	3.3 %	0.9 %	4,257	127,297

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	80.1 %	2.8 %	5,000	6,000
2016	75.8 %	3.5 %	4,000	6,000
2015	74.4 %	3.6 %	4,000	6,000
2014	69.5 %	3.5 %	4,000	6,000
2013	70.9 %	3.5 %	4,000	6,000
2012	69.7 %	3.6 %	4,000	6,000
2011	62.3 %	3.7 %	4,000	6,000

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	69.4 %	2.0 %	74,579	107,462
2019_2020	68.2 %	1.9 %	75,163	110,209
2018_2019	59.4 %	2.4 %	65,254	109,893
2017_2018	59.5 %	2.1 %	66,985	112,653
2016_2017	59.9 %	2.4 %	67,605	112,957
2015_2016	58.9 %	2.5 %	68,529	116,408
2014_2015	62.4 %	2.0 %	72,831	116,791
2013_2014	58.6 %	2.1 %	69,802	119,228
2012_2013	61.1 %	2.5 %	72,142	118,103
2011_2012	56.5 %	2.8 %	67,394	119,210
2010_2011	47.9 %	3.9 %	57,762	120,588
2009_2010	51.2 %	3.3 %	59,539	116,287

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	87.0 %	2.1 %	29,766	34,212
2019	82.0 %	2.2 %	28,097	34,277
2018	78.3 %	2.5 %	27,247	34,811
2017	78.7 %	2.6 %	27,793	35,315
2016	70.3 %	2.8 %	25,390	36,105
2015	67.4 %	2.8 %	24,618	36,547

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	95.1 %	1.1 %	32,547	34,212
2019	94.3 %	1.4 %	32,340	34,277
2018	95.1 %	1.3 %	33,095	34,811
2017	92.8 %	1.5 %	32,771	35,315
2016	93.8 %	1.4 %	33,878	36,105
2015	95.8 %	1.3 %	35,027	36,547
2014	93.4 %	1.7 %	34,543	36,991
2013	91.9 %	1.9 %	34,977	38,083
2012	93.1 %	1.9 %	36,062	38,718
2011	90.1 %	1.7 %	35,744	39,677
2010	82.7 %	2.6 %	33,322	40,314
2009	70.7 %	2.6 %	29,221	41,315

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	91.0 %	1.8 %	31,149	34,212
2019	93.6 %	1.4 %	32,086	34,277
2018	90.0 %	1.8 %	31,341	34,811
2017	84.2 %	2.4 %	29,726	35,315
2016	86.4 %	2.0 %	31,203	36,105
2015	84.4 %	2.2 %	30,834	36,547
2014	81.3 %	2.6 %	30,079	36,991
2013	79.2 %	2.7 %	30,168	38,083
2012	72.6 %	3.1 %	28,126	38,718
2011	65.7 %	2.9 %	26,070	39,677
2010	54.2 %	3.3 %	21,828	40,314
2009	43.9 %	2.8 %	18,137	41,315

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	7.0	0.6	139	19,808
2019	7.6	0.6	152	20,014
2018	8.8	0.7	182	20,676
2017	10.1	0.7	206	20,438
2016	10.3	0.7	213	20,747
2015	11.6	0.7	245	21,092
2014	14.3	0.8	307	21,478
2013	14.5	0.8	317	21,854
2012	16.3	0.9	361	22,200
2011	16.7	0.9	375	22,461
2010	17.9	0.9	401	22,437
2009	17.3	0.9	393	22,699

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	11.9 %	1.2 %	578	4,850
2019	10.0 %	1.2 %	501	5,030
2018	10.7 %	1.1 %	548	5,103
2017	11.5 %	1.2 %	622	5,397
2016	12.7 %	1.2 %	699	5,505
2015	10.5 %	1.1 %	592	5,624
2014	11.6 %	1.0 %	679	5,847
2013	11.2 %	1.1 %	638	5,711
2012	10.2 %	1.0 %	586	5,763

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	2.3 %	0.5 %	2,655	113,258
2018_2019	1.6 %	0.5 %	1,899	115,409
2017_2018	1.6 %	0.5 %	1,848	117,420
2016_2017	1.2 %	0.3 %	1,406	118,516
2016	1.3 %	0.4 %	1,533	119,059

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Vermont

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	91	91	92	92	92
Annual Indicator	81.9	89.3	89.9	90.2	90.4
Numerator	4,748	4,773	4,919	4,650	4,936
Denominator	5,797	5,345	5,471	5,154	5,461
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
2022	**2023**	**2024**	**2025**
Annual Objective	93.0	93.0	93.0	93.0

Field Level Notes for Form 10 NPMs:

None

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	38	40	42	45	45
Annual Indicator	27.7	38.0	37.2	36.8	36.5
Numerator	1,560	1,976	1,946	1,811	1,921
Denominator	5,637	5,195	5,227	4,926	5,257
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	45.0	45.0	45.0	45.0

Field Level Notes for Form 10 NPMs:

None

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		60	70	75	75
Annual Indicator	39.7	37.0	45.3	57.8	51.8
Numerator	5,111	5,399	6,939	7,281	5,882
Denominator	12,865	14,604	15,303	12,592	11,351
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	75.0	80.0	80.0	80.0

Field Level Notes for Form 10 NPMs:

None

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CHILD					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			40	42	44
Annual Indicator	39.7	32.4	29.9	34.1	33.5
Numerator	14,153	12,528	11,872	12,757	12,572
Denominator	35,688	38,672	39,659	37,374	37,570
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	46.0	50.0	50.0	50.0

Field Level Notes for Form 10 NPMs:

None

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		93	94	95	95
Annual Indicator	88.0	87.4	87.4	88.0	84.8
Numerator	40,460	35,604	35,604	38,754	35,611
Denominator	46,004	40,737	40,737	44,020	42,018
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2016_2017	2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	95.0	95.0	95.0	95.0

Field Level Notes for Form 10 NPMs:

None

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			25	25	30
Annual Indicator	21.8	20.4	25.1	27.6	30.8
Numerator	2,189	1,808	2,162	3,016	3,811
Denominator	10,050	8,853	8,632	10,947	12,391
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	30.0	35.0	35.0	35.0

Field Level Notes for Form 10 NPMs:

None

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		92	92	95	95
Annual Indicator	87.4	85.7	83.3	84.3	84.5
Numerator	98,305	95,571	91,502	92,788	91,792
Denominator	112,465	111,490	109,884	110,125	108,658
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	95.0	95.0	95.0	95.0

Field Level Notes for Form 10 NPMs:

None

NPM 14.1 - Percent of women who smoke during pregnancy

Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	12	10	10	8.5	8.5
Annual Indicator	15.5	15.5	14.2	13.2	13.1
Numerator	881	868	758	697	667
Denominator	5,676	5,587	5,348	5,284	5,073
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2016	2017	2018	2019	2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	8.5	7.0	7.0	7.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Vermont's maternal mortality rate is not reportable due to small sample sizes. We provide individual case data from our vital statistics system to our maternal mortality review committee on a regular basis, using all deaths to women while pregnant, up to 365 days after a linked birth, or having an ICD-10 mortality code for an obstetrical condition. Multi-year rolling estimates of this higher than-previously reported rate could be made using this number of cases as a numerator and the number of Vermont-resident births as a denominator if desired.

Form 10
State Performance Measures (SPMs)

State: Vermont

SPM 1 - % of children 6 month to 5 years who meet all 4 flourishing items

Measure Status:	Active

State Provided Data

	2017	2018	2019	2020	2021
Annual Objective	83	84	86	88	90
Annual Indicator	67.6	67.6	86.7	83.2	82.3
Numerator	22,213	24,152	31,277	28,178	25,654
Denominator	32,842	35,708	36,090	33,879	31,183
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016-17	2018	2018-19	2019-20
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives

	2022	2023	2024	2025
Annual Objective	90.0	90.0	90.0	90.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: For children age 0-5 years, four questions were asked that aimed to capture curiosity and discovery about learning, resilience, attachment with parent, and content with life. These were captured through: (1) child is affectionate and tender, (2) child bounces back quickly when things don't go his/her way, (3) child shows interest and curiosity in learning new things, and (4) child smiles and laughs a lot. The "Definitely true" response to the question indicates the child meets the flourishing item criteria.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

	Field Note: For children age 0-5 years, four questions were asked that aimed to capture curiosity and discovery about learning, resilience, attachment with parent, and content with life. These were captured through: (1) child is affectionate and tender, (2) child bounces back quickly when things don't go his/her way, (3) child shows interest and curiosity in learning new things, and (4) child smiles and laughs a lot. The "Definitely true" response to the question indicates the child meets the flourishing item criteria.	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: For children age 0-5 years, four questions were asked that aimed to capture curiosity and discovery about learning, resilience, attachment with parent, and content with life. These were captured through: (1) child is affectionate and tender, (2) child bounces back quickly when things don't go his/her way, (3) child shows interest and curiosity in learning new things, and (4) child smiles and laughs a lot. In 2018, the survey questions changed "How true…" to "How often…" with a corresponding change in the response options to: Always, Usually. Sometimes, Never. Previous years' results are not comparable.	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: For children age 0-5 years, four questions were asked that aimed to capture curiosity and discovery about learning, resilience, attachment with parent, and content with life. These were captured through: (1) child is affectionate and tender, (2) child bounces back quickly when things don't go his/her way, (3) child shows interest and curiosity in learning new things, and (4) child smiles and laughs a lot. In 2018, the survey questions changed "How true…" to "How often…" with a corresponding change in the response options to: Always, Usually. Sometimes, Never. Previous years' results are not comparable.	
5.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
For children age 0-5 years, four questions were asked that aimed to capture curiosity and discovery about learning, resilience, attachment with parent, and content with life. These were captured through:
(1) child is affectionate and tender,
(2) child bounces back quickly when things don't go his/her way,
(3) child shows interest and curiosity in learning new things, and
(4) child smiles and laughs a lot.

In 2018, the survey questions changed "How true…" to "How often…" with a corresponding change in the response options to: Always, Usually. Sometimes, Never. Results in years prior to to 2018-19 survey are not comparable with subsequent years.

SPM 2 - % of adolescents that feel they matter to people in their community

Measure Status:	Active				
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	55	58	60	63	65
Annual Indicator	60.5	60.5	58.2	58.2	58.2
Numerator	16,108	16,108	14,285	14,285	14,285
Denominator	26,614	26,614	24,524	24,524	24,524
Data Source	YRBS	YRBS	YRBS	YRBS	YRBS
Data Source Year	2017	2017	2019	2019	2019
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	65.0	66.0	66.0	66.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: This is a state-specific question not found on the national YRBS.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: This is a state-specific question not found on the national YRBS.	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: This is a state-specific question not found on the national YRBS.	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: This is a state-specific question not found on the national YRBS.	
5.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: This is a state-specific question not found on the national YRBS. Official analysis of the 2021 YRBS survey is delayed due to COVID response - can update this data next year.	

SPM 3 - Percent of Women advised by a healthcare worker to abstain from alcohol during pregnancy

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective			85	87	90
Annual Indicator	83.6	85.1	83.5	84.1	84.7
Numerator	4,596	4,587	4,321	4,301	4,160
Denominator	5,499	5,388	5,176	5,116	4,910
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	90.0	90.0	90.0	90.0

Field Level Notes for Form 10 SPMs:

None

SPM 4 - Percent of high school students who made a plan to attempt suicide in the past 12 months

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective			8	8	8
Annual Indicator		11.2	13.4	13.4	13.4
Numerator		3,048	3,454	3,454	3,454
Denominator		27,166	25,727	25,727	25,727
Data Source		YRBS	YRBS	YRBS	YRBS
Data Source Year		2017	2019	2019	2019
Provisional or Final ?		Final	Final	Final	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	7.0	7.0	7.0	7.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Due to COVID-19 deployments, official 2021 YRBS survey data is not yet available. These provisional results can be replaced next year.

SPM 5 - Percent of MCH programs that partner with family members, youth, and/or community members

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective			75	75	90
Annual Indicator		66.7	77.8	88.9	88.9
Numerator		6	7	8	8
Denominator		9	9	9	9
Data Source		Program Data	Program Data	Program Data	Program Data
Data Source Year		2018	2019	2020	2020
Provisional or Final ?		Final	Final	Final	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	90.0	100.0	100.0	100.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: MCH Programs with Partnerships in 2018: Family planning Adolescent health Health care/school health services CSHN (Pending) NBS and EHDI WIC (Pending) HMG Injury	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

	Field Note: MCH Programs with Partnerships in 2019: Family planning Adolescent health Health care/school health services CSHN NBS and EHDI WIC HMG	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: MCH Programs with Partnerships in 2020: Family planning Adolescent health Health care/school health services CSHN NBS and EHDI WIC Help Me Grow	
4.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: MCH Programs with Partnerships in 2020: Family planning Adolescent health Health care/school health services CSHN NBS and EHDI WIC Help Me Grow Injury program partnerships are pending 2021 data not yet available. 2020 data used as provisional data for now.	

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Vermont

ESM 4.1 - % of 10 Step compliant or designated Baby-friendly hospitals

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	16.7	25	33.3	33.3	41.7
Annual Indicator	16.7	16.7	18.2	18.2	18.2
Numerator	2	2	2	2	2
Denominator	12	12	11	11	11
Data Source	Program-level data	Program-level data	Program-level data	Program-level data	Program Data
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	50.0	50.0	50.0	50.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Numerator Source: https://www.babyfriendlyusa.org/for-parents/baby-friendly-facilities-by-state/
Denominator Source: Vermont Department of Health

ESM 6.1 - Number of providers trained in developmental surveillance and screening

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective			150	100	50
Annual Indicator			352	224	224
Numerator					
Denominator					
Data Source			Program Data	Program Data	Program Data
Data Source Year			2019	2020	2020
Provisional or Final ?			Final	Final	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	50.0	50.0	50.0	50.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Cumulative total in 2019 Help Me Grow Annual Report = 977 minus the cumulative total of 625 in the 2018 report.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 215 were early childhood educators & 9 were health care providers.	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: 2021 data is not yet available (6/1/2022). 2020 data is used as provisional.	

ESM 8.1.1 - Number of classrooms or schools that sign on to 3-4-50, including a commitment to daily recess

Measure Status:				Active	
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			12	12	12
Annual Indicator			9	4	0
Numerator					
Denominator					
Data Source			Program Data	Program Data	Program Data
Data Source Year			2019	2020	2021
Provisional or Final ?			Final	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	12.0	12.0	12.0	12.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: In calendar year 2019, 2 classrooms and 7 schools joined the program.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: COVID-19 has impacted this program negatively, with many schools switching to remote learning in 2021.	

ESM 10.1 - Number of public schools implementing the PATCH for Teens curriculum as part of their Health Education Curriculum

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective			5	10	15
Annual Indicator			0	0	0
Numerator					
Denominator					
Data Source			Program Data	Program Data	Program Data
Data Source Year			2019	2020	2021
Provisional or Final ?			Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	25.0	35.0	35.0	35.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Due to competing priorities and the ending of in person classes during the winter/spring of the school year due to COVID-19, we have not recruited high school sites to participate in using the curriculum yet. We plan to revisit recruitment in the next school year. Right now COVID-19 preparations continues to be the priority for school planning at this time. We hope to identify schools willing to try this curriculum and report back on reactions. We also plan to share information about PATCH through other electronic communications with schools, and through the Health Department School Liaisons.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Due to competing priorities and the ending of in person classes of the school year due to COVID-19, we have not recruited high school sites to participate in using the curriculum yet. Re-emphasizing this program in future years or replacing it as an ESM are being considered.	

ESM 12.1 - % of CYSHN that have had a transition planning meeting by their 18th birthday

Measure Status:	Inactive - Replaced				
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			30	50	70
Annual Indicator			38	38	38
Numerator					
Denominator					
Data Source			Program Data	Program Data	Program Data
Data Source Year			2019	2019	2019
Provisional or Final ?			Final	Final	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Because all of our CSHN care coordinators were deployed to the HOC as early as March 2020 and well in to 2021, we did not track that data for most of last year. 2019 data is used as a substitute.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: 2021 data is not yet available (6/1/2022). 2019 results are used as provisional data for now and can be replaced when newer data becomes available.	

ESM 12.2 - # of families, transition-aged youth, and providers who participated in transition-focused trainings using established/high-quality/best- practice transition resources

Measure Status:	Active		
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	175.0	175.0	175.0

Field Level Notes for Form 10 ESMs:

None

ESM 13.2.1 - # of students participating in Vermont's 802Smiles Network of School Dental Health Programs receiving oral health services

Measure Status:				Active	
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			3,000	3,100	3,300
Annual Indicator	1,606	1,422	3,088	3,088	3,088
Numerator					
Denominator					
Data Source	Oral Health Program	Oral Health Program	Oral Health Program	Oral Health Program	Oral Health Program
Data Source Year	2016-17	2017-18	2018-19	2018-19	2018-19
Provisional or Final ?	Final	Final	Final	Provisional	Provisional

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	3,400.0	3,500.0	3,500.0	3,500.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: The program's focus has expanded in 2018-19 to include children seen in school-based programs. Previous years' data only took into account those seen in a dental office who were referred by a school-linked 'Tooth Tutor' program.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Due to COVID-19 data team reassignments, the previous school year's data has not yet been analyzed. 2018-19 data has been re-entered for now as provisional data. In the future, we plan to revise this measure from a count to a percentage, when valid denominator data for the 802Smiles program becomes available.	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Due to COVID-19 data team reassignments, the previous school year's data has not yet been analyzed. 2018-19 data has been re-entered for now as provisional data. In the future, we plan to revise this measure from a count to a percentage, when valid denominator data for the 802Smiles program becomes available.	

ESM 14.1.1 - % of pregnant smokers who register with the QuitLine or QuitOnline

Measure Status:					Active
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	5	5	7	7	10
Annual Indicator	2.5	2.4	6.2	6.3	8.4
Numerator	19	16	37	35	47
Denominator	769	654	599	558	558
Data Source	QuitLine and Vital Statistics	QuitLine and VT Vital Statistics	QuitLine and VT Vital Statistics	QuitLine and VT Vital Statistics	QuitLine and VT Vital Statistics
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	10.0	10.0	10.0	10.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: 2018 VT Vital Statistics data is not yet available.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Numerator: In 2019, we have additional data available on those who are using the website as well as the phone helpline. 12 of the 37 cases reported here are from the QuitLine, while 25 are from the website. Denominator: 2019 Vital Statistics births data	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Numerator: In 2020, we have additional data available on those who are using the website as well as the phone helpline. 9 of the 35 cases reported here are from the QuitLine, while 26 are from the website. Denominator: 2020 Vital Statistics births data	
4.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Numerator: In 2020, we have additional data available on those who are using the website as well as the phone helpline. 10 of the 47 cases reported here are from the QuitLine, while 37 are from the website. Denominator: 2021 births data are not yet available (as of 5/10/2022). 2020 VT Vitals results are used to compute a preliminary rate, which will be revised when 2021 VT Vital statistics are finalized.	

Form 10
State Performance Measure (SPM) Detail Sheets

State: Vermont

SPM 1 - % of children 6 month to 5 years who meet all 4 flourishing items
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Promote protective factors and resiliency among Vermont's families.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** % of children 6 month to 5 years who meet all 4 flourishing items **Denominator:** # of children 6 month to 5 years
Data Sources and Data Issues:	Data source: National Survey of Children's Health
Significance:	Childhood experiences, positive or negative, can have a major impact on long-term growth and development, and health. Negative or adverse childhood experiences can contribute to chronic disease, including mental and emotional conditions, in adulthood. These negative experiences are often referred to as toxic stress or adverse childhood experiences (ACEs). Studies demonstrated that traumatic or stressful experiences such as abuse, neglect, witnessing domestic violence, parental substance use disorder and/or mental illness, divorce, and economic hardship lay down a common pathway to social, emotional, and cognitive impairments. This, in turn, can lead to increased risk of unhealthy behaviors, re-victimization and violence, disease, disability and premature death. The impacts of these experiences are cumulative—the more adverse experiences an individual undergoes—the higher the risk and incidence are for health and social problems in adulthood. This measure is based on the NSCH Indicator 2.3: Flourishing for young children ages 6 months to 5 years. It is the percentage of those responding "yes" to all four component variables: 1. Child is affectionate and tender 2. Child bounces back quickly when things don't go his/her way 3. Child shows interest and curiosity in learning new things 4. Child smiles and laughs a lot

SPM 2 - % of adolescents that feel they matter to people in their community
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	Youth choose healthy behaviors and thrive.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of adolescents that feel they matter to people in their community **Denominator:** # of adolescents that answer this question on the survey
Data Sources and Data Issues:	Data source: YRBS
Significance:	Vermont aims to promote healthy behaviors among youth through an empowerment and engagement model. Youth empowerment is a process where young people are encouraged to take charge of their lives. They do this by addressing their situation and then take action in order to improve their access to resources and transform their consciousness through their beliefs, values, and attitudes. Youth empowerment aims to improve health and quality of life. Youth engagement is the result when young people are involved in responsible, challenging actions to create positive change. This means involving youth in planning and in making decisions that affect themselves and others. Research demonstrates that youth who feel empowered and feel they matter to people in their community, are engaged in their own health and well-being in a way that promotes healthy behaviors (nutrition and physical exercise) and decreases harmful ones (alcohol, tobacco, and other drugs, impaired driving, and risky sexual activity). This only leads to long term positive health outcomes: improved mental health, reduced teen suicide, reduced teen pregnancy and STI transmission, reduced obesity and other chronic health conditions, and fewer motor vehicle accidents, to name a few.

SPM 3 - Percent of Women advised by a healthcare worker to abstain from alcohol during pregnancy
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	Ensure optimal health prior to pregnancy
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women receiving prenatal care who were advised by a healthcare worker to abstain from alcohol during pregnancy. **Denominator:** Number of women who received prenatal care.
Data Sources and Data Issues:	PRAMS
Significance:	Prenatal care and other health care providers can have a significant impact on prenatal education and health behaviors.

SPM 4 - Percent of high school students who made a plan to attempt suicide in the past 12 months
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	Youth choose healthy behaviors and thrive
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of public high school students who made a suicide plan in the last 12 months. **Denominator:** Number of public high school students.
Data Sources and Data Issues:	YRBS
Significance:	This indicator, coupled with Vermont's numbers of actual youth suicides, will inform our knowledge of population-based suicide related behaviors. These data can inform practitioners and public health planners as to how to plan interventions that are designed for both the individual practitioners and also community-based prevention. This indicator is also included in the Healthy Vermonters 2020 which documents the health status of Vermonters and the population health indicators and goals that will guide the work of VT public health through 2020. http://www.healthvermont.gov/about/performance There are several measures that describe risk behaviors related to suicide and VT MCH is using these measures to fully understand the scope of the issue of teen suicide and how to address related factors, such as bullying, mental health, substance abuse, etc. to promote effective prevention actions. For example, from the Middle School YRBS: 1) 19% of middle school students felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities, and 2) 18% of middle school students have seriously thought about killing themselves; 12% have ever made a plan about how they would kill themselves; and 6% have ever tried to kill themselves. In the high school YRBS, 16 % of the students hurt themselves on purpose without wanting to die, such as by cutting or burning during the past 12 months. Coordination with other programs and partners will be key to force a reduction in teen suicide and related behavior such as suicidal ideation and making a suicide plan. Examples include the work of the VDH Title V MCH Injury Prevention Coordinator to collaborate with health care providers and mental health on clinical screening for suicidality and follow up. In addition, the Vermont Center for Health and Learning implements the UMatter Youth and Young Adult Mental Health and Wellness Promotion Program in ten schools statewide.

SPM 5 - Percent of MCH programs that partner with family members, youth, and/or community members
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Comprehensive coordinated system of care
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of MCH programs that partner with family members, youth, and/or community members. **Denominator:** Number of MCH programs in Vermont
Data Sources and Data Issues:	Program data
Significance:	Family partnership ensures that programs and services are family-centered. Family partnership also increase leadership and engagement across the continuum and ensures that programs and services are continually engaged in self-reflection, innovation, and striving for improvement.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Vermont

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Vermont

ESM 4.1 - % of 10 Step compliant or designated Baby-friendly hospitals
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Promote optimal infant health and development, by increasing breastfeeding education and supports at birthing hospitals
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of 10 Step compliant or designated Baby-friendly hospitals **Denominator:** # of Vermont birth hospitals
Data Sources and Data Issues:	Data source: program-level data; no known data issues
Significance:	Birth hospital policies and practices significantly impact whether a woman chooses to start breastfeeding and how long she continues to breastfeed.

ESM 6.1 - Number of providers trained in developmental surveillance and screening
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Achieve a comprehensive, coordinated, and integrated state and community system of services for children.
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** Number of providers trained **Denominator:**
Data Sources and Data Issues:	Data source: Help Me Grow Annual Reports (https://www.healthvermont.gov/children-youth-families/infants-young-children/help-me-grow-program)
Significance:	To assure that children are receiving developmental screening, Vermont Title V aims to train health and social service providers in the most up-to-date and validated tools and increase awareness of referral and support resources, through provider-level, childcare, and community trainings.

ESM 8.1.1 - Number of classrooms or schools that sign on to 3-4-50, including a commitment to daily recess
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Reduce the risk of chronic disease across the lifespan.
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of classrooms or schools that sign on to 3-4-50, including a commitment to daily recess **Denominator:**
Data Sources and Data Issues:	Data source: Program data
Significance:	Recognizing the tendency to address chronic disease prevention and health promotion from discrete silos based on behavior or disease, HPDP has planned and implemented a two-pronged approach to communicate a coordinated message about chronic disease and engage new partners from multiple sectors to address it. 3-4-50 is a statewide initiative to create an epiphany about chronic disease and spur action to reduce the incidence of disease. Based on San Diego County's efforts using the three numbers, Vermont's chronic disease unit has created a series of data briefs, communication tools and partner engagement materials that focus attention on the three behaviors of tobacco use, physical inactivity and poor diet that lead to the four chronic diseases of cancer, cardiovascular disease, diabetes and lung disease that together result in more than 50 percent of deaths in Vermont. This initiative seeks to make chronic disease prevention simple and to help leaders across multiple sectors in the community recognize that they are partners in prevention. Engaging worksites, schools and childcares, cities and towns, retailers, and faith communities, the message and strategies of 3-4-50 bring data and evidence-based interventions together to create a simple to understand initiative that spurs urgent action. Specifically in schools and childcare programs, 3-4-50 calls out ways to help children learn healthy behaviors from the start. Tips for each include ways to help children eat healthier foods, be more physically active and, for older children, information and skills that will help them say no to tobacco use. The 3-4-50 tips and sign on sheets build from simple, effective interventions to more complex but longer lasting policy changes that will solidify strong nutrition and physical activity programs and prevent tobacco use initiation.

ESM 10.1 - Number of public schools implementing the PATCH for Teens curriculum as part of their Health Education Curriculum
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	Youth choose healthy behaviors and thrive.
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of public schools implementing the PATCH program **Denominator:**
Data Sources and Data Issues:	Data Source: Program data
Significance:	The PATCH (Providers and Teens Communicating for Health) program provides school health educators, health-related professionals, youth workers, and other adults the materials and resources needed to teach young people about their rights and responsibilities in health care settings. Learning objectives include: Students will understand the importance of learning to manage their own health care experiences; Students will learn how to advocate for their own health and well being in health care settings; Students will explore steps they can take to make sure they get the care they need and deserve. The main messages of the program are: Teens need and deserve a good relationship with their health care providers; Teens have legal health care rights; Teens have a personal responsibility to learn to manage their own health care.

ESM 12.1 - % of CYSHN that have had a transition planning meeting by their 18th birthday
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Measure Status:	Inactive - Replaced
Goal:	Achieve a comprehensive, coordinated, and integrated state and community system of services for children.
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of CSHCN who receive transition meetings before their 18th birthday.</td></tr><tr><td>**Denominator:**</td><td>Number of CSHCN turning 18</td></tr></table>
Data Sources and Data Issues:	Data source: Program data
Significance:	It is important for all youth to be connected to programs, services, activities, and supports that prepare them to manage their physical, mental and emotional well-being and develop life skills to make informed choices. The ability to manage one's health is a critical factor in success in school and transitioning into employment. This is especially true for youth with life-long health conditions. By assuring that youth working with the state CSHN program receive a transition meeting prior to their 18th birthday, we can better ensure youth are on the path to experience a positive transition.

ESM 12.2 - # of families, transition-aged youth, and providers who participated in transition-focused trainings using established/high-quality/best- practice transition resources
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Measure Status:	Active
Goal:	Improve transitions
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** # of families **Denominator:**
Data Sources and Data Issues:	CSHN Program Data
Evidence-based/informed strategy:	Best-practice training is a key strategy to improving competence and therefore supporting transition
Significance:	Improves competence with transitions

ESM 13.2.1 - # of students participating in Vermont's 802Smiles Network of School Dental Health Programs receiving oral health services
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	Increase the number of children, ages 1 through 17, who had a preventive dental visit in the past year, and therefore reducing the risk of oral health disease across the lifespan.
Definition:	**Unit Type:** Count **Unit Number:** 10,000 **Numerator:** # of students participating in Vermont's 802Smiles Network of School Dental Health Programs receiving oral health services **Denominator:**
Data Sources and Data Issues:	Data source: Vermont oral health program records; no known data issues.
Significance:	Vermont's 802Smiles Network of School Dental Health Programs helps to ensure that children have access to preventive, restorative and continuous oral health care. The 802Smiles Network includes school-linked programs (students are linked to local dental practices through care coordination), school-based programs (preventive dental care is provided on site), and school dental health clinics which offer both preventive and restorative dental care in a school setting. Receiving oral health services means that the student received dental care in a school-based program, in a dental van or at a dental office.

ESM 14.1.1 - % of pregnant smokers who register with the QuitLine or QuitOnline
NPM 14.1 – Percent of women who smoke during pregnancy

Measure Status:	Active
Goal:	Reduce the number of Vermont women who smoke during and after pregnancy.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of pregnant smokers who register with the QuitLine or QuitOnline **Denominator:** # of pregnant smokers
Data Sources and Data Issues:	Data sources: 802Quits Network registration information; and Vermont's Vital Statistics birth certificate data. Data issues: we are not able to track the number of pregnant women participating in Quit-in-person, so we are limited to contacts by phone or internet.
Significance:	Quit Lines and online Quit support are proven strategies to increase quit attempts and sustained quitting. Vermont's pregnancy protocol includes: 9 calls with a personal coach, text messaging support available for free, fee Nicotine Replacement Therapy with doctor's prescription, and up to $65 in incentive payments

Form 11
Other State Data

State: Vermont

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
MCH Data Access and Linkages

State: Vermont

Annual Report Year 2021

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	More often than monthly	1		
2) Vital Records Death	Yes	Yes	More often than monthly	1	Yes	
3) Medicaid	Yes	Yes	More often than monthly	1	Yes	
4) WIC	Yes	Yes	Monthly	1	No	
5) Newborn Bloodspot Screening	Yes	Yes	More often than monthly	0	Yes	
6) Newborn Hearing Screening	Yes	Yes	More often than monthly	0	Yes	
7) Hospital Discharge	Yes	Yes	Quarterly	6	No	
8) PRAMS or PRAMS-like	Yes	Yes	Annually	7	Yes	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None