Maternal and Child Health Services Title V Block Grant

Vermont

FY 2022 Application/ FY 2020 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

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Agency of Human Services

September 1, 2021

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 FY2022 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 VTers. 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, and it is attached.

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: 13.2% in VT (NVSS 2019) compared to the U.S. at 6.0%. This data is more striking when stratified by WIC participation. Yet, VT has good cessation benefits for pregnant women 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. Upcoming 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. 12.3% of women drank during the 3rd trimester of pregnancy compared to 7.5% in the US, and this is an increase from 2018 when VT's rate was 11% (PRAMS 2019 and

2018) .16% of women age 35+ drank alcohol during the last 3 months of pregnancy. Moreover, 14% of women who drank before pregnancy reported that their providers did not advise them to abstain from alcohol during pregnancy. (PRAMS 2018—note that 2019 analysis is delayed due to COVID-19) 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 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 (90.2% in 2017, compared to 84.1% for the U.S. population), there is substantial room for improvement in sustained breastfeeding (36.8%). 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 57.8% of VT children have been screened for development, and an increase from 45.3% last year (to be interpreted with caution). Data from VT's statewide medical home initiative: Blueprint for Health suggest a slightly higher rate of 66% in 2019 (63% in 2018).

MCH, with key partners, continues work on our system of universal developmental screening through *Help Me Grow*. Through a partnership with VCHIP, we have trained primary care practices and early care and education providers in using validated tools. Developmental screening is a standard for all home visiting programs and is an ACO measure, bringing synergy across multiple initiatives. Several years ago, VT launched a UDS registry to support and promote screening and coordination among health care, early learning and learning and other partners. In this reporting period, HMG staff trained 11 medical practices (including the University of Vermont Children's Hospital Neonatal Medical Follow Up Clinic), 4 Strong Families Vermont Nurse Home Visiting programs, and 12 early childhood education programs (including two Children's Integrated Services/Part C Early Intervention teams and two Head Start/Early Head Program with associated partner childcare programs). HMG's ASQ Enterprise Online System will be integrated with Vermont's Universal Developmental Screening Registry Use of the ASQ Online more than tripled in the reporting period. Previously, the system included 1,200 screens, and it is now at over 4,000 screens entered.

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 (34.1% in VT compared to 28.3% in the U.S.- NSCH 2018-19) and a slight increase from the previous year's 29.9%, 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.

Over 84% of VT children ages 1-17 had a preventive dental visit in the past year, compared to 80% for the U.S. population (NSCH 2018-19). 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 NSCH, 83.2% 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. 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 new 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 2018-19 NSCH, only 27.6% 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 VocRehab Transition Counselors.

Data from the 2018-19 NSCH shows that youth without special health needs receiving transition services (24.3%) is similar with to those with special health needs (27.6%) and slightly higher when compared to the nation (17%). 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

88%, US 80% in 2019, 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%. 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 CollN 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 2020 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

VT'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 Alcohol and Drug Abuse Programs on shared planning around substance use in pregnancy and youth substance use. MCH epidemiology, data analysis, and surveillance is conducted by staff within the Division of Health Surveillance, as is our immunization program.

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 NPMs, such as breastfeeding, tobacco & physical activity to further integrate across the health department, 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.

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 the planned ECCS funding to provide a comprehensive system of care for children & families.

III.A.3. MCH Success Story

MCH Success Story

Challenge

Although Vermont is traditionally strong in identifying delays and needs, the COVID-19 pandemic created new challenges in early identification and supporting the needs of infants and children. Primary referral sources, such as early education programs, home visiting services, pediatric practices, and the Women Infants and Children (WIC) were not able to interact directly with children and families at the onset of the pandemic. With the closure of programs and reduced ability of providers and programs to interact with children and families, developmental monitoring, screening, and referrals for early identification services dropped. Identifying food insecure families became more difficult with the limited in-person programs and services. These challenges exacerbated existing inequitable access to services and supports to meet the needs of children and families and address social determinants of health.

Solution

Vermont's Title V program has long had strong infrastructure and enduring partnerships to support our cross-cutting Help Me Grow (HMG) system. HMG's Resource Hub offers a statewide, coordinated information and referral system for earlier identification of concerns in both development and social determinants of health. HMG hosts a statewide developmental screening platform, the Ages and Stages (ASQ) Enterprise Online System, for both providers and families to access screening tools (e.g. ASQ-3 and ASQ:SE-2). HMG staff responded to the urgent need to mitigate the impact of the pandemic on children's development and early identification efforts by expanding access to the ASQ Enterprise Online system. HMG staff trained 11 medical practices (including the University of Vermont Children's Hospital Neonatal Medical Follow Up Clinic), four Strong Families Vermont Nurse Home Visiting programs, and 12 early childhood education programs (including two Children's Integrated Services/Part C Early Intervention teams and two Head Start/Early Head Program with associated partner childcare programs). HMG's ASQ Enterprise Online System will be integrated with Vermont's Universal Developmental Screening Registry Use of the ASQ Online more than doubled (during the reporting period) from 1,200 screens to over 4,000 screens entered.

Sustaining success

HMG developed and strengthened partnerships and improved our credibility with the field. These gains can be leveraged to improve early childhood MCH outcomes and advance early identification efforts long into the future.

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 623,989 (Census population estimate, 2019). 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 he or she 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 38.5 years. And the state/national age gap is widening, from about two years in 2000 to over four years in 2019.

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 7.4% of the total population (2019 Census population estimates), are proportionately small compared to the rest of the U.S., the percentage of people of color has nearly 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 8,200 who identify as Black/African American, 2,100 as American Indian/ Alaskan Native, 12,000 as Asian/Pacific Islander, 12,700 as Hispanic, and 11,500 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. 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 $35,702 (ACS) and the median household income was $63,001, approximately the national average. Ten percent of Vermonters earned incomes below the Federal Poverty Level. 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 312,790 (April 2020), according to the U.S. Bureau of Labor Statistics. The state unemployment rate in May 2021 was 2.6% compared to 5.9% 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. In 2019, 93.7% of adults age 25 and older had a high school education or more, compared to 88.5% for the U.S., and 38.7% had earned a bachelor's degree or higher, compared to 33.1% 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 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 2019, 85.3 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 2019, 6.6 percent of Vermont resident births were low birth weight (less than 2,500 grams or 5 pounds, 8 ounces) and 0.9 percent 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 8.3 percent. Vermont has very high rates of children enrolled in health insurance (98%). All pediatric providers in Vermont accept Medicaid. The 2021 Annie E. Casey *Kids Count* ranks Vermont 4th in overall child well-being and 4th in the health domain for children and 3rd in family and community rank. The 2020 Kids Count reports that Vermont is ranked 9th in economic well-being. Data from the 2021 *Kids Count* report shows troubling economic indicators for Vermont:

12%	children in poverty (2018)
27%	children whose parents lack secure employment (2018)
26%	children living in households with a high housing cost burden (2018)
7%	teens not in school and not working (2018)

According to the 2021 Kids Count report (based on 2017-2019 ACS data), 36% of 3- and 4-year-olds were not enrolled in school, including prekindergarten education or kindergarten. Nationally, Vermont has the highest per pupil spending and the lowest student-to-staff ratio. The state projects continuing declines through at least 2030. These projections also indicate that the number of working age adults and taxpayers will decline through at least 2030. These demographics are prompting critical community and state discussions on public school funding and the make-up of Vermont's rural school districts. According to the Annie E. Casey Foundation, VT has a low, but growing percentage of high school students that do not graduate in four years ranged (16% for 2018-2019).

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.

According to the 2019 BRFSS, more than nine in ten (93%) Vermont adults under the age of 65 said they have a health plan, in 2019. This is significantly higher than the 86% 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-six percent of Vermont adults reported having a personal health care provider in 2019, significantly higher than the 77% reported by U.S. adults. Less than one in ten (9%) 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 12% among U.S. adults. Vermont is a Medicaid-expansion state with generous Medicaid benefits and a global commitment waiver that allows Vermont a high degree of flexibility and innovation.

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 ~51 primary and ~13 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 (attached to CAHs), 12 Planned Parenthood of Northern New England health centers, 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.

In 2019, there were 5,361 babies born to Vermont residents. The crude birth rate in 2019 was 8.6 per 1,000 residents, a slight decrease from the 2018 rate. The teen pregnancy rate for ages 15-19 was 11.7 per 1,000, lower than the 2018 rate of 12.8 and the 2017 rate of 14.4. In general, the teen pregnancy rate has been decreasing since 1991. Teen pregnancies vary significantly among communities. Due to COVID-19, teen pregnancy rates for 2019 have not yet been calculated, but the 2018 rates show that while Burlington/Chittenden County (Vermont's only MSA) has a teen pregnancy rate of 6.5 per 1,000 female 15-19 population, rural communities such as Newport (34.1) , Springfield (25.2), Morrisville (22.0), and Bennington (21.6) 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 3.3% of first births for 2018, slightly higher than the 2017 rate of 3.1%.

Although Vermont has low rates of teen births, high rates of health insurance and access, Vermont is faced with ongoing and emerging economic, social, and health issues that impact the maternal and child health population in significant and troubling ways. Vermonters have among the highest rates of alcohol, tobacco use, and substance use during pregnancy, placing the health of mothers and children at risk. According to the most recent data from Vermont's 2018 PRAMS:

24%	women smoked in the 3 months prior to pregnancy; 15% in the last trimester
68%	women drank at least some alcohol in the 3 months prior to pregnancy; 18% had at least one binge during this same time
11%	women drank during the last 3 months of their pregnancy; 16% of women age 35 or older drank alcohol during the last 3 months of pregnancy
10%	smoked marijuana during pregnancy,
67%	women felt they had too little time off available to them after delivery
63%	had their teeth cleaned during pregnancy

Opioid and other substance abuse and dependence during pregnancy is a significant problem in Vermont. The rate of infants born exposed to opioids is increasing in Vermont: 23.7 per 1,000 live births in 2018 (a significant reduction from 29.4 per 1,000 live births in 2017; 2019 data not available due to COVID-19 capacity challenges) compared to a rate of 16.8 per 1,000 live births in 2008. The increase may be partially explained by an increase in provider awareness and increased access to treatment. The U.S. rate is calculated slightly differently from the VT rate. When using the same diagnosis code, the VT rate is four times higher than the national average in 2018 (23.7 compared to 12.9 in the New England states and 6.7, nationally) (birth hospitalization data, HRSA). Quality improvement data have shown that the clear majority of women delivering an infant with neonatal abstinence syndrome (NAS) are on Medication-Assisted Treatment (MAT). 81% of women delivering an NAS infant were on Medicaid (2019 data not available due to COVID-19 capacity challenges).

Vermont's child protection system has struggled in the past few years—with rising caseloads and increasingly complex cases, including substance use. In 2020, there were:

- 15,722 reports were made to the Child Protection Line in 2020 — 4,356 fewer than in 2019
    - This 21.69% decrease in reports is almost certainly an anomaly due to the COVID-19 pandemic. Stay-at-home orders and school closures kept children away from the watchful eyes of mandated reporters — especially educators who typically make about a third of all child abuse and neglect reports in Vermont
    - At the conclusion of the 3,620 child safety interventions, 794 cases were opened for ongoing services representing 649 unique child victims

During the last quarter of 2020, there were:

- 1,093 children in DCF custody

- 435 children in the conditional custody of a parent, relative or other person known to the child and family
- 348 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/2020-CP-Report.pdf)

The impact of trauma and adverse family experiences are felt in Vermont, as they are throughout the country. According to the National Survey of Children's Health 2018-19, 20.3% of children and youth in Vermont has experienced two or more adverse family experiences (AFE), compared to 18.2% nationally. While most children fare well, a sizeable number of Vermont children live in families that are experiencing challenges. These challenges have the possibility of directly and indirectly impacting the social-emotional development of children.

6.7%	Vermont children live in a home where the family demonstrates little to no qualities of resilience during difficult times
6.7%	Vermont children live in a household where mother's mental/emotional health is fair or poor
5.3%	Vermont children live in a household where father's mental/emotional health is fair or poor
5.4%	Vermont children have parents who felt aggravated by parenting during the past month

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 will help 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 full up-to-date.

The Public Health Accreditation Board (PHAB) Accreditation Committee awarded five-year accreditation status to the VT Department of Health on June 18, 2014, and Vermont is in the process of applying for reaccreditation this year. 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 in order to continue to improve the quality of our services and performance. We are in the final phases of submitting our application for reaccreditation.

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

Our legislative sessions ended with notable new laws to protect maternal and child health:

S.114 (Act 28) An act relating to improving prekindergarten through grade 12 literacy within the State.

H.171 (Act 45) An act relating to the governance and financing of Vermont's child care system.

H.430 (Act 48) An act relating to eligibility for Dr. Dynasaur-like coverage for all income-eligible children and pregnant individuals regardless of immigration status.

S.115 (Act 66) An act relating to making miscellaneous changes in education laws

H.426 (Act 72) An act relating to addressing the needs and conditions of public school facilities in the State (Section 12 requires all schools to test for radon)

H.439 (Act 74) An act relating to making appropriations for the support of government (Appropriations were made to support polychlorinated biphenyls testing in schools, including $500,000 to the Vermont Department of Health)

III.C. Needs Assessment
FY 2022 Application/FY 2020 Annual Report Update

Needs Assessment Update: FY 2022

Vermont conducted a new needs assessment last year; however, VT continually reviews MCH data & gaps in services. Vermont's COVID-19 has impacted MCH efforts over the last year, and while the Department of Health is committed to building additional capacity to manage the COVID-19 response moving forward, the majority of VDH employees have been and will be part of the COVID-19 response in the state. MCH is proud of this work including contact tracing and index patient interviews, quality improvement & data review to support contact tracing efforts, standing up the School & Childcare branch of the COVID-19 response, leading the effort to create a case manager program for Vermonters in need as a result of COVID-19 diagnosis or requests to quarantine, & 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 2021-2022.
- VT MCH completed in depth briefs on many of our Title V performance measures.
- 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. Recent examples include: "Maternal Substance Use", "Depression" and "LGBT Health. 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 and partners such as: The Office of Head Start, Department for Children and Families and Alcohol and Drug Abuse 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's 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.

New legislation passed to allow for the licensing of a new midlevel dental therapist in VT, which will significantly increase access for all patients to dental providers. Nurse home visitors, parent educators, & WIC staff regularly screen pregnant women for tobacco use & refer to the Quit Line resources & medical follow up..

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. VT just recently passed legislation to require paid sick leave for employees, which is of major significance in supporting perinatal, infant & family health. There are currently multiple bills before the Vermont legislature to promote paid family leave—although in the past Vermont's Governor has vetoed a mandator leave program. Additionally, Vermont is exploring whether to expand postpartum Medicaid coverage from 60 days to 1 year. 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 will be revisited this coming year.

Children's Health

VT continues to expand its services & supports for early childhood. VT's Help Me Grow system is about to celebrate its fifth 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.

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 remains committed to the enhancement of its Medical Home/CSHN Care Coordination Model, whereby we redefined & redeployed care coordination efforts by placing medical social workers into medical homes. 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 including their Children, Youth, & Family division.

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. More recently, the AHS Secretary has signaled interest in expanding childhood physical activity and nutrition activities.

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 VTers. In fact, he allocated funds in the SFY20 budget for sustained home visiting which unfortunately was put on hold due to COVID, yet the leadership remains fully committed to a continuum of home visiting from universal to episodic/targeted to sustained.

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, Title X, PREP, EPSDT/school health & significant pieces of the Preschool Development Grant. 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 licensing 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. Our division collaborates with the health education consultant at Agency of Education to align skills and content in our state's approach to health education in pubic 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 2021-2022 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

VT'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 is also participating 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.

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, we are jointly planning around Family First prevention funds that will be coming and how MCH programs, especially home visiting, is an essential and effective child maltreatment prevention strategy.

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.

Until recently, Planned Parenthood made up VT's Title X network of family planning centers. On August 15, 2019, Vermont relinquished our Title X funding. 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. 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 be the same as it was funded under Title X. Consequently, funding for the administration of this new state-funded program (staff time) is now supported directly through Title V. With the new administration's commitment to restoring Title X without these restrictions, MCH is looking forward to rejoining the Title X program in the months to come.

Five-Year Needs Assessment Summary
(as submitted with the FY 2021 Application/FY 2019 Annual Report)

III.C.2.a. Process Description

This needs assessment was conducted from July 2019 through February 2020 in accordance with these statutory mandates and priorities, with a broad goal of ensuring that VT's women, adolescents, children, children with special health needs, as well as all parents and families have what they need to be healthy and well, in accordance with VT's State Health Improvement Plan, which envisions that *"All people in VT have a fair and just opportunity to be healthy and to live in healthy communities."* The assessment focused on understanding strengths and needs across VT for MCH's five identified population domains:

- women's and maternal health
- perinatal and infant health
- children's health
- adolescent health
- children with special health needs

Results will inform future MCH efforts to improve health and access to care for women, infants, children, adolescents, and families.

GOALS, FRAMEWORK AND METHODOLOGY

Assessment activities were conducted independently by Noonmark Services, a Burlington-based consulting firm with expertise in public health assessment and evaluation, strategic planning, and organizational development. Noonmark worked closely with MCH staff leaders to establish the scope of the assessment inquiry, to develop assessment plans and instruments, and to reach a wide cross-section of MCH leadership partners, stakeholders, service users, and members of the community at-large. VT's Title V assessment was conducted concurrently with a five-year needs assessment for the Maternal, Infant, Early Childhood Home Visiting (MIECHV) program, as many states have done, in accordance with federal guidance from both programs. VT stakeholders concurrently conducted a statewide needs assessment of VT's early childhood systems under the Administration for Children and Families Preschool Development Birth through Five (PDG B-5) grant, which provided some additional data because MCH is a PDG B-5 stakeholder. Data from this assessment have been used for both the Title V and MIECHV needs assessment reports. The assessment received a VT Agency of Human Services Institutional Review Board (IRB) waiver.

Noonmark conducted interviews with VT state agency partners and leaders, as well as MCH division staff members. Data from these interviews were summarized and used to formulate plans to reach priority populations from all regions of the state, and to reflect MCH's five identified population domains.

The assessment team collected and reviewed data from a variety of state-level public health surveillance systems to identify key topics for the assessment. The assessment team generated two open-ended focus group question lists for (1) service providers and practitioners and (2) consumers/service users and community members. A focus group plan was established to reach identified groups in each region of VT. Question lists are provided in Appendix 1.

An online community survey using Survey Monkey was developed, drawing on published MCH community needs assessments from other states to develop the survey questionnaire. The survey was disseminated via MCH partners and stakeholders, as well as by purchasing statewide distribution via Front Porch Forum, a statewide email listserv for community information exchange (Figure 1). These methods engaged individuals who reside in and/or who provide services for individuals in every VT county. The assessment included focused efforts to reach VT BIPOC residents, including immigrant and refugee parents and families, as well as youth (ages 13 to 18).

STAKEHOLDER INVOLVEMENT, INCLUDING FAMILIES, INDIVIDUALS AND FAMILY-LED ORGANIZATIONS

Using the methods described above, Noonmark collected assessment data from 466 individual contacts. In total, 28% of contacts were people who administer or provide services to MCH populations and 72% were people who use MCH services, have used services in the past, or are members of the larger community, including parents, grandparents, foster parents

and guardians, and people who care for children with special health needs.

State agency and service provider stakeholders: Noonmark conducted interviews with 17 key stakeholders and ten focus groups with service providers, which engaged 85 individuals. State agency representatives, service providers, and practitioners who participated in interviews and focus groups included representatives from the VT Department for Children and Families, VT Department of Mental Health, One Care VT (the state's Accountable Care Organization), VT Child Health Improvement Program (VCHIP), VDH Alcohol and Drug Abuse Programs (ADAP), Help Me Grow VT, VT Family Network, Burlington School District Diversity and Equity Team, the State Refugee Coordinator.

In addition, MCH Coordinators (public health nurses at the local level), Children's Integrated Services (CIS) coordinators, MIECHV nurses, supervisors and other home visiting program staff, primary care and OB/GYN physicians and nurses, MCH Children with Special Health Needs staff, Parent Child Centers, school nurses, and community organizations (mental health, early childhood, youth) participated in the assessment.

Service users and community members: The community at large primarily participated via a statewide survey (described under *Quantitative Data*, below). Noonmark worked closely with MCH partners to conduct five focus groups with consumers and community members:

- Two groups of immigrant/ refugee parents in Burlington (grouped by language for translation) (20 participants)
- VT Rays high school youth (5 participants)
- Prevent Child Abuse VT Parent Support Group- Caledonia County (2 participants)
- Clarina Howard Nichols Center Moms Group- Lamoille County (5 participants)

Each focus group participant who was a service user or community member received a $20 gift card or cash incentive for their participation. Childcare and interpretation in multiple languages were provided as needed.

QUALITATIVE DATA SOURCES

Interviews, focus groups, and open-ended survey questions provided a substantial body of qualitative data. In these sessions, interviews/ facilitators asked open-ended questions about health and wellness, access to care, needs and concerns, and emerging issues using a pre-planned list of questions. Each focus group or interview had a designated note-taker who documented the session. The assessment team standardized transcripts from each session, removed identifying information, and generated a master transcript. From the master transcript, qualitative date was coded and grouped into domains and themes..

QUANTITATIVE DATA SOURCES

Data collected via VDH annual, semi-annual, and special reports, and responses to survey data comprise the quantitative data collected and reviewed for this assessment. Survey results were analyzed using Survey Monkey, Microsoft Excel, and STATA to provide descriptive statistics including totals, averages, percentages, and medians. Raw population-level indicator data from public health surveillance systems was standardized, and Z-scores were calculated to indicate health risks for MCH domains at the state and county levels. Front Porch Forum's analytics and Survey Monkey user data provided information about the survey's reach across the State of VT.

DATA SOURCES USED TO INFORM THE NEEDS ASSESSMENT PROCESS

MCH staff provided state-level indicator data from public health surveillance system sources such as the Behavioral Risk Factor Surveillance System (BRFSS), VT Youth Risk Behavior Survey (YRBS), the Pregnancy Risk Assessment Monitoring System (PRAMS), School Health Profiles, and other population-level data systems. Other data sources included recent publications and data summaries from state agencies such as the VT Child Health Improvement Program (VCHIP) at UVM and VT Department for Children and Families (DCF) annual and legislative reports, and from collaborative efforts such as the recent report from Building Bright Futures, *"How are VT's Young Children and Families?"*, *the VT Early Childhood and Afterschool Workforce Report*, and the *Stalled at the Start* report from Let's Grow Kids and numerous others.

III.C.2.b. Findings

III.C.2.b.i. MCH Population Health Status

Vermont is home to 257,000 adult women and 118,425 children and youth ages 0 to 18. In FY 18, VT's Title V services reached 86% of pregnant women, 94% of infants, 98% of children and youth ages 1 to 21, and 98% of children with special health needs. Women, infants, children, and youth across the life course are generally found to be healthier than their U.S. counterparts across numerous health status indicators. At the same time, factors related to VT's rurality, and the unique obstacles rural geography creates for low-income women and families provide a critical context for understanding and interpreting identified needs.

The role of rurality in maternal and child health: According to the U.S. Census, VT is the second least populated state and has the highest percentage of rural residents, with 82.6% of the population residing in rural areas compared to only 14% nationwide. VT's rural geography and context give the state a distinct social and political character.

Low-income residents of rural counties encounter poorer health outcomes for all ages and sub-populations. VT's mountainous geography, the limited availability of many kinds of services in small, geographically remote communities, lack of access to public transportation, and difficult winter driving conditions exacerbate the barriers vulnerable populations encounter in accessing services and support. Having access to a vehicle plays a critical role in the ability to receive health and social services.

For MCH populations, access to care, including access to prenatal, OB/GYN, maternity, and perinatal services are more limited in rural areas. In VT, declining and aging populations in rural communities contributed to two hospital maternity program closures in the last two years, meaning that women in some southeastern VT towns must travel an hour or more to reach labor and delivery services, with greater variability in their access to prenatal care.

ADDRESSING BASIC NEEDS

Addressing basic needs such as housing, food security, and transportation are integral to health and wellbeing. In focus groups and surveys, access to housing was the most commonly identified unmet need for families.

Housing issues centered around the lack of affordable housing in all regions of the state, where 46% of renters pay more than 30% of their income for housing,[1] and as do 33% of homeowners. The DCF Office of Economic Opportunity reported that it served 3,872 people at publicly funded homeless shelters in FY18, including 1,102 children. While the total number of people served has declined from a high of 4,303 in 2015, the number of homeless children was at its highest in 2018.[2]

Transportation barriers, including lack of public transportation in rural areas, no usable vehicle (including no winter tires, need for repairs, vehicle not insured or not inspected), difficulty accessing family-friendly transportation for low-income households where a child or adult has special health needs were common themes. In many instances service providers identified unmet housing needs, while community members/service users identified needs for employment or a stable source of income, reflecting their different orientation to fundamental basic needs concerns. For families, having a secure income may be viewed as a pathway to meeting all basic needs, including housing.

For low-income households, access to affordable, healthy food was a frequently identified challenge. Despite the decrease, one in seven children in VT is food insecure.[3]

The Annie E. Casey Foundation's Kids Count report ranked VT 17th in the US in economic well-being, acknowledging the close connection between child and family health and economic well-being.

In many cases, the extent to which families can effectively address children's and adolescents' health needs was viewed as secondary to addressing basic needs. Families that struggle to maintain stable housing or adequate food viewed these concerns as the most significant issues they face. According to individuals who responded to the *Access to Health and Wellness Survey*, housing, food, and accessible and affordable healthcare were the three most "critically necessary factors for women, children, and families to thrive." Because Title V services are especially focused on meeting the needs of low-income families, identifying creative and innovative strategies to increase equity and mitigate obstacles to meeting basic needs must continue to be a high priority.

Survey respondents were the least likely to view support for breastfeeding (56%), culturally relevant support and services (56%), and help navigating systems (63%) as critically necessary. Community members who responded to the survey

frequently commented on a need to address “social isolation” and “connectedness.” The frequency of open-ended responses which named needs for interpersonal support, and those which described positive relationships as a significant contributing factor to health and wellness suggest that there are additional opportunities to strengthen approaches that nurture the interpersonal connections that promote health.

Access to services: MCH services before, during, and after pregnancy were the most commonly identified as “always” or “usually” accessible resources. Survey respondents were least likely to identify services to reduce stress, train parents on care coordination, and promote health and safety for youth.

“Where do you physically go in your neighborhood or community for health information or discussion about health issues or health information?”

Survey respondents overwhelmingly seek health information from health care providers and formal health settings, for all three populations. Informal spaces such as hair salons were the least likely resource for health information. Schools were the second most commonly identified health information resource for children and youth, but were less commonly identified for other groups.

WOMEN/ MATERNAL HEALTH

Summary: VT’s Title V women’s and maternal health programs and services address prenatal care, pregnancy planning and prevention, sexual and domestic violence, and maternal mental health, among others. Assessment participants generally identified prenatal and maternal health care services as a strength in VT. VT Medicaid covers pregnancy care up to 200% FPL, facilitating access for a substantial proportion of those with the greatest barriers to access.

In focus groups, providers referenced a variety of maternal health efforts that are working well, including the Women’s Health Initiative, home breastfeeding support, and perinatal depression services funded under VT’s STAMPP grant (described below). The MCH workforce was frequently cited as a strength, with many examples of stakeholders who view the nurses, social workers, home visitors, OB/GYNs, primary care providers and numerous others as exhibiting tremendous professionalism, dedication to their roles, and an investment in maintaining a high level of expertise within their fields.

“There are so many people in VT doing good work, and countless folks throughout the state wanting to make things work. This is the strength of the state.”

Strengths: The state has the highest 1st trimester prenatal care rates in the country, with 87.1% of infants were born to mothers who began prenatal care in the first three months of pregnancy (2017). VT exceeded its goal for providing free and low-cost family planning services.

Needs: VT’s overall rate of live births from intended pregnancies is the same as the national average (59.6% compared to 58.9%)[4]. However, according to 2018 PRAMS data, young women and low-income women in VT experience substantially higher rates of unintended pregnancies. The high rates of unintended pregnancies for those under 24 suggest that there continues to be a need for pregnancy prevention and family planning services for younger women.

In focus groups, immigrant and refugee women described numerous differences in their expectations about the prenatal and labor/delivery care they received, including cultural factors about motherhood and childbirth. For example, many immigrant and refugee women stated that they wanted longer hospital stays after delivery. Most agreed that they received a high quality of care.

The closure of the childbirth center at Springfield Hospital in 2019 was identified as a challenge for women in Southeast VT. Two hospitals with maternity services are located within a 45-minute drive from Springfield. This closure follows the closure of the maternity ward at hospital in Lebanon, NH in 2018. Women in this region may need to travel up to one hour for prenatal care.

MATERNAL/ PRENATAL SUBSTANCE USE

Substance use and dependence during pregnancy is a significant problem in VT, where the rate of substance use during pregnancy (28.2/1,000 births) is four times higher than the U.S. rate (6.8/1,000 births).

The incidence rate of infants born with a diagnosis of drug withdrawal syndrome peaked in 2014.[5] The incidence remains

more than double the 2007 rate of 12.8 cases per 1,000 live births, suggesting that substance use treatment intervention for pregnant women continues to be a high priority concern. QI data have shown that most women delivering an infant with neonatal abstinence syndrome are on Medication-Assisted Treatment. Among women who delivered an infant with NAS, 89% were insured under Medicaid.[6]

Few consumers who participated in the assessment raised topics related to maternal and prenatal substance use. MCH providers agreed that addressing substance use among pregnant women is difficult, largely because of significant stigma. Providers stated that pregnant women may be reluctant to identify and seek care for substance use, fearing negative responses from health care providers. Home visitors noted that they may receive and follow different guidance pertaining to substance use during pregnancy than the physicians who are providing prenatal care.

Providers identified the lack of specialized services available for low-income pregnant women who need substance use disorders treatment as a persistent challenge in many regions of the state. Providers generally agreed that when a postpartum mother with SUD treatment needs is effectively linked to services, the system works well. At the same time providers found that stress during the postpartum period can jeopardize SUD recovery, and that many families would benefit from more intensive support for a longer period of time.

Maternal Mental Health

All MCH populations identified mental health conditions and access to mental health care as important concerns.

PERINATAL/INFANT HEALTH

Summary: VT offers far-ranging services for new parents and infants, touching the lives of approximately 94% of all newborns and 86% of all pregnant women, including high rates of breastfeeding and WIC eligibility.

Strengths and Assets: Both service providers and service users generally identified perinatal and infant health needs as being well addressed, and view these services as valuable to public health. MCH programs such as DULCE *(see Formal and Informal Collaborations and Partnerships for a description*), home visiting, breastfeeding support, immunization and well-child services were identified as “working well.” Service providers who were familiar with the DULCE model of integrated care cited a variety of benefits to the program and endorsed the idea of making this approach available statewide.

The quality of home visiting services available for eligible families, including those with newborns, young parents, low-income parents, and parents with a history of or risk for substance use, was identified as a strength. Home visiting providers agreed that there is less stigma about receiving home visiting services than they found in the past, and that families are generally respond positively to receiving home-based care.[7]

Needs: Providers who deliver perinatal and infant health services identified needs to improve the quality or accessibility of services, especially for low and middle-income mothers and those with complex circumstances and support needs. In general, providers noted that low-income families’ needs have become more complex, and that providers are rarely called upon to address only one category of need. Fully addressing families’ diverse needs requires substantial cross training among providers of services for families, and well-coordinated team approaches when multiple kinds of specialized expertise are needed.

In keeping with national trends, the number of WIC participants in VT has declined steadily, reaching roughly two-thirds of eligible households. Focus group participants noted that the 2016 transition to eWIC has facilitated better access for some households, but posed challenges for the most isolated, underserved, and remote families.

As with other MCH populations, access to mental health care, including mental health providers for women who experience postpartum depression, was identified as a significant unmet need throughout the state. Few consumers discussed maternal mental health concerns. One survey respondent used an open-ended survey field to describe her experience:

“More support-- and early on-- for postpartum depression would have been hugely helpful after giving birth. I felt there were limited resources given to me when I was struggling.”

Providers identified the current HRSA-funded ***Screening, Treatment and Access for Mothers & Perinatal Partners (STAMPP***) project as a promising opportunity to improve responses to postpartum depression and address maternal mental

health needs.

Providers identified regional differences in the availability and/or quality of prenatal and maternal health care. Specifically, some regions identified needs for more free or low-cost prenatal/ birth planning classes for women with Medicaid, access to same-day contraceptive care, and general gynecology resources and services for women who are not pregnant, including those addressing fertility concerns, as well as better support for middle income families who have less access to income-based services.

Child Health

Summary: VT children have high rates of developmental screening, immunizations, and health insurance coverage. Most VT children are enrolled in health insurance (98%) and 91% of young children saw a health care provider in the last year. All pediatric providers in VT accept Medicaid. For most children, factors related to health and well-being are directly connected to family stability and economic security.

Strengths: Children in VT have access to pediatric primary care and school-based health services such as screenings and prevention programs. Regions where primary care providers are operating as the child's medical home were described as working well and effectively connecting children and families to the range of physical, emotional, behavioral, and developmental supports they need most. VT has one of the highest rates of child health care coverage in the United States, with 98% of children covered by a health insurance plan.

Help Me Grow VT is administered by MCH, and is part of the national *Help Me Grow* program, which seeks to ensure all young children receive developmental screenings to support healthy development by engaging families, pediatricians, childcare providers, and others in the early childhood system. Help Me Grow's child development specialists provide information and referrals, provide developmental monitoring and screening, offer care coordination among multiple service delivery systems, and also assist women and families in accessing perinatal support. Help Me Grow's work has generated important results[8]:

Needs: According to the NSCH 2017, approximately 23% of children and youth in VT have experienced two or more adverse experiences, compared to 19.3% nationally.[9] Family adversity may directly and indirectly impact children's physical, social, and emotional development.

VT's child protection system under the Department for Children and Families (DCF) has encountered rising caseloads and increasingly complex cases, including rising cases where parental substance use is a factor. In its *Annual Report on Outcomes for VTers* (2019), DCF reported conducting 20,758 child abuse and neglect intakes, with very little change from the prior year (20,985 intakes). [10] From 2014 to 2019, the number of children in DCF custody increased by 29%.

***Need for pediatric mental health care and screening*:** School-based mental health services for school-aged children are available in some regions of the state but not others. Many MCH providers stated that mental health support for children, including screening, psychiatric evaluations, outpatient counseling, and intensive/inpatient treatment services are largely unavailable, or that there are long waitlists for pediatric mental health specialists. The number of children who accessed mental health services has increased substantially in the last two decades.[11]

Other children's health needs that were identified via the survey and focus groups are addressed under the *Adolescent Health* and *Children with Special Health Needs* sections that follow.

Adolescent Health

Summary: VT youth fare better than their same-aged peers nationwide on numerous indicators. Many stakeholders commented on the relative invisibility of services for youth within MCH's scope, noting that the transition points that come

with aging out of programs for younger children make adolescent populations uniquely vulnerable.

Strengths: In 2017, 89% of students completed high school in four years. Over the past decade there has been a 50% decrease in the number of students who smoked cigarettes during the past 30 days. On most YRBS indicators, VT youth fare better than their peers nationally. While only 22% of high school students reported participating in 60 minutes of daily physical activity, 46% of students reporting physical activity at least five days in the previous week. VT's adolescent health systems are well served by effective collaborations with a number of youth-serving efforts

Needs: In the *Access to Health and Wellness Survey*, 43.9% of respondents said developmental programs for youth are either "never" or "seldom" available, compared to only 34.4% of respondents who indicated that such programs are "usually" or "always" available. Most survey respondents were adults who are parents and caregivers, who may not be well aware of services that do exist or may have been responding based on a perception about what was available for themselves, their children or grandchildren. According to VT Afterschool, between 12% and 30% of VT middle and high school students do not participate in any sort of group activity supervised by trained adults when they are not at home or school. [12] Similarly, bullying prevention and support to transition to the adult health care system were identified as "never" or "seldom" available by most respondents. As the majority of respondents indicated that such programming is not accessible, these areas may warrant additional investigation.

A 2018 survey of more than 500 VT high school youth identified drug and alcohol use, sexism (body shaming and harassment), personal emotional safety, and bullying as major concerns.[13] Family poverty and lacking resources were identified as a top concern for older youth and for LGBTQ youth. At home, youth were concerned about stress, mental health for themselves and other household members, and emotional safety. This survey, YRBS data, and input from focus group participants identify mental health, substance use, sexual violence, and transitioning to adult systems of care as significant needs for youth.

Substance use: Youth and adults who work with youth who participated in focus groups expressed concerns about the rapid increase in rates of vaping and prevalence of electronic vaping products among youth, and the need for continued effort to reduce risk behaviors that are associated with substance use for youth.

At the system level, stakeholders acknowledged that addressing substance use for youth is under-resourced in VT. Treatment programs for young adults are specialized in nature, making it difficult for small communities to provide an adequate level of care. Providers noted that these services aren't well integrated into the adult treatment systems.

Sexual and dating violence[14]:

Nearly one in five high school students (18%) have ever had unwanted sexual contact (kissing, touching, sexual intercourse), including 28% of female students and 8% of male students. More than one in three LGBT youth (38%) reported experiencing sexual harm. 27% of high school students reported emotional abuse in an intimate relationship; 8% reported physical violence in a dating relationship.

In 2018, VT's CDC-funded Rape Prevention Education (RPE) Program conducted interviews and focus groups with roughly 40 adults who work with youth, including prevention educators, youth specialists, and school personnel.[15] The assessment identified opportunities to strengthen sexual violence prevention (and other risk-behavior focused prevention) systems for youth.

***Mental health needs*:** The percentage of students who reported feeling sad or hopeless in the past 12 months increased from 21% in 2009 to 31% in 2019. Among youth and adults who work with youth who participated in focus groups identified mental health concerns (and especially stress, anxiety, and depression) as one of the most important topics for VT youth. Youth spoke about the prevalence of mental health concerns among peers, while providers spoke about the scarcity of youth-friendly clinical resources, long waits for counseling, and need for more outreach and education to increase recognition of mental health concerns when they arise, and to decrease the stigma associated with seeking help. Relatedly, youth focus group participants agreed that more is needed to help young adults "find purpose," learn about goal setting, and receive support as they enter adulthood.

Systems of support for the transition to adulthood: Adults who work with youth indicated that systems of healthcare and support are not seamless when youth reach adulthood, and that youth may not have sufficient health literacy to navigate

the transition from pediatric to adult care systems. Adults who work with youth also frequently identified concerns about how well youth access services as they reach adulthood. This transition period presents a unique opportunity for service providers, who acknowledge that there are a variety of firm barriers and boundaries between programs and services for youth and those intended for adults.

LGBT youth reported more high-risk behaviors and worse mental health than their non-LGBT peers. LGBT populations are a priority for MCH programming. MCH partners with, and has received training from Outright VT, a statewide organization that serves LGBT-identified youth and their families.

CHILDREN WITH SPECIAL HEALTH NEEDS (CSHN)

Summary: VDH's CSHN team coordinates care for approximately 700 children. Medical social workers provide care coordination to help families navigate the healthcare system; provide respite funding for parents and caregivers; bring teams of providers and educators together to coordinate care; and help families manage specialized care. VT's high rate of children with Medicaid coverage is a strength, because it ensures that CSHN can access medical care, developmental and behavioral therapy, dental care, and other needed support.

Strengths: Providers and consumers find that the level of coordinated care families with CSHN receive, systems for early identification/ developmental screening, and "collaborative teaming" to provide care are "working well." Statewide, approximately 61% of children ages 0 to 3 received recommended developmental screenings, which are one of the tools that identify CSHN.[16]

Needs: Unmet needs and areas where the system is not working well for CSHN were among the most frequently discussed topics focus group participants identified, even in instances where the group was not specifically focused on CSHN populations. MCH providers identified needs for a stronger CSHN workforce, with a more robust system of training and support for personal care assistants (PCAs) and paraprofessionals. Providers expressed concerns about the stress that inadequate workforce resources place on providers and on families, citing a lack of available respite providers even when a family receives funds to support respite care.

Providers stated that in most regions of VT families with CSHN encounter difficulty when children reach any transition point, including as CSHN age (from 0-3 to pre-K/school-age services, across grade levels, and from pediatric to adult systems), as well as when families are "handed off" from and/or served by multiple systems. In focus groups, providers gave several examples of ways transition points are difficult for families.

Providers and consumers described difficulty finding local childcare providers who are trained and registered to provide care for CSHN; issues with providers "expelling" young children with CSHN (and especially CSHN with spectrum disorders) from care; and a lack of providers for specialized services such as physical therapy, speech language therapy, occupational therapy, and other services outside of Chittenden County.

All survey respondents who identified as the parent/ guardian/ caregiver of a child with special health needs identified transportation, eligibility, and physical access as barriers that they or their child has experienced. "Needed services not covered by insurance" (95%) and "access to information" (94.7%) were also commonly identified barriers.

CROSSCUTTING/ PRIORITY POPULATIONS

IMMIGRANT AND REFUGEE POPULATIONS

Summary: VT welcomed 7,956 refugees from 1989 through 2019, majority of whom reside in Chittenden County. The largest numbers of migrants have come from Bosnia, Vietnam, Bhutan, the Democratic Republic of Congo, and Somalia. There is limited health data about these populations because most systems only ask about race and ethnicity, which aggregates migrant and non-migrant populations. In addition, some migrant populations from a single ethnic or cultural group may have only a few hundred people, making it difficult to provide accurate summary data because of the small sample sizes.

Needs: Needs that were identified included limited access to dental care, needs for more culturally responsive mental health care services, and needs for culturally responsive prenatal, maternity, and perinatal services and supports. For the

most part, mothers stated that the maternity care they received was good, despite differences in what they expected. Even when services exist, members of these communities may be reluctant to access them because of cultural and linguistic barriers, and described a lack of self-advocacy skills within medical care settings. When a doctor, nurse, or social worker gives information that is not well understood, many focus group participants described a reluctance to ask questions, and stated that they often feel that "something is not right," but feeling uncomfortable raising concerns.

Establishing relationships with medical homes, including by using community liaisons and nurse home visitors, was identified as a promising approach, when medical homes can provide services that are culturally responsive, have adequate access to translation, and can provide for patient confidentiality given the small size of VT's immigrant and refugee communities.

Some immigrant and refugee focus group participants and program providers expressed concern that demonstrating "self-sufficiency" is critical to refugees' immigration status, creating a reluctance to seek care if they perceive that doing so will jeopardize their immigration status or has the potential to undermine the appearance that they are able to maintain self-sufficiency.

Among the concerns that immigrant and refugee adults named for themselves and their children, stress and anxiety, meeting basic needs, and having adequate time and places to build positive social connections were high priorities.

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[1] ACS, 5-year estimates United States Census Bureau, Table B25070, Table B25091

[2] VT Department for Children and Families. 2019. Annual Report on Outcomes for VTers. VT Agency on Human Services.

[3] Feeding America. (2019). Child food insecurity in VT 2014-2017.

[4] cdc.gov/prams/prams-data/mch-indicators/states/pdf/2018/All-PRAMS-Sites-2016-2017_508.pdf

[5] VT Uniform Hospital Discharge Data Set (VUHDDS) (2019). Data analysis was performed on the VT Uniform Hospital Discharge Data Set (VUHDDS) 2007-2017, as published in the *2019 How Are VT's Young Children and Families* report.

[6] VDH. Neonatal Abstinence Syndrome Surveillance Pilot Project, 2015 VT results. August, 2019. healthVT.gov/sites/default/files/documents/pdf/HS_Stats_NAS_pilot_project.pdf

[7] Home visiting assessment results are addressed in VT's Maternal, Infant, and Child Home Visiting Program (MIECHV) Needs Assessment report, prepared concurrently with the Title V Needs Assessment.

[8] Help Me Grow Annual Report. 2019. helpmegrowvt.org/

[9] Kasehagen, L. 2015. Adverse Family Experiences: The VT Story, Power Point Presentation. VT Care Partners and VT DMH.

[10] VT DCF. 2019. The Annual Report on Outcomes for VT Families. VT Agency on Human Services.

[11] VT DMH (2019). Data provided by the VT Care Partners Data Repository through the Department of Mental Health Interagency Planning Director.

[12] Schwab, E. "VYP Data Shows Lack of Third Space Activities for MS/HS Youth." Blog post dated February 10, 2020 retrieved from VTafterschool.org/fall2019-vypdata.

[13] VT Network Against Domestic and Sexual Violence. 2018. *Askable Adults: A survey of VT's Youth.* VT Network Against Domestic and Sexual Violence.

[14] VDH. 2019 VT Youth Risk Behavior Survey Statewide Results. March 2020.

[15] VDH. 2019. VT RPE Sexual Violence Prevention Stakeholder Assessment.

[16] DVHA, VT Blueprint for Health (2018). Community Health Profiles.

III.C.2.b.ii. Title V Program Capacity

III.C.2.b.ii.a. Organizational Structure

Situated within the Agency on Human Services, Department of Health (VDH), MCH Division, VT's Title V is actively engaged in ensuring a statewide system of services, which reflect principles of comprehensive, community-based, coordinated,

family-centered care. VDH is the single public health agency, 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.

VDH and all public health efforts, including Title V, are overseen by Commissioner of Health, Dr. Mark Levine. VDH is one of six departments within the AHS. Within AHS, VDH is closely connected to the leadership and resources of the Departments of Mental Health, Health Access (Medicaid & health reform), Disabilities, Aging, & Independent Living, Children & Families, & Corrections. The AHS Secretary reports directly to VT Governor Phil Scott. The Governor's administration has prioritized increasing early childhood and higher education funding as a critical continuum of support for VT's children and youth. The AHS Secretary and Governor have a strong interest in prevention and have identified home visiting as a promising strategy for supporting statewide health improvement goals.

The MCH Division has been led by Dr. Breena Holmes since 2010 and oversees all Title V programming. In September 2020, Dr. Holmes will be transitioning to a new part-time role as MCH Medical Advisor and Ilisa Stalberg, MCH Deputy Director since 2013 will be taking on the role of MCH Director. Other federal initiatives housed within the MCH Division include WIC administration, MIECHV, Title X, PREP, EPSDT/school health and significant pieces of the Preschool Development Grant. VT's CSHN program is under the MCH Division.

VT's *State Health Assessment (SHA)* and *State Health Improvement Plan* (SHIP) are used to 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 or have documented health disparities. VDH used a collaborative process to develop the SHA/SHIP; key department and external stakeholders reviewed health status indicators. 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 Prevention Model, an adapted five-level Social-Ecological Model framework. 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. VDH leaders recognize 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.

VDH emphasizes that public health actions are based in researched strategies and in measurement and accountability. Resources from national agencies, such as the CDC, SAMHSA, and MCHB are used to guide staff and policymakers to select successful evidence-based interventions.

III.C.2.b.ii.b. Agency Capacity

The VT Department of Health (VDH) Division of MCH provides programming across the life course: before, during and after pregnancy, and throughout infancy, early childhood and the school years, with an emphasis on adolescents and young adults, recognizing that the health and wellness of VT's women, children and families is fundamental to the health of all Vermonters, under the its vision that *"strong, healthy families power our world,"* and mission to "*invest in people, relationships, communities and policies to build a healthier VT for future generations*."

MCH provides direct services, linkages and referrals, population-based supports, education and monitoring, quality oversight, and policy and systems development. MCH supports professionals who work with children and families in health care, early care and education settings, and with human service agencies, and collaborates with partners across VT and nationally to achieve high quality health and health care for children and families. These efforts are family-centered, evidence-based and data-driven.

The Title V funds VT receives are applied across all of MCH's efforts, directly or indirectly serving thousands of Vermonters each year. Title V funds are frequently used to seed novel and innovative efforts and partnerships, explore emerging topics for MCH service populations, and to assure that MCH leaders are represented in collaborative multi-agency and interdepartmental efforts.

Details about the ways funds are applied in each domain are included in the *Findings* section, as well as in the *Program*

Partnerships, Collaboration, and Coordination sections.

VDH's CSHN team coordinates care for approximately 700 children. Medical social workers provide care coordination to help families navigate the healthcare system; provide respite funding for parents and caregivers; bring teams of providers and educators together to coordinate care; and help families manage specialized care. VT's high rate of children with Medicaid coverage is a strength, because it ensures that CSHN can access medical care, developmental and behavioral therapy, dental care, and other needed support. Details about VT Title V-funded CSHCN services are detailed in the *Findings* section.

III.C.2.b.ii.c. MCH Workforce Capacity

Vermont's MCH workforce includes professional staff who hold degrees in medicine, nursing, public health, social work, and numerous allied health and social service professions. During FFY18, 13.9 FTEs, representing 49 staff worked directly on behalf of Title V programming. These staff are located at the VDH central office in Burlington, in the local health offices across the state, within the division of Health Surveillance (immunization, health research and statistics), and within the division of Health Promotion and Disease Prevention. There are 56 staff in the MCH Division (including CSHN). Vermont leverages Title V funding along with other federal grants and Vermont's Global Commitment Waiver to support these staff.

MCH Coordinators (MCHCs) are public health nurses working at within Office of Local Health to provide direct connections to every region and community of the state. The MCHCs positions are not funded by Title V but play a critical role in administering Title V activities. School Liaisons work with schools to promote the MCH mission and further EPSDT mandates. MCHCs and School Liaisons are administered under the organizational structure of the Offices of Local Health and are not managed by MCH, but MCH directs their workplans.

MCH SENIOR MANAGEMENT AND PROGRAM STAFF

Strengths: MCH direct service providers, including nurse home visitors and CSHN staff, are highly dedicated to their profession and to the families and children for whom they care, and have personal and professional values that strongly align with the work they perform. Providers recognize that working in the public health arena (and outside of hospital settings) affords them greater flexibility and autonomy than positions in inpatient settings.

Needs: Staffing and workforce issues were among the most frequently discussed topics for focus group participants. Nurse home visitors, CSHN staff, and other MCH providers identified workforce shortages as a significant issue. Concerns related to this theme included high turnover, limited professional pathways, need to protect staff from burnout, lower pay in public nursing settings when compared to hospital-based positions, and a desire for greater flexibility and autonomy within their roles. Many direct service providers stated that their roles require "too much paperwork," and that the time burden of administrative tasks detracts from their professional satisfaction.

For nurse home visiting, supervisors expressed concern that many nurse home visitors have an income below the median in VT, and face similar basic needs concerns as they families they work with. At the same time, many nurse home visitors spoke about the benefits available to them including strong support from supervisors and peers, feeling like their work makes a meaningful contribution, and greater flexibility.

For CSHN services, assessment participants identified needs for more personal care assistants, better systems to train, support, and compensate PCAs; more specialized care providers with pediatric specialties and more accessible providers throughout the state; and more respite care providers who can alleviate burnout.

There are several recent reports describing workforce concerns among MCH stakeholder groups, including those within the CIS system, early childhood care (and primarily early childhood education), and other DCF systems.

III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

MCH works very closely with other divisions within VDH to carryout activities under and connected to Title V. VT is served by a statewide network of local offices. MCH Coordinators and School Liaisons in each district office carry out Title V and other MCH activities within communities. The chronic disease division houses programmatic activities related to tobacco control and prevention, oral health, physical activity and nutrition. MCH works with the Division of Emergency Preparedness,

Response and Injury Prevention to address childhood injury, Environmental Health around toxic exposure, and the Alcohol and Drug Abuse Programs on shared planning around substance use in pregnancy and among youth. MCH epidemiology, data analysis, and surveillance is conducted by staff within the Division of Health Surveillance, as is our immunization program.

As a small rural state, VT has proportionally small state government agencies. Committed staff at children and family-serving state agencies and nonprofit organizations collaborate to address the needs of VT children and families.

MCH holds strong partnerships with the professional organizations that serve women of childbearing age, pregnant women, children, and families, including the VT chapters of the AAP, AAFP, ACOG, AMA, the VT NP Association, and multiple statewide organizations.

VT MCH works with a large number of state agency and community partners, too many to name them all here. Below are a few examples:

Children's Integrated Services provides support to families, children, and childcare programs through specialized childcare, early childhood and family mental health, early intervention and nursing/family support programs.

Department for Children and Families (DCF) Family Services Division (child welfare). Efforts are underway to ensure the medical and dental needs of children in custody are known to Caseworkers and foster parents, as well as the clear identification of children with special health needs. Additionally, MCH and DCF are jointly planning around Family First prevention.

Department of Mental Health (DMH). MCH partners with DMH on numerous projects. Most recently joint work includes the HRSA-funded maternal depression and other related disorders grant, suicide prevention, the child and family trauma workgroup, and a host of projects related to promoting resilience and strengthening families.

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

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

Agency of Education. MCH collaborates with AOE to align skills and content in our state's approach to health education in public schools. MCH also works closely with AOE around essential school health services through the state school nurse consultant, and more recently around COVID.

Parent Child Centers are a network of 15 non-profit organizations across VT that provide support and education to families with young children.

VT Family Network (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. VFN regularly participates in our annual Title V submission, needs assessment, and attends the block grant review yearly.

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

Developmental Understanding and Legal Collaboration for Everyone is an innovative intervention embedded within pediatric primary care. DULCE proactively screen for and address SDOH to promote the healthy development of infants from birth to six months and provide support to their parents.

Planned Parenthood makes up VT's network of family planning centers. VT recently made the decision to decline federal Title X funding due to recent rule changes that were in direct conflict to VT's approach. Although this could have created significant challenges to meeting the family planning needs of low-income Vermonters, officials made the decision to use state funds to fill this gap until the federal rule is overturned.

Outright VT is a statewide organization whose mission is to build safe, healthy, and supportive environments for LGBTQ youth. Outright worked with MCH to increase knowledge and skills among employees around gender-inclusive language and identify opportunities to use more inclusive language in programming and communication.

Women's Health Initiative Women receive primary care and preventative care services in both Patient-Centered Medical Homes, obstetrics and gynecology practices, and Planned Parenthood.

III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

Overall, the services MCH provides under Title V are well aligned with the needs that were identified across VT, and the generally strong health outcomes MCH indicators reveal are strong evidence of all that is "working well" in MCH systems of care. The needs assessment found several important themes that cut across all of MCH's work that relate to the domain-specific themes and findings:

1. Addressing basic needs and social determinants has a direct impact on the health of MCH populations. Especially in light of COVID-19, the primacy of meeting basic needs as a cornerstone of public health was well founded throughout this assessment. For low-income families, meeting basic needs is the highest priority, and when these needs are not well addressed, it is difficult to engage in any other kinds of service.

2. Consumers and providers are concerned about the prevalence of mental health issues and the availability of care. Topics related to depression, anxiety, suicide and postpartum/ maternal mental health issues came up in every focus group. Participants were especially concerned about the limited availability of mental health providers who specialize in serving families, young children, and adolescents and postpartum mental health conditions.

3. Regional differences in levels of care may undermine equity and positive results in some areas of VT. VT's rural nature means that many kinds of health and human services are concentrated in a few larger towns. In VT's most remote counties, residents may have to travel outside of their region to receive services.

4. Building relationships and informal connections contributes to health and wellness for MCH populations. A surprising finding of the needs assessment was the large number of individuals who expressed a desire for more opportunities to connect. Concerns about the negative impact of isolation on health and wellness came up across all MCH population domains.

5. Seek opportunities to replicate effective programs and services. MCH stakeholders especially value the DULCE model, home visiting, and many traditional Title V/ MCH programs such as those that support breastfeeding, provide postpartum and well-baby care, and pregnancy prevention. STAMMP and the Women's Health Initiative were named as strategies that consumers and/or providers have especially valued.

6. Address the full scope of MCH health needs among Black, Indigenous, and People of color (BIPOC) communities. Amid VT's shifting racial demographics, and in light of historic health disparities and structural inequities, all health and human services must consider how well they are equipped to provide high quality care for BIPOC communities.

LINKING TO PERFORMANCE MEASURES

Priority needs were identified by reviewing needs assessment findings and data from all sources in light of VDH performance measures and agency-wide plans. The decision regarding Priority Areas and performance measures was completed by the MCH Leadership Team, with input from key stakeholders through the process.

Over the course of several months, the MCH Leadership Team comprehensively reviewed the quantitative data and findings from the key informant interviews. Each member ranked priority areas/performance measures according to 1) impact; and 2) feasibility. Following this individual ranking process, scores were compiled and a list of top priorities emerged. The MCH Leadership Team was largely unanimous in our decision making. Only small shifts in the priority areas were made in cases where there wasn't complete agreement among Team members or where there wasn't alignment with the population domains.

IDENTIFIED PRIORITY NEEDS

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 VT's families.

NATIONAL PERFORMANCE MEASURES

1. Breastfeeding
2. Developmental screening
3. Physical activity in children
4. Adolescent well visits
5. Transitions to care for CSHN populations
6. Preventive dental visits in children
7. Smoking during pregnancy

STATE PERFORMANCE MEASURES

1. Early childhood flourishing
2. Adolescents who feel they matter to people in their community

3. Alcohol use in pregnancy
4. Suicidal ideation
5. Family and consumer partnership

III.D. Financial Narrative

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,647,551	$1,569,679	$1,583,663	$1,077,815
State Funds	$1,402,756	$1,344,784	$1,354,840	$808,361
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$2,225,199	$1,421,785	$1,000,000	$943,702
SubTotal	$5,275,506	$4,336,248	$3,938,503	$2,829,878
Other Federal Funds	$20,726,478	$19,253,720	$25,713,114	$18,466,433
Total	$26,001,984	$23,589,968	$29,651,617	$21,296,311

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,627,812	$708,834	$1,633,060	
State Funds	$1,387,652	$522,685	$1,224,795	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$1,276,000	$379,730	$900,000	
SubTotal	$4,291,464	$1,611,249	$3,757,855	
Other Federal Funds	$19,123,790	$20,397,465	$23,183,762	
Total	$23,415,254	$22,008,714	$26,941,617	

	2022	
	Budgeted	Expended
Federal Allocation	$1,633,060	
State Funds	$1,224,795	
Local Funds	$0	
Other Funds	$0	
Program Funds	$0	
SubTotal	$2,857,855	
Other Federal Funds	$22,925,928	
Total	$25,783,783	

III.D.1. Expenditures

Fiscal Year 2020 Expenditures for 2022 Application

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 FY 2020 or prior years. The audit report can be found on the State Auditor's website at http://auditor.vermont.gov.

III.D.2. Budget

Fiscal Year 2022 Budget Narrative

In general, financial resources for Vermont's FY22 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. For FY20, Vermont anticipates 56.9% of expenditures will be made in Component B and 30.1% for Children with Special Health Care Needs. Our FY22 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 component of the allocated costs that are attributable to the support services of payroll, buildings, etc. The definition of "administration" costs does not include costs such as the policy direction activities of the Health Commissioner, etc. The administrative costs of the Maternal and Child Health Block Grant can be readily determined by analysis of the allocated costs, and these costs are tracked on a quarterly basis to ensure that there is no increase in the costs that would exceed the allowable maximum. Administrative costs for FY20 are anticipated to be 1.7% of total costs. The FY20 Administrative costs remained low 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 FY22 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 FY22.

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 anticipates a resumption of some FY22 funding from the DHHS Title X Family Planning grant. The timing and amount of funding is in the process of determination. The state will continue to fund these activities pending a new federal funding award.

We do not currently anticipate FY22 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 FY22, as in recent years. Title V will continue with support for the costs of home visiting and 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.

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 VT'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 and infant safe sleep)
- 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, alcohol and drug abuse programs, immunization, environmental health, emergency preparedness) within VDH to carryout activities under and connected to Title V. VT 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. VT'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. 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 FFY20, 9.60 FTEs, representing 36 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 Surveillance (immunization, health research and statistics), and division of Health Promotion and Disease Prevention (physical activity and nutrition and oral health.) There are 52 (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 (including former Title X programming)
- Breastfeeding
- WIC
- Early childhood including *Maternal Infant and Early Childhood Home Visiting, Help Me Grow, 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 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 recently demobilized, 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. 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 committee to support staff's emotional health and well-being through organized listening sessions, trauma-informed trainings, and additional opportunities to reflect and release.

The Health Department's Health Equity Advisory Team (HEAT) is a cross-departmental workgroup to support health equity work at the health department. Its goals are 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 the HEAT team's work 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 engages partners across the state and enhances the HOC educational, prevention, and outbreak response strategies. It is the role of the HECE Team to help improve the effectiveness of the HOC's COVID-19 response in communities where systems and institutions have created

injustice and oppression. The HECE contributes to and supports the work of partners across the HOC, the Department, our communities, and the state to promote a fair and just opportunity for all Vermonters to be healthy and live in healthy communities. The HECE team focus on priority populations, communication, data collection, partnership, culturally appropriate COVID-19 plans, and workforce development.

Through new CDC Health Disparities funding, the Health Department will be able to continue and expand the HECE's teams work, as well as address health equity across public health areas, not limited to the COVID-response. As part of this expansion, the Division of MCH will be able to hire for a Health Equity lead. As a member of the MCH Leadership Team, this position will 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.

Through additional COVID funding, MCH is planning to expand our workforce to support COVID response, recovery and ongoing MCH work. We are currently hiring for 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 plan to hire for an MCH Evaluator 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 women of childbearing age, pregnant women, 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 led 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

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. In recent years, VT advanced a new state performance measure on family partnership which aims to ensure that MCH programming partners with families across all levels of engagement.

VT's Title V five-year needs assessment routinely includes input from families. In the last cycle, our needs assessment contract conducted focus groups with individuals and families statewide. We also routinely solicit satisfaction and engagement metrics from clients, consumers, & the public.

MCH/CSHN continues to contract with a Family Engagement Coordinator. They implement strategies to improve engagement across all MCH programs based on a division-wide assessment last year. A committee worked together to assist in the development of a Family Engagement Toolkit which is now used by programs across MCH to engage family partners in all aspects of work. We now have a vetted process for onboarding Family Partners to support work with a variety of scopes, from time-limited payment reform projects to longer term re-imagining work that will evolve over the course of the next year. Family Partners are given a stipend for their time. Family partners who needs translation services will have those available in an effort to further eliminate barriers to participation and decrease health disparities.

MCH partners closely with the VT Family Network (VFN). VFN is national Family Voices VT chapter and Parent-to-Parent Program. VFN empowers and supports all families of children with special needs. VFN regularly attends the MCH Division's leadership team meetings – providing strategic direction, action planning, and workforce development around MCH content and competencies. VFN participates in our annual Title V submission, needs assessment, and attends state block grant review, when possible.
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.

In response to the COVID-19 pandemic, the Family Engagement Coordinator in partnership with VFN, coordinated a series of learning and sharing opportunities to provide updates on changes to Medicaid policy, educational access & vaccination planning for CYSHN, to name a few.

VFN developed and implemented a 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. There have been well over 120 graduates from the FLP over the last 5 years, with a steady increase in interest and participants. 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. Graduates are a blend of caregivers and self-advocates.

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. A few examples are included below.

The care coordination delivery system for CYSHN has in some ways become more confusing as new services and supports have been introduced. Recently, in an effort to understand the new era of care coordination, CSHN engaged with a variety of families in different forums to gain their perspective on the quality of care coordination services they received, and what makes care coordination successful. In a survey developed and implemented by our contracted Family Engagement Coordinator, less than 50% of families reported having a clearly identified care coordinator. Of those families who could identify a lead care coordinator, 30% of them were uncertain with which organization that individual was associated. For those families who did know which organization their lead care coordinator was from, only 13% identified the Medical Home.

This survey was only representative of 63 respondents out of almost 500 families enrolled in CSHN for whom we could contact via email. Family for whom English is not their preferred language, were called and offered the survey via interpreter services. Nonetheless, we are engaging with the families who self-identified in wanting to partner with CSHN to re-imagine the care coordination system of care to gather more feedback and strategies to move forward.

In response to the lack of adequate services for children and youth with ASD, AHS leadership, in partnership with Children's Disability Services and CSHN, convened the VT Autism Workgroup, comprised of a multidisciplinary cross-section of stakeholders from across the state, including 8 (20%) parents of children with ASD.

VT's Hearing Advisory Council is the longest standing council at VDH. The council is comprised of professionals, parents and deaf and hard of hearing adults. Through the Newborn Screening (NBS) Advisory Committee, our NBS program requests input from professional and public stakeholders before any additions or other changes are made. This group of parents, providers, subspecialists, public health personnel and other interested parties meets on an ad-hoc basis to consider issues and make recommendations to the Health Commissioner.

VT has a young adult representative on our Adolescent and Young Adult CoIIN team. Additionally, in partnership with the VT Child Health Improvement Program (VCHIP)), we convene a 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. The council aims to voice the views of young adults in accessing health care. Please see the Adolescent Report section for additional information.

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) 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.

The development of Vermont's State Health Assessment (SHA) and State Health Improvement Plan (SHIP) sought to incorporate the voices of underrepresented populations. The Advisory Committee intentionally included voices from populations who experience or are at risk of experiencing health inequity. Some Advisory Committee members were not able to attend the committee meetings or preferred participating and communicating in a smaller group. The large Advisory Committee meetings are our "IN" engagement. We also coordinated "OUT" engagement where we went and met with people in the community, focusing again on populations who experience or may be at risk of experiencing health inequity.

VT Title V routinely interviews parents in the development of new communications campaigns. As described elsewhere, we held focus groups with parents during the formative research parents in the development of a new infant safe sleep campaign and programming. As described elsewhere, consumer input was central to our formative research and eventual messaging campaign around substance use in pregnancy. 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 which includes family partners who are compensated for their time.

Lastly, VT regularly enlists family voices around legislative advocacy. A recent example includes the fight to eliminate the

philosophical exemption for mandatory immunizations. Families that supported the removal were recruited to provide testimony; hearing from their constituents had a significant impact on legislators' opinions and ultimately resulted in successful removal of the exemption.

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, the Research & Statistics Chief (supervisor of this section), who is also the SSDI Project Director, 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. These responsibilities will be transferred to another R&S analyst once everyone has been relieved of duties in the COVID response. The R&S Chief also 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. The plan is to begin recruitment for this position at the end of summer 2021.

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
- This year, VCHIP and MCH are (finally) standing 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

As reported elsewhere in the report, MCH leadership and staff are an integral part of Vermont's COVID-19 response and served as contact tracers, care coordinators, architects and leaders in the School and Childcare Branch, and provided leadership in the state's overall response.

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 recently 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 will be working on HP2030 in the coming months.

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.

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. 192 calls were conducted between 3/18/20 and 6/30/21 with 1,181 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.

- Worked as part of the vaccine task team to ensure vaccine rollout addressed the needs of adolescents and families; currently supporting the development of the 2-11yo vaccine implementation plan; 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.

Of note, 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.

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, completed a yearlong QI project on implementing the two pediatric measures in VT's ACO: developmental screening & adolescent well care. Additional collaborative QI projects include implementation of the new *Bright Futures* guidelines around SDOH screening, maternal depression, & food insecurity. Through this collaboration, Title V staff participate in QI calls to connect community partners with pediatric providers to improve these measures. Last year's project was "Strengthening VT's system of high-performing pediatric medical homes". Next year's project will be a continuation with changes: 1) incorporating parental depression & social emotional screening & follow-up; 2) maximizing the use of practice-based care coordination; 3) racial & health equity; 4) aligning practices with health reform payment incentives.

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 child- & youth-serving organizations. As of July 2021 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.

192 calls were conducted between 3/18/20 and 6/30/21 with 1,181 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 & 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 o-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.

A RCT at Boston Medical Center, the first DULCE site, showed DULCE supports parents & strengthens families, accelerates access to concrete supports, results in better well-child visits & immunization rates, reduces use of unnecessary ED care, & detects & responds to maternal depression & interpersonal violence. DULCE is accepted by a wide array of families of different marital status, race/ethnicity & household characteristics.

MCH continues to provide infrastructure & convening support to school-based health centers. We have begun to assess SBHC & are working to ensure connection to medical homes & common indicators & measures across centers. 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, & gather youth perspectives. YHII will be conducting interviews of our SBHC peer collaborative members, developing a survey tool, & will share findings with MCH & stakeholders.

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 Board (MEAB); MCH convenes the EPSDT subgroup of the MEAB, which consists of consumer advocates around the state. 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.

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. In 2017 the GC waiver was extended to December 31, 2021. In 2018 it was amended to authorize VT to receive federal financial participation for the continuum of services to treat SUD. Vermont's 1115 Waiver is currently under review with CMS—Vermont anticipates some potential changes that may improve health outcomes for children and families including care coordination and the financing of the DULCE model. 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 a five-year (2018-2022) 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.

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

State Action Plan Introduction

State Action Plan Introduction

Vermont's Title V activities have demonstrated success and innovation through the implementation of evidence-based programs and services, systems improvement activities, relationship building, and bringing additional capacity to projects and programs to move the vision and goals of MCH forward. Vermonters including families, Health Department employees, human service employees, mental health providers, and medical providers have pulled together to make Vermont a consistent leader in the country's COVID-19 response across multiple domains.

Vermont continues to do well in the National Performance Measures. 13 measures are better than the corresponding US rates including breastfeeding, safe sleep, developmental screening, adolescent well-visit and medical home, oral health, and adequate insurance measures. We still have work to do to improve the rate of perpetration of bullying and the two components of the smoking measure (smoking during pregnancy and children in homes where someone smokes). We report a statistically significant decline in the rate of physical activity in adolescents between 2017 and 2019, but there are no other statistically significant differences between current and previous Vermont rates.

Vermont's rates also compare favorably to the new HP2030 target rates. Vermont exceeds the HP2030 target rates for low-risk cesarean births, breastfeeding, developmental screening, adolescent well-visits, and medical homes for non-CSHCN children. We are working to improve adolescent physical activity, smoking during pregnancy, and medical homes for CSHCN children.

Regarding Title V National Outcome Measures, areas of strength include prenatal care, low birth weight, preterm births, CSHCN systems of care, obesity, health insurance, overall health status, immunizations, teen pregnancies, postpartum depression, and access to care. We continue to have the same two measures which need improvement compared to the rest of the US: drinking during pregnancy and neonatal abstinence syndrome.

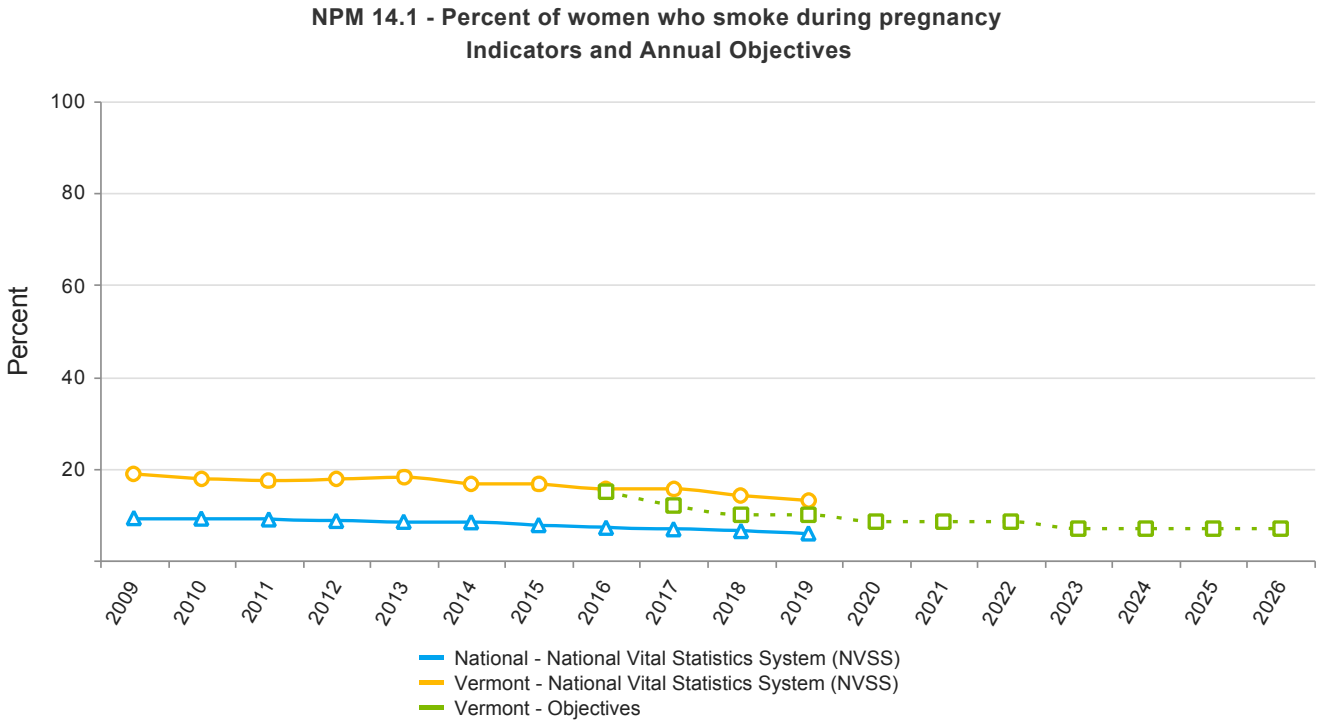
Vermont has improved from year to year in two measures: obesity-ages 2 thru 4 years and flu vaccination; otherwise, outcome rates are statistically stable. For the new HP 2030 target rates, Vermont already exceeds the target rate in three areas: prenatal care, maternal morbidity, and CSHCN systems of care. Vermont's infant mortality rate is above the HP2030 baseline and target rates. We continue to address the rate of drinking during pregnancy as this has been consistently higher than the rest of the country.

Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2018	60.4	NPM 14.1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2015_2019	Data Not Available or Not Reportable	NPM 14.1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2019	6.6 %	NPM 14.1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2019	8.4 %	NPM 14.1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2019	22.9 %	NPM 14.1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2018	4.2	NPM 14.1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	6.4	NPM 14.1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2018	3.1	NPM 14.1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	3.3	NPM 14.1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2018	Data Not Available or Not Reportable	NPM 14.1
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	Data Not Available or Not Reportable	NPM 14.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	94.7 %	NPM 14.1

National Performance Measures



Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	15	12	10	10	8.5
Annual Indicator	16.6	15.5	15.5	14.2	13.2
Numerator	965	881	868	758	697
Denominator	5,825	5,676	5,587	5,348	5,284
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	8.5	8.5	7.0	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					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		5	5	7	7
Annual Indicator	3.4	2.5	2.4	6.2	6.3
Numerator	29	19	16	37	35
Denominator	865	769	654	599	556
Data Source	QuitLine and Vital Statistics	QuitLine and Vital Statistics	QuitLine and VT Vital Statistics	QuitLine and VT Vital Statistics	QuitLine and VT Vital Statistics
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	10.0	10.0	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
Annual Objective			85	87
Annual Indicator	83.6	85.1	83.5	83.5
Numerator	4,596	4,587	4,321	4,321
Denominator	5,499	5,388	5,176	5,176
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2016	2017	2018	2018
Provisional or Final ?	Final	Final	Final	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	90.0	90.0	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 2021, increase the percentage of pregnant women who contact 802Quits (or other cessation resources) by 25%	
By 2021, increase the percentage of families with young children who contact 802Quits (or other cessation resources) by 25%	
Strategies	
Collaborate with Medicaid to promote billing among pediatricians and Ob/Gyns for cessation counseling	
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	
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	
Digital promotion of 802Quits pregnancy protocol (incentive payments, increased access to NRT, uncapped counseling sessions)	
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	
Work with (formerly 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 counseling and Reproductive Life Planning efforts	
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).	
Work with the Rutland District Office to support and evaluate contingency management programming to Rutland OB practice to improve rates of smoking in pregnancy	
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 2022, increase to 90% the percentage of women that advised by a healthcare worker to abstain from alcohol during pregnancy.

By late 2021, outreach to 100% of prenatal and pediatric providers regarding the risks of alcohol use during pregnancy (if COVID-19 allows).

Beginning in late-2020, 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

Collaborate with the Vermont Blueprint for Health on the Women's Health Initiative and reproductive health and family planning (formerly Title X) providers to support women's health specialty practices to communicate risks of alcohol, smoking or vaping tobacco and cannabis use in pregnancy

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

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 in pregnancy with clients

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.

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

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, the OB Outreach program at VCHIP seeks to:

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

Additional information is provided in the perinatal 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

Over the past year the preventive reproductive health program has changed to adolescent and reproductive health as some staff focus areas have 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. We are presently watching Title X developments closely and anticipate a new NOFO in the fall of 2021.

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.

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 two years ago as many members also served on the Blueprint Women's Health Initiative's Steering Committee and wanted to avoid redundancy.

The Vermont Department of Health has been a key partner throughout the process of planning the Women's Health Initiative, and several Title X health centers have 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.

Due to COVID-19 some of this work has been paused. In the coming months we will work with our partners across the Women's Health Initiative to determine the best direction for future efforts.

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.

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. Since that time, the Director of Adolescent and Reproductive Health has been covering many aspects of our MCH work, including PREP. The Adolescent Health Program Manager role as a health equity technical advisor has been critical to our state's COVID-19 response, and in this role, she has managed a team of six. This experience will further enhance her future PREP activities as she returns to her position. 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 fourth 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 continued to contribute to our PREP newsletter, in an "Ask the Expert" column, entitled "Q+A with Dr Gibson." The newsletter has been an important supplement to our training activities, as it includes a reminder of reporting deadlines and important dates, information about registration for any training, resources for PREP facilitators around general adolescent health, information about sexual and reproductive health to pass along to youth (usually from sites like Answer, Sex Etc., or Scarleteen – information for youth, by youth), a facilitator spotlight, and links to the websites of each implementing agency.

With PREP funding that was unspent due to COVID-19, we are planning to support the participation of 10-15 people in a fall 2021 Elevatus training: Three-Day Certificate Training: *Become a Sexuality Educator and Trainer for* people who work with individuals with I/DD and want to lead sexuality education classes, staff training and parent workshops. Participants complete the training and get a copy of the curriculum and other supportive materials.

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
- Adults engaged with youth

Our long-time injury prevention coordinator retired in April 2021. We are currently engaged in the hiring process for this position. This position was reclassified to a non-nurse and will also include violence prevention. Our RPE work will now sit under the MCH Injury and Violence Prevention Program Manager's umbrella. This is an 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 (CoIIN) 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. In Vermont, when pregnant women are identified with a physical dependence on opioids or an OUD, their newborns often receive an NAS diagnosis code at delivery regardless of number, type, or severity of symptoms. This approach allows hospital staff to monitor a newborn for up to four days ensuring that both mother and newborn receive any needed services. Newborns with few or mild symptoms are often discharged from the hospital with treatment continuing on an outpatient basis. Over the past years, Vermont hospitals made the switch to the "Eat, Sleep, Console" method.

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 new 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 participating 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 women 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. Over the past two 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.

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. In the coming year 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 will be especially important to examine considering the impact of COVID-19 on family planning services l in Vermont.

MCH is working on reconvening the Maternal Mortality Review Team and updating its membership. 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

MCH leadership continues to work with stakeholders to promote the integration of One Key Question into clinical practice, home visiting, and other community settings. In 2017, One Key Question was moved to the National Campaign to Prevent Teen and Unplanned Pregnancy, now called Power to Decide, so there is a national platform to support this work. MCH has reached out 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 2021-2022 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 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 *Healthy Moms, Happy Babies* evidence-based training 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) and has chaired a department level Domestic Violence Advisory Group, which is part of an AHS-wide Domestic Violence Steering Committee. The latter two2 groups have been paused due to AHS staff turnover. We will assess this work in the coming year to determine the best direction forward
- 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 women:

- 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

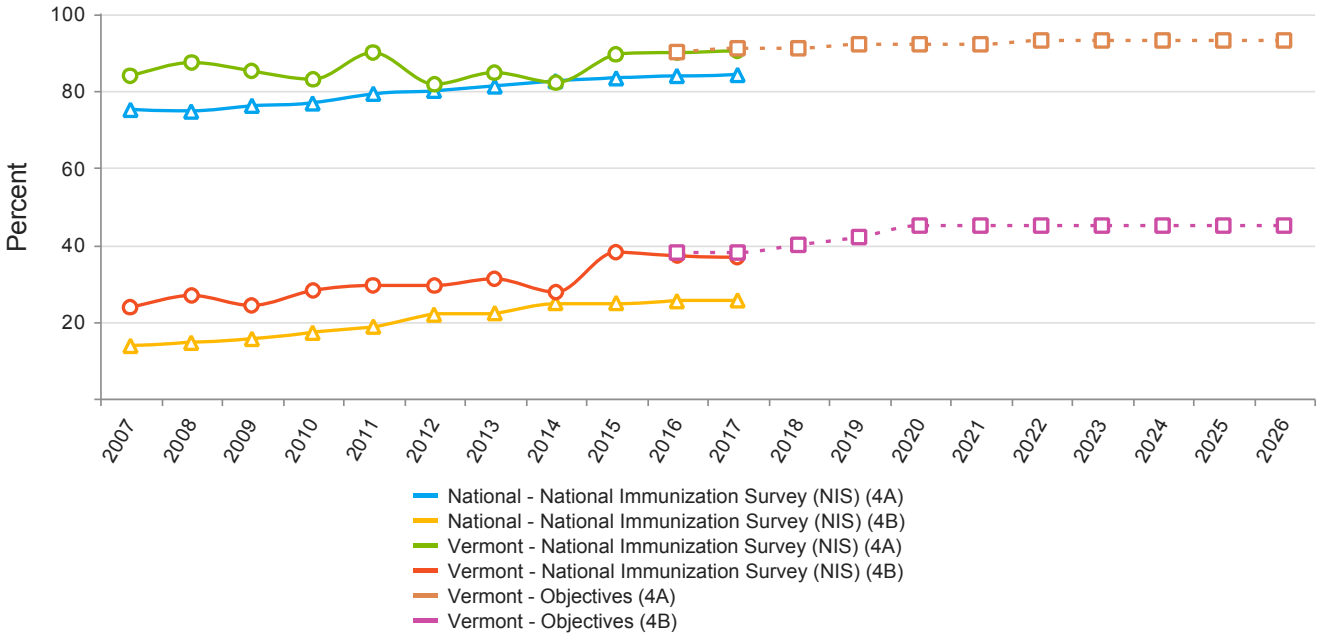
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	6.4	NPM 4
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	3.3	NPM 4
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	Data Not Available or Not Reportable	NPM 4

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)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	90	91	91	92	92
Annual Indicator	84.5	81.9	89.3	89.9	90.2
Numerator	4,599	4,748	4,773	4,919	4,650
Denominator	5,445	5,797	5,345	5,471	5,154
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	92.0	93.0	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)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	38	38	40	42	45
Annual Indicator	31.3	27.7	38.0	37.2	36.8
Numerator	1,629	1,560	1,976	1,946	1,811
Denominator	5,203	5,637	5,195	5,227	4,926
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	45.0	45.0	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					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		16.7	25	33.3	33.3
Annual Indicator	16.7	16.7	16.7	18.2	18.2
Numerator	2	2	2	2	2
Denominator	12	12	12	11	11
Data Source	Program-level data	Program-level data	Program-level data	Program-level data	Program-level data
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	41.7	50.0	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 2022, increase the number of designated “Breastfeeding Friendly Employers” by 10%
By 2022, increase the percentage of WIC recipients who utilize a peer counselor by 10%
By the end o f2022, develop local level breastfeeding implementation plans informed by state-level strategic plan
By 2022, implement 50% of strategic priorities identified in breastfeeding strategic planning process.

Strategies
Promote “Baby Friendly” hospital initiative and Vermont 10-Steps approach to improve maternity care practices in support of breastfeeding
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.
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).
Continue to support Rutland, Middlebury, St. Albans, Bennington and Burlington Peer Counseling programs to maintain trained peers and recruit replacements. Assess the need for bi-lingual peer counselors in the immigrant and refugee communities. Add peers who speak the languages that are currently dominant in our communities.
Continue to promote awareness of Vermont breastfeeding laws and the breastfeeding provisions of the Affordable Care Act.
Coordinate with the early care and learning professional development to offer breastfeeding education to child care providers.
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.
Promote and support community-clinical linkages to increase professional and peer support and care coordination.
Embed breastfeeding education and support in VT’s Quality Improvement and Rating System (QRIS) for early care and learning providers.
Build framework and convene Perinatal Quality Collaborative—Vermont.
Implement Vermont’s Breastfeeding Strategic Plan and local action plans, developed pre-COVID

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 (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 5 of 12 local health offices; 4 of the 5 historically have lower breastfeeding rates than the state average. Funding from USDA increased in FFY 2020 and the additional funds have been used to expand peer counseling to additional local health offices over the past 6 months. WIC peer counseling services will be available to pregnant and breastfeeding individuals in all districts by the end of FFY 2021.

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. 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 has begun 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 stakeholders 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 will be 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 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.

Vermont Title V is the recipient of the federal MIECHV funding. Vermont is close to completing year three of the Maternal Early Childhood Sustained Home Visiting (MECSH) model. Vermont has worked hard to ensure a comprehensive statewide and local early childhood systems. Evidence-based home visiting has been fully integrated into Vermont's early childhood system of care: Children's Integrated Services (CIS). From the outset, we sought to incorporate MIECHV home visiting into CIS. By integrating all Vermont home visiting programs, we have taken steps to ensure that the program is part of Vermont's system for early childhood and not a standalone program. It also ensures that resources are effectively allocated so that participants are directed into the most appropriate program model.

As a result of leadership stability and intentional capacity building to support the transition, there are many positive aspects of the VDH MIECHV program over this reporting period. Highlights include: (a) the development and implementation of the MECSH database, (b) the continuation of 85% service capacity across the program during a worldwide pandemic requiring virtual visitation, (c) the development and rollout of fidelity reports accessible by nurse visitors and nurse supervisors, (d) promoting and cultivating the capacity building needed for the MECSH model with nine trained trainers within the state and two in-country liaisons, and (e) the reconstitution of the Home Visiting Alliance (HVA) which will lead the planning and building of a continuum of home visiting in the state, supported by Medicaid and state match dollars.

Furthermore, during MIECHV's most recently completed performance measure period, Vermont demonstrated that the program results in improvements for eligible families participating in the program in at least four out of the six benchmark areas specified in statute that the service delivery model or models selected by the entity are intended to improve.

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.

In February 2021 a training on the evidence-based Mothers and Babies Curriculum for 52 CIS home visiting providers, 14 of which are MIECHV nurse home visitors occurred. Mothers and Babies is an evidence-based mental health intervention

to address perinatal depression and is effective in reducing depression, anxiety and stress and increasing social support and coping skills. This training builds on Vermont's first Mothers and Babies training in 2019 funded through STAMPP increasing the spread and reach of this evidence-based program in communities across the state. Interest in this model continues to grow.

Through braided funding from the Department of Health, One Care, the Center for the Study of Social Policy, and in one region, the Parent Child Center, Vermont implements the DULCE (Developmental Understanding and Legal Collaboration for Everyone) model in 5 pediatric offices in Vermont. 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.

Throughout the COVID-19 pandemic, DULCE Family Specialists have been integral to the COVID-19 response. Their work with families at this vulnerable time when guidelines and workflows related to COVID-19 were rapidly changing provided access to information, supports, and services to keep families connected to their pediatrician and community. Practices worked to keep Family Specialists involved with patients even when many well child checks moved to virtual. Family Specialists were able to connect with families virtually via phone and video depending on the workflow of the practices. DULCE has a very high rate of acceptance among families, and of those families screening positive for additional supports, a large majority accept referrals. Lamoille Health Partners had a 100% referral rate, and we believe that as the most mature DULCE practice in the state, they have the ability to mentor newer practices and share their lessons learned with other sites to increase the number of families across the model engaging with services.

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.

Vermont *Help Me Grow* is an effective, efficient system strategy for advancing developmental promotion, early detection and linkage to resources. *Help Me Grow* helps states implement universal developmental surveillance, screening and detection for all children through age eight, and then links families to existing community-based programs. *Help Me Grow* (HMG) proactively addresses families' concerns about their child's behavior, development and learning by making a connection to community-based programs, services and high-quality parent education resources. The *Help Me Grow* Vermont system leverages existing resources, like Children's Integrated Services (CIS), to build collaboration across sectors of child health care, early care and education, and family support services. The *Help Me Grow* Vermont system expands the reach of CIS through a "no wrong door" centralized telephone access entry point for all children and their families to link to community-based programs and services. With the Vermont Department of Health as the lead agency, our collaborating partners comprise four key system components: 1) family & community outreach; 2) child health provider outreach; 3) centralized phone access point: Vermont 2-1-1; and 4) data collection & analysis. *Help Me Grow* is described in further detail in the Child Health narrative section.

Through a grant agreement to the Vermont Child Health Improvement Program (VCHIP), UVM faculty research and

disseminate evidence-based guidelines and current best practice recommendations in perinatal care. Examples include standards of practice for pregnancy screening, such as screening for HIV and group B strep, and routine protocols for newborn care, such as bilirubin levels. They 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) established by legislation 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 requiring annual report from VDH and DVHA on high-risk pregnancy -- existing programs, scope of services including case management and women as identified as high-risk. MMRP was chaired by Dr. Holmes, former MCH Director until recently. The MMRP has not been able to meet since February 2020. The basic organization and facilitation of the MMRP is dependent on MCH staff and the OCME who were deployed to COVID 19 response. We plan to revive the meetings and the process of maternal death review in the fall and winter 2021-2022.

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, and contraception counseling. Service coordination also happens with the NICU and the intensive services for women living with substance use disorder.

Vermont was chosen to participate in the 2017 Policy Academy: Improving Outcomes for Pregnant and Postpartum Women with Opioid Use Disorders and their Infants, Families, and Caregivers sponsored by National Center on Substance Abuse and Child Welfare. A team of leaders from across the private and public sectors have been working together to create a state-specific policy agenda and action plan and strengthen collaboration across systems to address the multiple and complex needs of this population. The work of the policy academy team primarily focused on developing Vermont's Plan of Safe Care and outreach and integration with the OB and pediatric communities. The Vermont team worked hard to balance the requirements of the federal legislation, Vermont's well-established system of identification and treatment of pregnant women with substance use disorder, and the needs of women and families. Vermont recently updated the Plan of Safe Care and is actively working to rollout the new plan, as well as supports for implementation.

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 questions or concerns.

The NBS program provides hospitals with quality improvement reports that detail their performance on key indicators such as timeliness, specimen quality, and time from collection to receipt at the screening laboratory. In FY21, the program altered the format and frequency of the QA reports to allow for quality improvement in real time. The starting percentage of initial

unsatisfactory screens in January 2021 was 3.15%. After three months of implementation, the average percentage of initial unsatisfactory screens in April through June had decreased to 1.17%. These reports have been effective in encouraging hospital staff to examine internal processes and regularly review specimen collection technique. Additionally, these reports have facilitated regular communication between laboratory staff, nurse managers, and the Newborn Screening Coordinator.

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 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. Vermont Hands&Voices and Vermont's single point of entry for early intervention are two examples of organizations that provide support to families. Additionally, VTEHDI provides learning community opportunities for families and professionals that include leadership training, accessibility training, empathy training, legal education for parents of Deaf, Hard of Hearing and DeafBlind children, trauma-informed care and retreats for families to share their emotional journeys. The VTEHDI program in collaboration with the CSHN Parent Consultant have established a workgroup for families to review program materials including letters and pamphlets.

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 an infographic was developed with 10 guiding principles and will be shared with special education directors and case managers across the state.

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. Furthermore, VTEHDI works with state and national agencies and organizations to achieve the National EHDI goals of screen by 1 month, diagnose hearing loss by 3 months and 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 3rd year of this MIECHV funded nurse home visiting program. Over this next year, Vermont will strengthen collaboration with Help Me Grow Vermont and Building Bright Futures for MIECHV home visiting project planning and implementation. Additionally, a primary focus for this program year will entail further efforts to build health equity and provide culturally and linguistically competent services and leverage cultural brokers to engage priority populations.

Vermont is working hard to expand evidence-based home visiting and has Global Commitment funds to expand MECSH and Parents as Teachers (PAT) home visiting and their delivery will be in concert with the Vermont's early childhood system of care. In addition, Vermont has resumed efforts with the Department for Children and Families, Family Services Division to collaborate on planning for Families First Prevention Services Act to connect children at risk of child protection into evidence-based home visiting programming. 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 a number of proposed strategies aimed at promoting safe sleep practices in hospital and community settings:

- Continue the public messaging campaign as developed by the contractor, JSI, Inc. in 2018 and disseminate via MCH Nurse coordinators in district offices and via updates VDH website and Facebook. The active public messaging campaign ended in early 2019 because it was designed as a time limited but concentrated campaign. Ongoing outreach by MCH Nurse Coordinators to providers and communities was not able to happen due to COVID 19 response, however this is starting to resume on a smaller scale as of summer 2021.
- 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 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.

In order to enhance Vermont's rates of breastfeeding initiation and duration, Vermont MCH plans to resume promotion of the Vermont Breastfeeding Strategic Plan broadly across the state and support local coalitions and communities. 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. We anticipate being able to dive deeper into this work as staff are demobilized from their COVID response roles.

Successful implementation at 5 sites continues for 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, promotes 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.

The DULCE national model is rolling out a new data system (CORE) which will standardize data collection across the state. Vermont is the first state implementing DULCE to roll out substance use screening with parents and caregivers as part of the DULCE model. With CORE, it will be possible to track screening rates, positive screens, referrals, and connection to services for each type of screen including SUD screening. We believe this level of detail with the data will benefit families, DULCE sites, and Family Specialists. Even with the complications of COVID-19, the sites are committed to implementing this screening. The SUD screening field was added to the CORE data system, most sites have selected the UNCOPE screening tool, and we are scheduling training on the tool, and implementation will begin immediately after training.

Vermont's Newborn Screening Program is actively working towards several goals in the next year: increasing the use of Health Information Technology to maximize efficiency and improve results reporting, developing culturally and linguistically appropriate educational materials, and work alongside other states and the Newborn Screening Technical Assistance and Evaluation Program (NewSTEPs) to strengthen follow up procedures for the four newest conditions added to the RUSP.

In the coming year, the NBS Program aims to enhance service delivery by pursuing electronic reporting of results to hospitals and providers. The program has translated the newborn screening brochure into multiple languages and will be distributing those for use in the coming months. Enhanced courier services are being pursued in partnership with the NBS laboratory with the aim of reducing the time from specimen collection to receipt.

Vermont recently launched a Perinatal Quality Collaborative, in partnership with the Vermont Child Health Improvement Program (VCHIP). 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. This year will have a particular focus on standing up the PQC-VT 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.

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

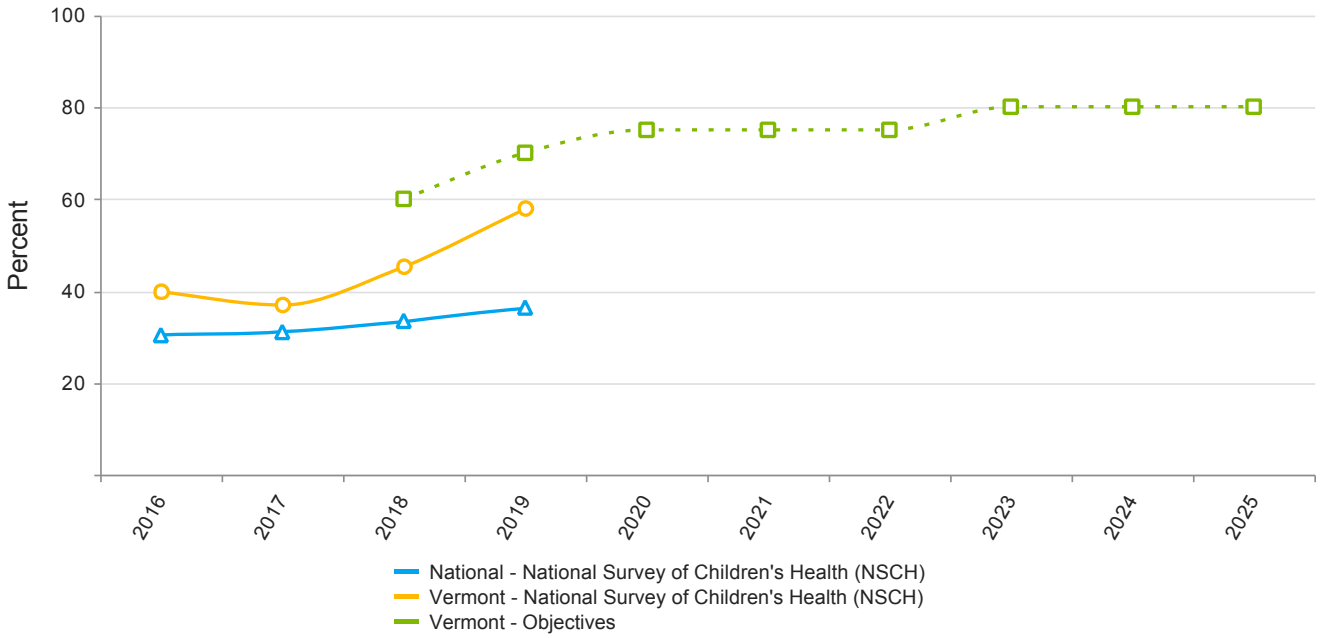
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available or Not Reportable	NPM 6
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2018_2019	10.3 %	NPM 13.2
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	23.5 %	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	94.7 %	NPM 6 NPM 8.1 NPM 13.2
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)	NSCH-2018_2019	14.0 %	NPM 8.1
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)	WIC-2018	12.9 %	NPM 8.1
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)	YRBSS-2019	13.1 %	NPM 8.1

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)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			60	70	75
Annual Indicator		39.7	37.0	45.3	57.8
Numerator		5,111	5,399	6,939	7,281
Denominator		12,865	14,604	15,303	12,592
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	75.0	75.0	80.0	80.0	80.0	80.0

Evidence-Based or –Informed Strategy Measures

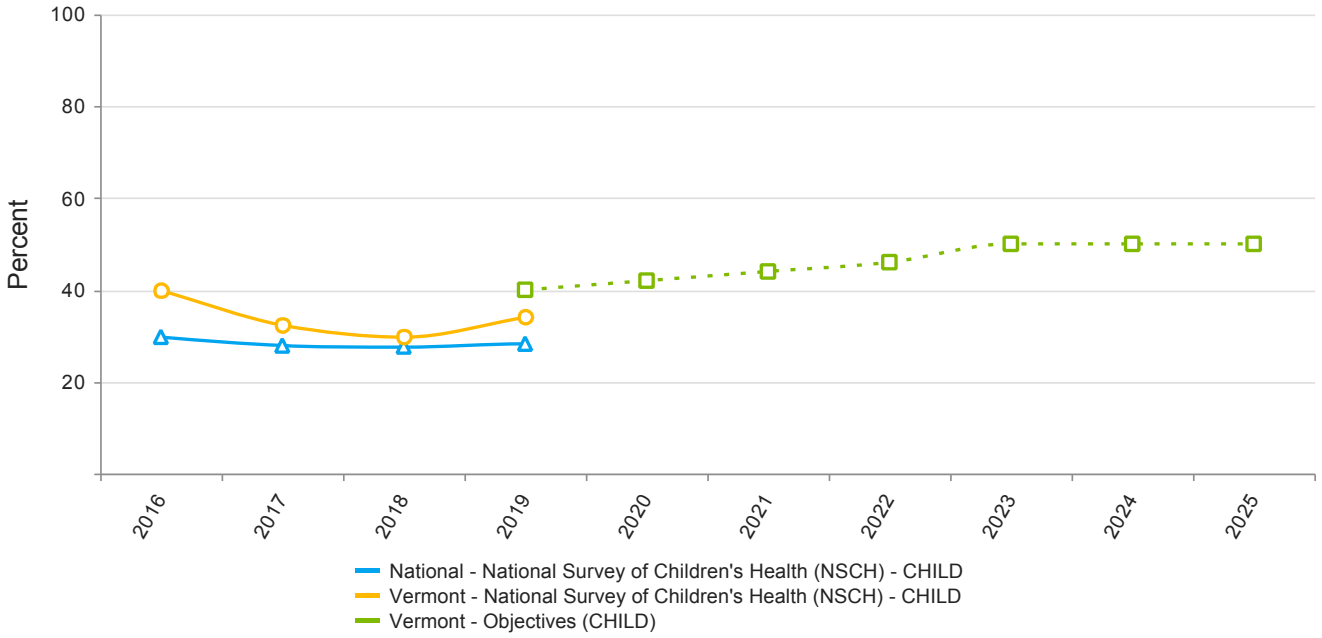
ESM 6.1 - Number of providers trained in developmental surveillance and screening

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			150	100
Annual Indicator			352	224
Numerator				
Denominator				
Data Source			Program Data	Program Data
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	50.0	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**
Annual Objective			40	42
Annual Indicator	39.7	32.4	29.9	34.1
Numerator	14,153	12,528	11,872	12,757
Denominator	35,688	38,672	39,659	37,374
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year	2016	2016_2017	2017_2018	2018_2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	44.0	46.0	50.0	50.0	50.0	50.0

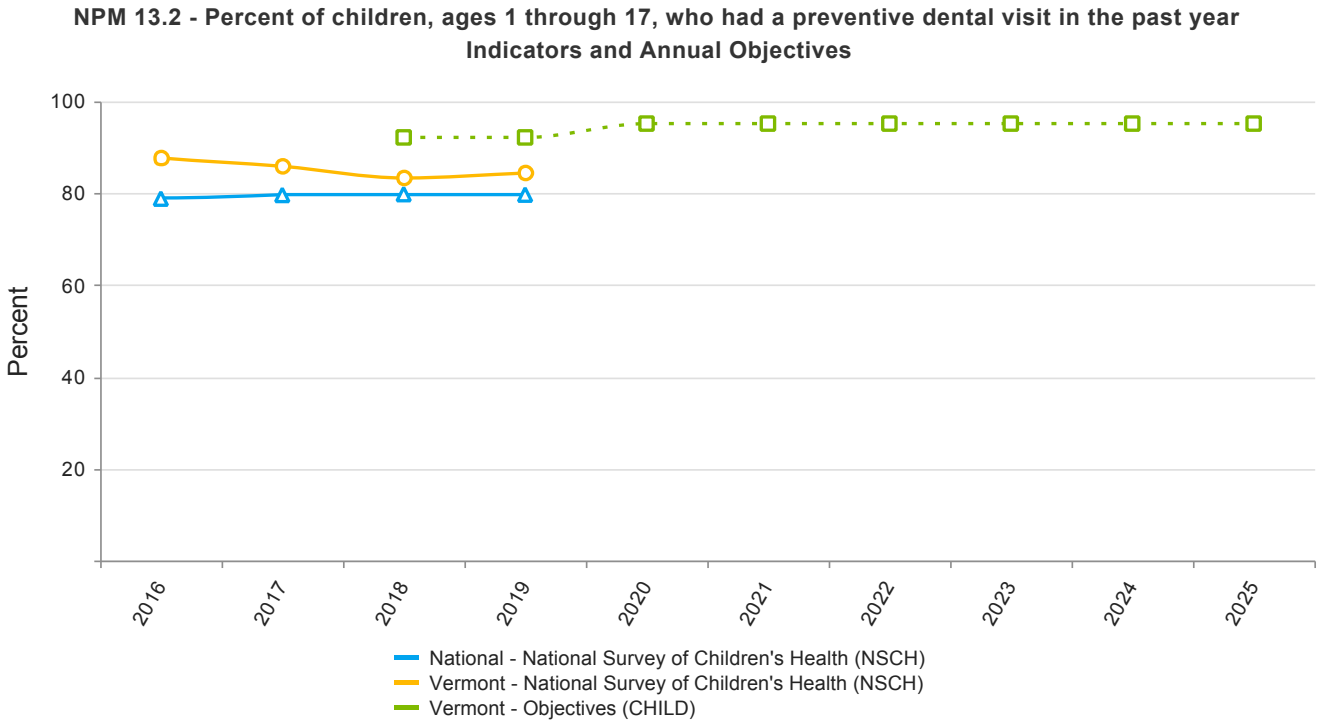
Evidence-Based or –Informed Strategy Measures

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
Annual Objective			12	12
Annual Indicator			9	4
Numerator				
Denominator				
Data Source			Program Data	Program Data
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	12.0	12.0	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)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			92	92	95
Annual Indicator		87.4	85.7	83.3	84.3
Numerator		98,305	95,571	91,502	92,788
Denominator		112,465	111,490	109,884	110,125
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			92	92	95
Annual Indicator	87.3				
Numerator	98,226				
Denominator	112,487				
Data Source	NSCH				
Data Source Year	2016				
Provisional or Final ?	Final				

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	95.0	95.0	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					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective				3,000	3,100
Annual Indicator	1,751	1,606	1,422	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	2015-16	2016-17	2017-18	2018-19	2018-19
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	3,300.0	3,400.0	3,500.0	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
Annual Objective	83	84	86	88
Annual Indicator	67.6	67.6	86.7	83.2
Numerator	22,213	24,152	31,277	28,178
Denominator	32,842	35,708	36,090	33,879
Data Source	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016-17	2018	2018-19
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	90.0	90.0	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 2022, 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 2022, increase the number of families who access a centralized resource hub (HMG/ Vermont 2-1-1) by 20%
By 2022, increase HMG calls and referrals from providers by 20%
By 2022, increase HMG follow up to families to ensure successful connection by 20%

Strategies
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) online developmental screening system for families and providers to access at HelpMeGrowVT.org b) 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)
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
Train providers to conduct developmental monitoring and screening and to use Vermont's USDR 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.
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
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 2021, 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 2021

Strategies

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

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

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

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

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

Increase distribution of AAP policy statement Crucial Role of Recess

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

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 2022 increase the percentage of children who access preventive oral health care in the past year.

Strategies

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

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

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

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

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 2) fluoride varnish

MCH leadership serves on the statewide oral health advisory panel

Regional MCH coalitions promote oral health messaging

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

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

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

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 2022, increase the percentage of families accessing HMG that received positive parenting information/resilience resources by 50%

Strategies

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

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

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

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

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

Provide support for the Vermont Family Based Approach

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

Report: Child:

Vermont continues to make gains in screening across multiple domains and works to ensure earlier access to existing resources for overall family resilience and wellbeing with Help Me Grow. HMG's Resource Hub offers a coordinated information and referral system for earlier identification of concerns in both development and social determinants of health. Addressing social conditions of health which impact *Optimal Child Development*, one of only six priority areas in Vermont's State Health Improvement Plan (SHIP), has become more urgent in light of the impact of the COVID-19 pandemic on Vermont's children and families. By leveraging Health Department COVID-19 communications, calls and referrals to our Help Me Grow (HMG) Vermont Resource Hub increased.

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 conditions of health to support individual, family, and community resiliency (flourishing). Prior to the pandemic and more so now, Vermont's MCH program is at the center of all these discussions and efforts. Resiliency is also central to the strategies of Vermont's SHIP: Invest in programs that promote resilience, connection and belonging, and includes strategies 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 cross-sector system to strengthen families' 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
- Vermont Resilience Messaging Project (VRMP) efforts have resulted in increased use of integrated messaging to align resiliency promotion effort across multi sectorial stakeholders; early results indicate 96% of partners have or will encourage others to adopt the shared definition of resilience
- 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

HMG Vermont promotes developmental screening to help families better understand their child's early development, celebrate milestones, and identify concerns so that young children get connected to the services they need at an early age when the benefit is greatest. 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 hosts a statewide developmental screening platform, the Ages and Stages (ASQ) Enterprise Online System, for both providers and families to access Ages & Stages Questionnaires at HelpMeGrowVT.org. This year, HMG staff responded to the urgent need to mitigate the impact of the pandemic on children's development and early identification efforts by expanding cross-sector provider access to the ASQ Enterprise Online System. Use of this online screening platform more than doubled (during the reporting period) from 1,200 screens to over 4,000 screens entered. The ASQ Online will be integrated with Vermont's Universal Developmental Screening Registry to improve communication and networking across providers and programs (see Vermont's Success Story).

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. Family practice and pediatric practitioners can use the UDS registry to view a screen done by another provider, interpret and discuss the results with families, and then work with them to create a plan to address any needs that may have been identified. Medicaid will reimburse the child health provider for these activities. If a child does not receive a screen in an early childhood setting, child health providers proceed with screening according to AAP *Bright Futures* guidelines. New AAP *Bright Futures* guidelines, 4th edition, include updated developmental milestones, surveillance questions and screening guidelines that support Vermont efforts to promote greater collaboration for improved early identification. Find more information on Vermont's public health dashboard.

Lessons learned from Vermont's overall efforts around screening in multiple domains suggest that pediatric health professionals are highly skilled at screening and identifying concerns in both development and social determinants of health, but they lack the ability to provide care coordination and connect families to necessary services to address the concerns identified. Another identified challenge is that early childhood professionals in childcare and other early childhood education and home visiting settings have the necessary expertise in child development and have important relationships with families, but often struggle to have difficult conversations with families when it comes to topics such as supporting basic needs. To address these challenges and increase earlier access to existing resources for children and families, HMG leveraged Health Department COVID-19 communications to increase medical provider use of the HMG Resource Hub and provided training opportunities to increase the capacity and professional development of local providers. Trainings included:

- A Food Insecurity Pilot to train a cohort of early educators to screen families for food insecurity and connect them to food resources. Over 12 weeks, seven programs serving 449 families in five Vermont counties formed a community of practice to pilot the use of the nationally validated Hunger Vital Sign two-question screener. Of the 358 families (79% of families) who completed the screening, 35% (127) were found to have some food insecurity (positive screen). All programs reported that the tool was easy to use for the programs and families and a valuable tool for connecting with families
- Two Screening for Resiliency Pilots for early educators to encourage home and center-based programs to screen using the HMG's ASQ Enterprise Online system. Training resulted in ten programs, each with between one to 19 staff, now trained and using the ASQ Online (see also MCH Success Story)
- *HMG* trained 224 medical providers, early childhood educators, and others to conduct developmental and social/emotional screening and to refer families for further evaluation and services. Of these providers, 215 were early childhood educators
- Additional developmental screening outcomes include the percentage of children screened in the first three years of life using a standardized screening tool increased from 48% in 2013 to 63% in 2018. These children are among the 65-70,000 who are attributed to primary care practices participating in the Vermont Blueprint for Health

HMG creates a reliable, centralized resource grid so families and children from all communities in Vermont can plug in and easily access the resources and services they need to thrive. HMG supports ongoing COVID-19 recovery by connecting families to mental health services, emergency food resources, developmental services, and many other supports. This year's highlights include:

- HMG received 1,629 incoming calls and 87 referrals (during the reporting period)
- HMG made 1,788 follow up calls; a 13% increase from the year prior
- There were 2,228 referrals made on behalf of families for services; 311 were for food resources
- There was an 188% increase in calls and referrals from providers and families for mental health services and supports

Help Me Grow Vermont 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 outreach staff provided 4,500 customized HMG materials, including CDC's *Learn the Signs. Act Early. (*LTSAE*)* Program materials, to food drop sites run by the Vermont Foodbank and the Vermont National Guard which served thousands of households across the state to support pandemic recovery. Customized HMG/LTSAE materials were included in every packed lunch distributed via school districts and delivered to town offices, community centers, and health clinics across Vermont
- In partnership with Building Bright Futures, HMG hosted 69 meetings, 29 trainings, and 15 public events where customized HMG/LTSAE tools were promoted. Most of this year's outreach and professional development with early educators and community providers had to be done virtually or creatively by supporting families with Welcome Baby Bags, delivery of packets of developmental resources and activities, and social media promotion of LTSAE tools. Outreach activities reached 1,674 families and 1,242 community partners

Recognizing the tendency to address chronic disease prevention and health promotion from discrete silos based on behavior or disease, the Health Department 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. Since its inception, this initiative has garnered more than 135 partners statewide across all sectors to commit to straight-forward, low or no cost strategies that will help promote better nutrition, more physical activity, and less tobacco use thus helping to prevent chronic disease.

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. To date, 31 childcare programs and schools have 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.

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 this year if COVID-19 priorities allow or in the future if there is a delay due to the pandemic.

Partnerships

Help Me Grow Vermont is a massive system change effort involving many partners. These include: VCHIP, MCH coordinators, Vermont 2-1-1, a program of the United Ways of Vermont, Vermont Family Network, Building Bright Futures State and Regional Councils, Child Development Division of the Department for Children and Families, Agency of Education, and Let's Grow Kids, among others.

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

Action Plan: Child:

Towards achieving Vermont's new 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 the *Help Me Grow (HMG)* Vermont system by health, early education, human service providers, and consumers/families. We will leverage the newly awarded HRSA *Early Childhood Comprehensive Systems: Health Integration Prenatal to Three Program* grant opportunity to provide leadership for coordinated, cross-sector efforts between medical homes and early childhood settings to improve developmental screening rates and address social conditions of health. We plan to increase child health provider use of the HMG Resource Hub to expand the capacity and professional development of local providers to increase earlier access to existing resources for the prenatal to age eight population.

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 to access screening tools at HelpMeGrowVT.org. We will increase cross-sector provider use of Vermont's Universal Developmental Screening Registry (USDR) to improve communication and coordination for earlier identification of developmental concerns. We will fully integrate the USDR with HMG's ASQ Enterprise Online System, an effort delayed this year by COVID-19, to 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.

Additional planned strategies include:

- Increase family engagement and understanding of early childhood development by promoting CDC's LTSAE tools and offering screening questionnaires at HelpMeGrowVT.org
- Continue to offer trainings and activities for families and providers to increase their knowledge of early childhood development, including social and emotional development, to address disparities, promote equity, and strengthen families and encourage positive parenting/caregiving practices that build resilience
- 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.
- Ensure communities are fully plugged into a reliable grid of resources, including elements such as quality early care and learning opportunities, healthy food, housing, and supportive relationships, to ensure that all children have what they need to thrive
- 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

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 deaths in child care
- 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 and farm related injury prevention

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 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 2) fluoride varnish application.

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*
- Continue to promote the Vermont Resilience Messaging Project (VRMP) resilience messaging toolkit for diverse audiences to unite the many efforts to foster resilience and build flourishing communities across the state. Increase the number of stakeholders serving as ambassadors for integrated messaging with their peers and other organizations through ongoing trainings, technical assistance, and promotional activities.
- Our full-time coordinator of Adolescent Sexual and Reproductive Health oversees the Division's PREP program and other adolescent sexual and reproductive health related efforts. This staff member is now one of 30 certified trainers in the state in the *Youth Thrive Framework*, which grew out of the *Strengthening Families model*. VT Afterschool now oversees Youth Thrive. Youth Thrive 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. We will continue to expand on opportunities to increase the number of people trained in the Youth Thrive approach
- With HMG system partners, MCH coordinators in district offices will continue to provide *HMG* Child Health Provider Outreach and training to child health providers and community partners to increase use of the *HMG* Resource Hub
- Promote and expand *Help Me Grow* Vermont to promote optimal child development by enhancing protective factors. Research indicates that referrals to *Help Me Grow* and subsequent linkages to community-based programs and services enhance protective factors, and perhaps even mitigate risk factors. Even among families with differing needs, *HMG* support to families and their connection to programs and services has been shown to enhance parents' perceptions of family functioning relevant to protective factors. This positive shift in parents' attitudes, knowledge, and behaviors contributes to engaged and educated parents better equipped to meet their children's needs and foster healthy development (Hughes, 2016)

    - Families accessing the HMG contact center are surveyed on follow up calls and asked to respond to two or three protective factors questions, when applicable: 1) I am able to access services if I need it; 2) I have a better understanding of services for me and/or my child; 3) I have a better understanding of my child's development and information that will impact my child's wellbeing. In addition to these survey questions, HMG contact center staff continue to refine and promote protective factors strategies to use during telephone conversations with families.

- MCH is supporting efforts to establish a Vermont Touchpoints site at VCHIP. We have begun initial planning efforts and have identified 5 trainers. We are hoping to send a VT team to the fall 2021 Brazelton Touchpoints Institute Train the Trainer Community Level Training program. The purpose of Vermont's Touchpoints site is to create a shared approach and common language to promote well-being for Vermont's families from pregnancy to early childhood using TP method. 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 health development

- 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 ACEs
    - 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

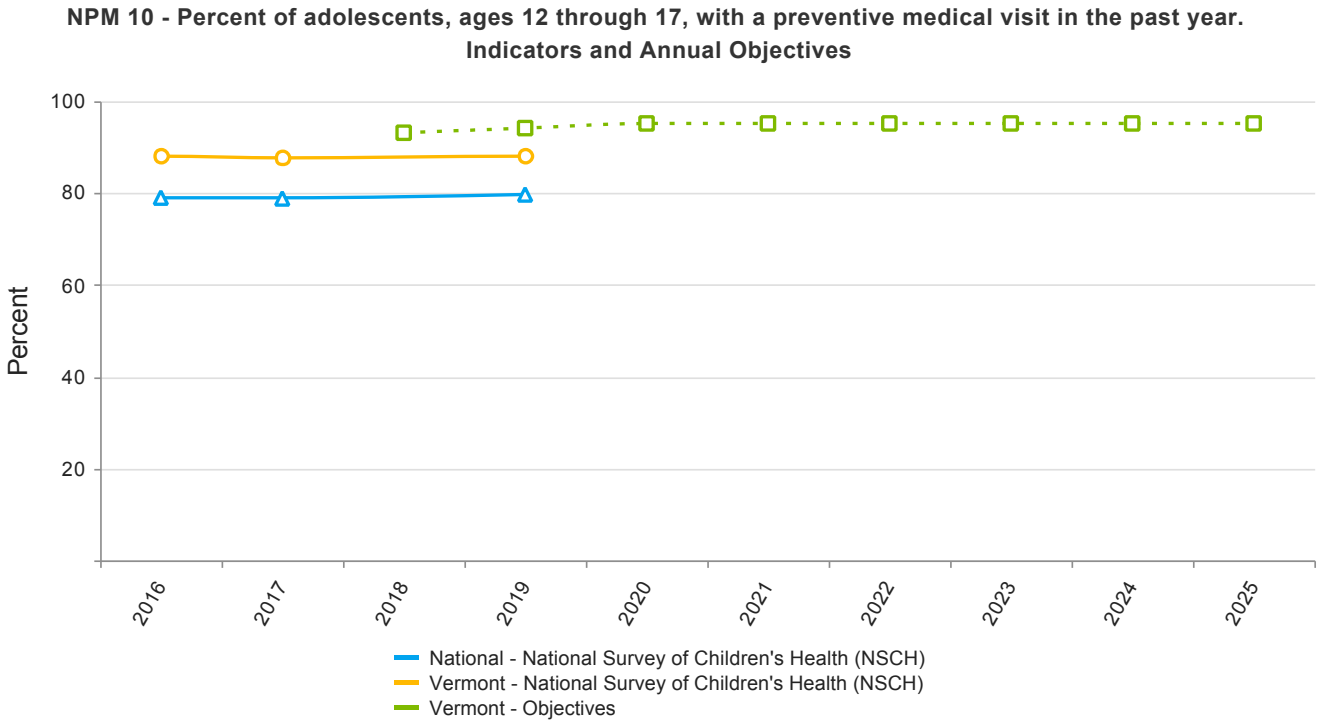
Please note: Only those strategies the link with national and state performance measures are identified in the Action Plan Table for this section.

Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2019	21.5	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2017_2019	11.2	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2017_2019	12.8	NPM 10
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	23.5 %	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	49.2 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	94.7 %	NPM 10
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)	NSCH-2018_2019	14.0 %	NPM 10
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)	WIC-2018	12.9 %	NPM 10
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)	YRBSS-2019	13.1 %	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2019_2020	68.2 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2019	82.0 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2019	94.3 %	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2019	93.6 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	7.6	NPM 10

National Performance Measures



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

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			93	94	95
Annual Indicator	88				
Numerator	41,007				
Denominator	46,622				
Data Source	NSCH				
Data Source Year	2016				
Provisional or Final ?	Final				

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	95.0	95.0	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
Annual Objective			5	10
Annual Indicator			0	0
Numerator				
Denominator				
Data Source			Program Data	Program Data
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	15.0	25.0	35.0	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					
	2016	2017	2018	2019	2020
Annual Objective		55	58	60	63
Annual Indicator	50.5	60.5	60.5	58.2	58.2
Numerator	13,258	16,108	16,108	14,285	14,285
Denominator	26,270	26,614	26,614	24,524	24,524
Data Source	YRBS	YRBS	YRBS	YRBS	YRBS
Data Source Year	2015	2017	2017	2019	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	65.0	65.0	66.0	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
Annual Objective			8	8
Annual Indicator		11.2	13.4	13.4
Numerator		3,048	3,454	3,454
Denominator		27,166	25,727	25,727
Data Source		YRBS	YRBS	YRBS
Data Source Year		2017	2019	2019
Provisional or Final ?		Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	8.0	7.0	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 2022, increase awareness among health care providers of the importance of annual preventive health visits for adolescents to 75%

By 2022, increase awareness among parents/ caregivers and patients (adolescents) on the importance of preventive health visits for adolescents to 75%

By 2022, increase access to preventive health visits in medical homes and school-based health centers by 20%

Strategies

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

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

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.

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

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

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

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

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

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

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

Promote the PATCH for Teens: Classroom Edition with Health Educators in public schools serving youth

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

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

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

Support Adolescent Medicine Specialist to train and provide TA to youth serving community providers and health care practices related to adolescent sexual and reproductive health and school-based health center collaborative

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

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 2022, increase the number of middle and high schools participating in youth empowerment projects by 50%

By 2022, increase the number of Vermont youth trained on M3 by 50%

By 2022, increase the percent of youth that agree or disagree that in their community they feel they matter to people to 63%

Strategies

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

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 (M3: Mindset, Metacognition and Motivation); schools receive ongoing coaching and support as they implement these training activities

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

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)

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 2023, increase the percentage of youth and adults screened for suicidality in the primary care setting by 25%

Strategies

Participate on the Vermont Suicide Prevention Coalition and the Vermont Suicide Data Committee

In partnership with the Vermont Child Health Improvement Program, collect and report on quality improvement data from pediatric practices on depression screening

Promote suicide screening in primary care using the nationally recognized Zero Suicide approach

MCH Leadership for the AYA CoIIN for systems improvement in screening youth for depression and other factors that may lead to suicidality

Support presence of Umatter Youth and Young Adults Mental Health Wellness Promotion and community Action in 10 schools statewide

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

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

Assess and act upon data analyses as produced by VDH injury data staff, NVDRS reporting, and ED-SNSRO surveillance of suicidality in emergency departments

Further develop and implement project with VCHIP on provider screening for youth suicide ideation, creating a plan, or suicide attempts

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

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 and ASCD'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.

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 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 school year. 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.

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 Over the last year we have solidified this collaboration with the introduction of a six-week youth advisory council effort focused on health equity in Vermont. Meetings will be held regularly this summer (2021) to discuss health equity, specifically as it relates to healthcare, third space, and mental health.

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 continues to advance on improving adolescent preventive care and maintains an Adolescent and Young Adult Resources web page for primary care practices in support of youth-friendly services. They facilitate expert consultation around confidentiality and youth-friendly care and facilitated in-person trainings with an expert on the topic of confidentiality pre-pandemic. They worked with this national partner to disseminate a Vermont specific confidentiality toolkit for interpreting confidentiality laws impacting health care services for youth and young adults in Vermont. A youth’s understanding of confidentiality impacts youth access of primary care and improves the quality of their visits with providers.

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: Classroom Edition. 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. 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 wellbeing in health care settings; students 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 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. 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 an 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.

We nurtured a new partnership between Up for Leaning and the Vermont Network Against Domestic and Sexual Violence, supported by a CDC grant administered by MCH that focused on the primary prevention of sexual violence. Up for Learning collaborated with the VT Network to plan and lead a learning series to support participating organizations to sharpen their lens and build a toolkit for youth-adult partnership to amplify youth voice & agency in learning and decision making. This powerful strategy strengthens the social and emotional fabric of organizations and communities, enhances motivation and engagement, and ensures equity. Essential questions addressed as part of the series included: Why does youth voice and agency matter? What does youth voice and agency look and sound like? What conceptual framework will help me better understand and build youth voice and agency in my organization or community? And, how will I further develop a sense of shared responsibility in learning and decision making in my organization or community? Youth adult partnerships build on the strengths of each group to create more effective outcomes. These partnerships have also been shown to support positive youth development and resiliency and decrease risky behaviors in youth.

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 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 M3: Mindset, Metacognition and Motivation project is a means to these ends. Youth become messengers with their advisory group peers, sharing the latest research and learning implications relating to:

- Mindsets: a critical examination of both youth and adults' ingrained beliefs about ability and the role of self-expectations and others' expectations on academic performance and life in general,
- Metacognition: learning about how we learn, and
- Motivation: key variables that impact the level of learning engagement.

Our support of this approach connects work on youth empowerment, in partnership with our Alcohol and Drug Abuse Prevention division.

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 M3). 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 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, 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 2021 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 Alcohol and Drug Abuse Prevention, 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 Group 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.

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 11 PREP subrecipients and the program is implemented across 13 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 fourth 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. In addition, MCH has worked collaboratively with the health department's division of Alcohol and Drug Abuse Prevention (ADAP) to incorporate activities into the scope of work to include a focus on decreasing prescription drug misuse and abuse among Vermont's youth and increase awareness of safe use, storage, and proper disposal of prescription medication. This work was expanded in the reporting year to include training on substance use prevention for afterschool professionals, as well as several groups of medical residents at the University of Vermont School of Medicine.

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 Director of Adolescent and Reproductive Health also served on a proposal review process led by VT Afterschool to fund summer programming expansion efforts focused on COVID recovery for children and youth.

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

Action Plan: 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:

- Support youth lead activities including the development of resources or materials that address youth focused COVID response and recovery topics [i.e., COVID-19 vaccine promotion, improving utilization of adolescent health preventive services; informing school based guidance/policy]
- Create opportunities with youth and medical community, public health officials and other stakeholders to share and promote youth voice and experience on COVID response and recovery efforts
- Access and utilize data to inform new initiatives, based on youth identified areas of concern
- Provide opportunities for trainings to build skills around youth leadership and/or specific public health priority areas [i.e., youth social emotional wellness].

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 for increasing awareness and promoting annual well care visits (in partnership with VCHIP).

The Health Department will be working closely with schools this fall as they begin to reopen while Vermont continues to deal with the 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 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 be able 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 21-22 school year over the summer 2021.

Over the past two 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 for the last two years 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.

During the most recent legislative session a condom availability in schools' law was passed and goes 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 are working 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.

In 2021-2022 MCH's Adolescent Health Unit will continue to inform the work outlined above. 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 will include representation from the Health Department, the Agency of Education, and community partner organizations, such as Planned Parenthood of Northern New England and Outright VT. School- based health educators will also be invited to serve on the team. Vermont will be part of the third LEAHP cohort and will participate in training and TA opportunities for a 2-year period which began in the spring of 2021.

For a fifth 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. This year, Dr. Gibson will also continue to provide TA to VT Afterschool Inc. In the plan year efforts will also 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.

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 YSAC will be completing a data analysis and developing policy recommendations on the seven youth wellness outcomes this year.

MCH will continue to fund Vermont Afterschool's work around preventing risky behavior and promoting strengths for youth. Vermont Afterschool will be entering its fourth 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.

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 will 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 and on 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 will 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 plans 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.

MCH continues 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: Classroom Edition. 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 two 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 school year. The PATCH program has 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, M3: Mindset, Metacognition and Motivation 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. 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 M3 concepts will move out of a siloed M3 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 M3 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 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 several months to implement telemedicine opportunities in primary care, 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 develop 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 conducting interviews of our SBHC peer collaborative members, developing a survey tool that includes both nationally validated assessment and performance indicators of SBHCs and locally derived process and outcome measures. They will then be sharing findings with MCH and other stakeholders.

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.

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

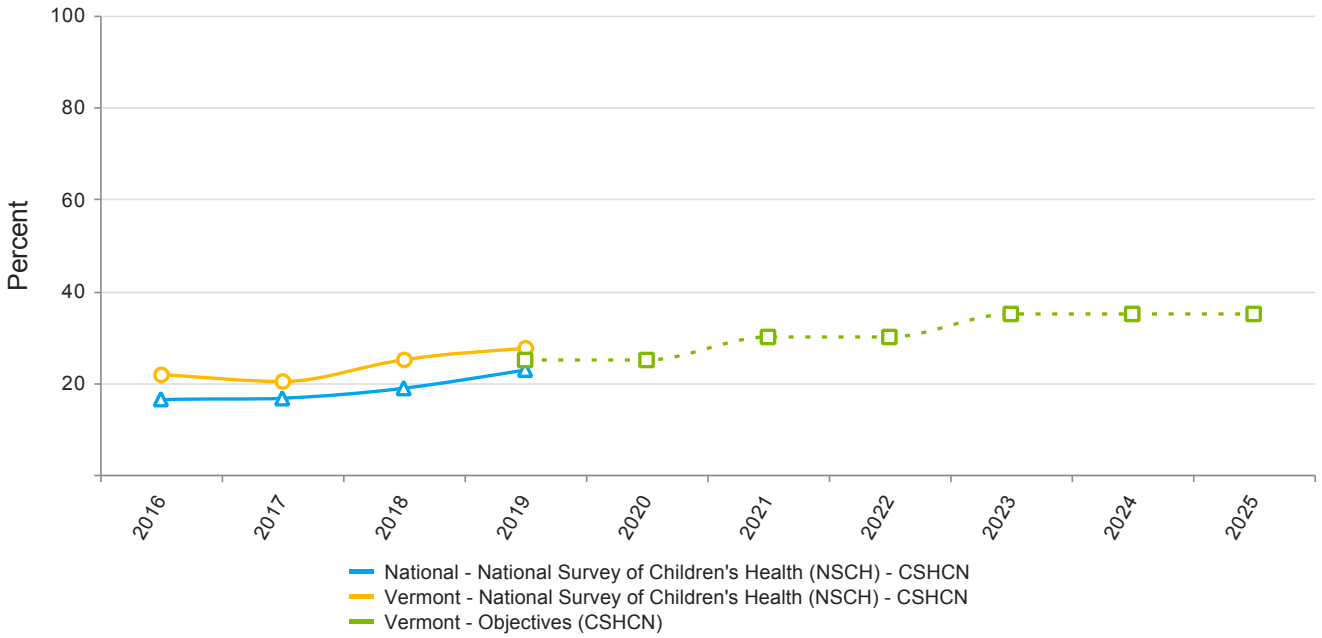
Children with Special Health Care Needs

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	23.5 %	NPM 12

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**
Annual Objective			25	25
Annual Indicator	21.8	20.4	25.1	27.6
Numerator	2,189	1,808	2,162	3,016
Denominator	10,050	8,853	8,632	10,947
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	30.0	30.0	35.0	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:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			30	50
Annual Indicator			38	38
Numerator				
Denominator				
Data Source			Program Data	Program Data
Data Source Year			2019	2019
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	70.0	80.0	90.0	90.0	90.0	90.0

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 2022, 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 2022, increase by 20% the percentage of primary care providers with proficiency to facilitate transitions from pediatric to adult care
By 20%, increase the percentage of families of CYSHCN who partner in decision making at all levels
By 20%, increase the percentage of families of CYSHCN who are satisfied with the services they receive
Family partners are well integrated into medical system and Vermont state plan for CYSHCN
By 2022, increase the percentage of primary care providers who provide preventive health assessments to CYSHCN, in accordance with Bright Futures by 20%

Strategies
Organize efforts to explore improved delivery of care coordination to CYSHN in an environment where there is a wide variety of care coordination available. Includes widespread stakeholder involvement, systems assessment, and presentation of findings to partners including ACO leadership
Lead statewide efforts to improve collaborative approach to transitions through partnership with VocRehab, VFN, and AOE. Includes guiding regional Transition Core Teams as well as organizing and funding trainings, conferences, and youth summit
Implement use of homegrown Family Engagement toolkit to create authentic family partnerships with our programs to inform our work
Partner with advocacy organizations and state partners to improve availably of nursing services to technology dependent/medically complex children in their home through payment reform, service delivery reform (Hub Model), paying skilled family members, and offering a family directed service model
Regional CSHN Social Workers are embedded/ affiliated with medical homes to provide care coordination, resource and referral, and provider education around the population of children and youth with special health needs, also 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
Continue family leadership program to develop family leaders to serve as advisors for improving the system of care within Vermont's medical home community; medical homes to have parent partners to inform and educate
CSHN and UVM's Center for Disability Community Inclusion to inventory statewide transition activities and identify opportunities through a statewide summit in late summer
Fund Vermont Family Network (VFN) to take the lead in the development and implementation of a four-part webinar series addressing state-specific transition supports
Establish and convene CSHN Advisory Committee
Program-wide assessment of cultural and linguistic competency

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

Children with Special Health Care Needs - Annual Report

Report: CHSN

It is important to note that throughout this past grant year, the vast majority of CSHN staff were deployed full time to the COVID-19 emergency response. Most were deployed as contact tracers or to support the School/Child Care response team. While this significantly impacted our ability to move CSHN-specific work forward, the skills of the CSHN team were integral during the COVID-19 response. For example, CSHN social workers were swiftly identified as leaders in contact tracing; supporting COVID cases and their contacts access resources that would have otherwise created barriers to following guidance; and working with culturally diverse Vermonters impacted by COVID. All CSHN staff 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. The COVID Care Coordination work dovetailed closely with the Health Equity response to ensure our most vulnerable populations were well-resourced and supported.

A small handful of CSHN staff were spared from deployment, primarily to focus on the key functions within CSHN would continue, which they did with very little interruption. Those functions include Newborn Bloodspot and Hearing screening, administration of medically necessary Medicaid services, and lastly an access point for providers needing consultation or families seeking care coordination.

Some key priorities were continued despite the pandemic, and in thanks to the tireless efforts of the CSHN staff and our strong partnerships.

Vermont's CSHN program has worked diligently to focus more on population-based and enabling services versus direct care and supports. Our programs and services continue to follow many children and youth from infancy into adulthood, from healthy newborns to some of the most medically fragile children in the state. Both the Newborn Screening and Early Hearing Detection and Intervention programs are housed within CSHN and are discussed elsewhere in this report. CSHN also continues to offer supports and services via our network of Medical Social Workers who provide care coordination for children with medical complexity and/or neurodevelopmental disabilities, as well as participate in systems-based work within their regional communities. Through an interagency agreement with Medicaid, CSHN administers the Children's Personal Care Services (CPCS), Pediatric High-Tech Nursing (HTN) Program, and Pediatric Palliative Care Program (PPCP).

After more than a year of planning and in partnership with the provider network and Vermont Medicaid, CSHN successfully transitioned the payment for nutrition services for CYSHN to our state's payors effective July 1, 2020. Nutritional services 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.

In calendar year 2019, 156 children between the ages of newborn through 21 received services provided by this network of registered dietitians. Of the 156 children who received services in CY2019, 89% had Medicaid as either primary or secondary insurance - 74% of them had Medicaid as primary, and 26% of them had Medicaid as secondary. There were less than 10 individual children identified as having private health insurance or being un- or underinsured. For children and families who encounter any difficulty in accessing nutrition services, we will provide both financial technical assistance and maintain 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.

CSHN remains committed to supporting the existing infrastructure and increasing capacity of current Registered Dietitians

caring for CYSHN. Clinicians or care teams providing services for CSHN will now have access to consultation and technical assistance of two Registered Dietitians who 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. Consultants will do the following:

- Develop and maintain an inventory of statewide nutrition services and supports that are available to CSHN
- Provide technical assistance and consultation to clinicians and teams caring for CSHN
- Conduct regional trainings for providers and teams caring for CSHN
- Engage in collaborative problem-solving around specific needs of CSHN with representatives of statewide agencies

As of April 2021, over 56 hours of consultation had been provided to care teams and providers needing assistance. Activities related to trainings and collaborative problem-solving were mostly put on the backburner given the pandemic. However, being forced to function in a more remote environment pushed some collaborative relationships forward.

VT remains committed to the enhancement of its Medical Home/CSHN Care Coordination Model, whereby we redefined and redeployed care coordination efforts by placing medical social workers, from the CSHN program, into medical homes. This re-designed CSHN medical social worker role emerged from the recent structural/system-wide redirection of the CSHN mission, away from fee-for-service-financial assistance and condition-specific clinics, towards a goal of supporting families and their children's service providers in the coordination of family-centered care. This activity is coordinated with the Blueprint for Health expansion in its scope to include pediatric populations, Early Intervention (Part C), and the medical home training projects of the Leadership Education in Neurodevelopmental Disabilities (LEND) program at UVM.

The role of the CSHN social worker has now been well-established for years, and the impact of various grant-funded activities around Medical Home implementation continues to evolve and improve. The environment of care coordination for CYSHN also continues to morph and grow, and as such, our program continues to regularly engage in work to improve the delivery of services. The care coordination delivery system for CYSHN has in some ways become more confusing as new services and supports have been introduced. Care coordination is offered through the Blueprint, Medicaid, Medical Homes, for ACO attributed beneficiaries, with the Children's Specialty Center, Part C Early Intervention, and so on. In an effort to understand the new era of care coordination, CSHN engaged with a variety of families in different forums to gain their perspective on the quality of care coordination services they received, and what makes care coordination successful. What we learned from families can most succinctly be summarized by stating that: one primary care coordinator is always preferable, and that their skills must align with the needs of the child (i.e. nurse care coordinators for those who are medically complex, social work care coordinators for those with social emotional support needs). Additionally, multiple care coordinators often make more work for families, rather than alleviate burden and provide the intended assistance. Engagement of care coordinators from a variety of organizations and roles demonstrated very similar impressions as those shared by families. Care coordinators shared that they often feel unsure of who is the "lead" coordinator working with a family, and this leads to confusion and potential redundancy or tasks slipping through the cracks. It has been the impression from this work that the adoption of care coordination for CYSHN has been excellent in Vermont, and now some refining of roles is required.

Much of 2019 was focused on sharing ideas about the future of CSHN care coordination to decrease burden on families and support massive transformation efforts underway. Vermont's single accountable care organization, OneCare Vermont (OCV) has for years, been trying to establish strong expectations for comprehensive care coordination in the medical home and invited MCH/CSHN participation to inform the pediatric care coordination reimbursement model for 2020. The outcome was that for children attributed to the ACO, the lead care coordinator assigned to that child can draw down monthly funds based on the care coordination activities accomplished. Of the nearly 700 children receiving care coordination through CSHN, over 90% are attributed to the ACO, thus eligible to reimbursable care coordination through their medical home. It seemed, that this would be an ideal time to encourage the delivery of care coordination for CYSHN through the Medical Home (vs. CSHN, a public health program), and instead support the medical home in doing so versus being an additional service provide for families and teams to have to coordinate with. For this to be successful, medical homes must have

adequate staffing to do the care coordination and document that activities in the OCV platform to draw down associated funding. CSHN engaged in a pilot with one pediatric practice, where a care coordinator is fully embedded in the practice to build capacity and test if with a fully staffed team of care coordinators to do and document the work, will the promised funds sustain the staffing. Additionally, families at that practice will no longer receive direct CSHN Care coordination from outside the medical home because the resources are now embedded within the practice. We are 6 months into the pilot now, and due to the pandemic, it has been hard to measure impact, but preliminary reporting from families and the practice have been positive. Most notably, it has been reported that there is great relief that there is less differentiation for care coordinators that “specialize” between mental health, developmental disabilities, behavior health and medical complexity. The skillset to coordinate care is applicable across many different patient populations and having one who is comfortable in working with a variety of families and circumstances has been far more beneficial for practices and families alike.

With so much of the healthcare field focused on emergency response efforts, our systems improvement work around CYSHN care coordination was paused. However, it was an opportunity to highlight how medical homes and providers with access to high functioning and well-established care coordination were able to pivot and support their patients and families during this pandemic, where less-resourced providers were perhaps less able to do so. We heard this directly from families who were engaged by our contracted Family Engagement Coordinator. All 700 families actively enrolled in CSHN were surveyed about their experience receiving care coordination generally, with various themes related to COVID highlighting strengths and opportunities. Of those 700 families surveyed, nearly a dozen volunteered to participate in focused workgroups to map some visions of an improved system of care coordination. This work is ongoing, and will be shared with partners at VCHIP, OneCare Vermont, Blueprint for Health and our state partners committed to this work.

Collaborative efforts to improve delivery of EPSDT with Vermont Medicaid continues. In 2018 a strategic plan was created, first and foremost, to educate and refresh the most critical units within Medicaid, and then provide technical assistance around necessary improvements. One example that has come out of this work, is the development of a new EPSDT policy review process for any requested service where the medical necessity is in question or if it is determined medically necessary and covered by EPSDT, but no current mechanism for payment exists. This process has been piloted using PDSA cycles since January 2019 with the two primary units that authorize services for children, including CYSHN. Since then, no services have been denied based on lack of medical necessity without an interdisciplinary review, nor have they been denied based on technical or systems issues. Furthermore, this information will be used to inform if certain services and supports should be considered as part of the regular Medicaid fee schedule.

CSHN was invited to participate in a review of the current Disabled Children’s Home Care (DCHC) application process. In partnership with mental health and disability experts, the eligibility process was reviewed and refined to ensure that the process clearly identifies those children who are eligible for DCHC. VT has historically had a very inclusive enrollment, however, inconsistency in decision making has led to difficulties for families and providers in understanding who this waiver is intended to support. Ultimately, this negatively impacts families and children because the guidance, process and eligibility are unclear. CSHN was eager to participate in this process as one of the primary organizations that supports families in the DCHC process.

The CSHN leadership continues to meet with VT Medicaid leadership to improve collaboration with Medicaid’s Chronic Care case management initiatives. In October 2018, Medicaid case management began actively outreaching newly enrolled Medicaid beneficiaries over age 18. The outreach involved a call from a nurse case manager, a 13-question screen, and appropriate referral and follow-up as necessary to ensure all connections were made successfully. Materials are also sent out as follow-up to both those where telephonic contact is successful or not. In October 2019, similar outreach began to newly enrolled beneficiaries less than 18 as well, using a screening tool and referral guidance developed by MCH/CSHN. The outreach involves not only reaching out to the guardians of the beneficiaries, but the minors themselves so they may gain some exposure in learning about their healthcare benefits. This process was informed by a youth advisory council who focuses on empowering youth to advocate and navigate the healthcare system. Medicaid is tracking data specific to utilization of their benefits after successful outreach so we can continue to track if the methods are successfully driving newly enrolled Medicaid beneficiaries to access their benefit. This opportunity will allow us to connect Medicaid beneficiaries

upstream to valuable resources such as Help Me Grow, WIC, CSHN, to name a few.

Nursing services for children who are significantly medically complex, continues to be a priority area of improvement in Vermont. Utilization had improved somewhat with a rate increase in 2014 but has since stalled. Under MCH leadership and through robust stakeholder involvement, 4 innovative strategies were identified to improve delivery of care to these medically fragile children and youth. All require significant leadership buy-in and representation from MCH and Medicaid, and thus far the efforts have been positively received. The strategies being explored include 1) Paid Family Caregivers, 2) Family Managed Services, 3) Hub Model Delivery, and 4) Payment Reform. In October 2019, two major policy changes went in to effect: paying parents/guardians who are Registered Nurses to provide services to their children, and a 40% increase in rates to the family managed nursing services allowing parents/guardians to recruit and hire their own nurses independent of an agency. Both policy changes have been applauded by advocates and families alike, and early utilization data shows a meaningful impact.

Significant resources by way of a committed team from Vermont Medicaid have been dedicated to crafting a reformed payment model for High Tech nursing. Throughout 2020 and ongoing, this team has conducted extensive modeling and stakeholder engagement to focus in on a model that might provide funding for services up front to agencies. This funding would be intended to help them manage their budgets more predictably (instead of waiting for reimbursement months after services are delivered) and ultimately improve recruitment and retention of nursing staff.

CSHN leadership has been invited to participate with cross-agency partners to plan for the 10% increase in Home and Community Based Services (HCBS) funding. Although early in the planning stages, CSHN is closely aligned with partners to commit this one-time funding to projects and opportunities that will sustainably lift and strengthen our services across the population.

In response to the pandemic, CSHN partnered with Medicaid policy to obtain a waiver provision to allow parents and caregivers to draw down funding intended to pay for Personal Care Attendant services through our Children's Personal Care Services program. Historically, paying parents to perform these duties has not been allowable under CMS, however given that many families were unable to access these services due the COVID-19 and were now providing all care and support on their own, temporary access was granted through the state of emergency. CSHN leadership has continued to work with Medicaid policy on the possibility of allowing the continuation of paid family caregivers beyond the emergency. This work will be ongoing throughout 2021 and likely beyond.

MCH/CSHN again contracted with a Family Engagement Coordinator, during which a division-wide assessment was conducted to understand the current state of family engagement and identify opportunities for new or further engagement. A committee worked together to assist in the development of a Family Engagement Toolkit, which will be used by programs across MCH to engage family partners in all aspects of work moving forward.

Best practice for transitions for CYSHCN into adulthood health care systems continues to capture national attention and definition and has been identified as one of Vermont's NPM. Through a grant to VCHIP, UVMMC was able to do patient experience mapping with transitioning youth and their caregivers, visually delineating some of the differences in need and perceptions of readiness in transitioning. As such, new techniques have been piloted with transitioning youth in a small number of the UVMMC Children's Specialty Clinics, namely messaging bots. These messages go directly to the youth's phone with reminders about appointments and suggested resources. Early data analytics showed significant engagement and the pilot has now expanded to three different specialties with the UVM Children's Specialty Center. The project team also presented at the Transitions to Adulthood national conference in Houston in October 2018.

Other efforts to support Transitions to Adulthood have included statewide engagement in the regional Transition Teams. Based out of the VocRehab division of the Department of Children and Families, these transitions teams have historically been education and employment focused. 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 provide ongoing support to the VT Family Network (VFN), a statewide system of family support, by families to families, through: a support line, informational/ educational materials, support groups, “sib shops” workshops for siblings of CYSHN, training and education to empower families and caregivers to engaged in system of care improvement (the Family Leadership Series), enhanced financial and technical assistance to families statewide, and family engagement with the Medicaid Exchange Advisory Board and the Autism work group. Annual VFN conferences continue to bring several hundred VT families, providers, and policy makers together. 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 and administered by the CSHN Respite Committee. Since March 2020, CSHN and VFN have partnered closely to bring information to families about changes in access to care related to the pandemic and we expect this will continue throughout the pandemic response.

VT is committed to cultural competency and outreach strategies to the New American and immigrant populations. CSHN continues to include funding in our annual grant to the VT Family Network to continue their VT Leadership Series, with the goal of growing and sustaining a strong group of passionate family leaders who will be engaged in a variety of state boards and councils within the system of care for CYSHCN. 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 Surveillance 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 cycles 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 OAE, 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, hitherto, 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.

It has been years since we collaborated with UVM Medical Center (UVMMC) Department of Pediatrics in the successful recruitment and hiring of a Developmental-Behavioral pediatrician, with the long-term goal of transitioning Child Development Clinic functions to UVMMC. In preparation for the opening of her clinical practice, VDH and UVMMC created a new, blended, unified point of referral, triage and intake for the diagnostic evaluation of Vermont children with concern for developmental conditions. VDH re-designated its own Child Development Clinic clinical manager position, filled by a medical social worker with years of experience in direct clinical service in CDC, care coordination, and management, to lead the single point of entry for referral sources. Referral and intake paperwork have been redesigned. This single point of entry now serves the new UVM DBP program in Burlington, as well as the Title V/Medicaid-funded UVM Autism Assessment Clinic

(AAC) in the Division of Child Psychiatry-Vermont Center for Children, Youth and Families (VCCYF). The long-standing VDH Child Development Clinic was shuttered when the COVID pandemic hit Vermont and there is no intention to reopen programming, with the small exception of a "tail" of families that were already enrolled prior to March 2020. VDH/Title V has also begun to fund a full-time medical social worker position at the UVM DBP program, while continuing to support the VDH/CSHN regional medical social worker positions that provide care coordination to children with special health needs, including children with developmental disorders, in a gap-filling model.

Since the inception of Part C, CSHN medical social workers in VT have had an integrated role to ensure streamlined navigation and care coordination for families. They work directly in CDC in the evaluation of children with ASD/DD; regionally based, they provide care coordination to families of children with a wide range of special health care needs; and they also are core members of the regional Part C Early Intervention teams. Participating in care conferences in the Medical Home has further integrated these roles and reduced categorical/programmatic silos and fragmentation.

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

Vermont's NPM is Transitions to Adulthood. As described elsewhere, transition of 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. Since shifting from a direct-service model to population-based health, CSHN has been able to reach more adolescents with special health needs who are needing to prepare for their adult needs. Through CSHN collaboration with medical homes we are able to participate in anticipatory planning for adolescents, directly with them, their families, and their medical homes. The interest in transitions, within UVMMC primary care and specialty care, presents a timely opportunity to promote the pediatric medical home/care coordination model within the adult care system into which our CYSHCNs are graduating. Largely in part due to our new data system that launched in July 2018, we will be able to more proactively provide anticipatory guidance about all steps related to transitions across the continuum of youth and adolescence.

CSHN will continue to work closely with VocRehab central leadership as well as the statewide system of Transition Counselors, both in hopes to partner around families, but also ensure that transitioning youth are aware of VocRehab as a resource. VT MCH will again sponsor a VocRehab organized event specifically around organizing local resources to support transitioning youth, of which CSHN social workers will be intimately involved. This year, CSHN will also be supporting and presenting at the Youth Summit, which is organized by and for transition aged youth with neurodevelopmental disabilities.

We remain dedicated to continuing our collaboration with Medical Homes in the role of care coordination. Medical social worker staff in the regions will be maintaining their partnership in regional practices and regional Part C teams and exploring additional partnerships. Lessons learned from the Collaborative, especially in Shared Plan of Care tools, will be applied. Continued promotion of *Help Me Grow VT* ensures that early detection leads to the linkage of at-risk children and their families to community-based programs and services, including medical homes. This coming year, as a result of nearly three years of stakeholder engagement and in collaboration with other statewide entities, CSHN care coordinators will shift from serving families directly based on their region of residence, but rather, supporting Medical Homes within certain regions. This shift will be to further support a centralized care coordination model out of the medical home where we are seeing and increased capacity across the state thanks to enhanced payments through OneCare Vermont, VT's Accountable Care Organization.

To formalize the organization of this work, CSHN is partnering with VCHIP to convene a broad, high-level group of stakeholders, including families, OneCare Vermont, Blueprint for Health, UVMMC Children's Specialty Center, Vermont Family Network and other key stakeholders with the primary goal of sharing what each organization is exploring or implementing related to care coordination for CYSHN, and to clearly define ways in which we can partner moving forward. Each of these stakeholders is actively engaged in this work and yet there is no coordination or cross-cutting leadership. Our first meeting will be held in late September 2021 and will be an invitational for each attendee to share findings from their related work. Time will also be spent ensuring the right stakeholders are present, and work on coming to consensus on a charter and next steps. For example, CSHN will share their findings from years of surveys and listening sessions with families and the care coordination workforce, which show an impressive amount of alignment and similarities in feedback.

In June 2021, Vermont applied for a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS) under section 9817 of the American Rescue Plan Act (ARP). In July, Vermont's initial state spending plan and spending narrative was partially approved. CSHN leadership will continue to participate on the workgroup that will inform ongoing spending and implementation planning. Already, early conversations have weighed heavily on topics relative to care management and IT infrastructure, which closely relates to the planning conversations mentioned previously around CYSHN care coordination. It is our intention that CSHN leadership participation in both of these exciting opportunities will have long-lasting impact for CYSHN as well as the population as a whole.

VT will continue to use some Title V funds to support access and capacity of specialty clinics managed by UVM Medical Center and other subspecialists, such as metabolic/genetics and child psychiatry. In the traditional sense, VT Title V helps to fill gaps in services that would otherwise leave patients and families with uncoordinated and insufficient care. At the same time, funds are used to ensure that medical services at these clinics are family-centered, and culturally responsive. Furthermore, CSHN Social Workers work in partnership with these specialty clinics to provide wraparound services and ensure that proper community supports are in place for patients. As these specialty clinics stabilize and adopt more comprehensive, coordinated family-centered practices, and previous gaps shrink, Title V funding can be redirected to even more foundational, public health systems approach to CYSHCN.

CSHN's Child Development Clinic is planned to fully transition to our partners at UVMMC later this year. The CDC is the last remaining direct service clinic and has been the most complex to transition, requiring a lengthy recruitment and regular meetings with meticulous planning. Until the transition is complete, CSHN will continue to provide centralize intake support and psychological evaluations in partnership.

With Title V funding in the coming year, we plan to continue family leadership programming to develop family leaders to serve as advisors for improving the system of care within Vermont's medical home community, as well as support to the VT Family Network's (Vermont's Family Voices organization) family support team. Additionally, this year the expectations around engagement of racially and ethnically diverse Vermonters have improved to include all MCH-funded activities at VFN, such as supplemental funding assistance, sib-shops, and conference attendees. A strong theme in the grant to VFN this year was that all of their programs, activities, and materials need be accessible by those who are of limited English proficiency or non-English speaking.

MCH/CSHN is also once again, contracting 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. Programs will be implementing the newly created Family Engagement Toolkit to partner more intentionally with families and stakeholders across programs. One of the projects family partners have already been identified for, is the payment reform project for the Medicaid High-Tech nursing program, in which the payment model is being reformed to ultimately increase utilization of services.

In addition to the activities described above to promote the medical home model and a coordinated system of care for children with special health care needs, we also aim to work on the following strategies: Promotion of the use of *Bright Futures, 4th edition,* as Vermont's EPSDT periodicity schedule; participation in multi-disciplinary collaboration to increase influenza vaccination rates and documentation of vaccination status for all children, and especially those with chronic diseases.

CSHN leadership will continue to be an active partner in EPSDT efforts as described in detail in the annual report, namely through participating in a policy level project to improve the understanding and delivery of EPSDT; co-leading the project specific to EPSDT Outreach and Informing; and continuing to represent the State on Vermont's Medicaid Exchange Advisory Board's EPSDT workgroup. CSHN will also continue to lead improvement efforts specific to our Medicaid High Tech Nursing program in collaboration with Medicaid leadership.

CSHN leadership will continue to participate in the Autism workgroup, revising the state autism plan and identifying gaps, opportunities, programs that work well, to strengthen the system of care for children with autism spectrum disorder and other neurodevelopmental disabilities.

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

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	90.0	90.0	100.0	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 202, 100% of MCH programs have family partnership across all levels of engagement
By 2022, 75% of families in MCH programs who are satisfied with the services and programming
Strategies
Continue long-standing partnership with Vermont Family Network
Continue contract 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
Convene advisory councils, including: CSHN, Hearing and Newborn Screening Advisory, ASD, mental health advisory, and other state and local committees
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
Support and partner with patient/family advisors and family partnership program at UVM Medical Center
Convene the Youth Health Advisory Council (YHAC)
Provide leadership to the Youth Service Systems Enhancement Council
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.

Last year 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.

VT-LEND collaborated with VFN to discuss health disparities and the need to serve racially diverse families. VFN has recruited and trained a cadre of racially diverse parents with children with disabilities in becoming Parent-to-Parent families and parents as teachers in VFN programs. The impact is great as they now have 8 racially diverse parents trained.

Vermont CSHN newly contracted 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 will be 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 [SI1](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.

[SI1]Check in with Nate about this being updated. You can pull from this for family partnership section—since it references the YHAC.

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. Continue contract 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.
3. Continue to implement the newly created 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 advisory, 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. Include parent- and family-voice in all communications campaigns and outreach strategies. Planned communication campaigns will include safe sleep (currently running), and substance use in pregnancy and breastfeeding (in the planning phases).
11. 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.

12. 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.) Annually, the MCH Director presents the Title V application to the Health Department leadership, which includes representation from our Divisions of Health Promotion and Disease Prevention, Environmental Health, Alcohol and Drug Abuse Programs, Health Surveillance, 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 of 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 was virtual.

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, and 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. The MCH Director facilitates the quarterly meetings of the VDH Office of Local Health MCH Coordinators 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. VFN regularly participates in the preparation of the annual Title V submission, the five-year needs assessment, and attends the state block grant federal review when able.

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 will soon welcome 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 has begun 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 - Org-MCH 2021.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Vermont

	FY 22 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 1,633,060	
A. Preventive and Primary Care for Children	$ 902,832	(55.2%)
B. Children with Special Health Care Needs	$ 493,184	(30.1%)
C. Title V Administrative Costs	$ 68,589	(4.3%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,464,605	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 1,224,795	
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)	$ 1,224,795	
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)	$ 2,857,855	
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)	$ 22,925,928	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 25,783,783	

OTHER FEDERAL FUNDS	FY 22 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 171,000
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) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 134,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 24,000
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 Disease Control and Prevention (CDC) > Injury Prevention and Control	$ 300,000
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Early and Periodic Screening, Diagnosis & Treatment (EPSDT)	$ 10,200,000
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	$ 1,544,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Newborn Screening State Evaluation Program	$ 323,500
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 8,800,000
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

	FY 20 Annual Report Budgeted		FY 20 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 1,627,812		$ 708,834	
A. Preventive and Primary Care for Children	$ 645,429	(39.7%)	$ 423,084	(59.6%)
B. Children with Special Health Care Needs	$ 660,205	(40.6%)	$ 165,843	(23.3%)
C. Title V Administrative Costs	$ 81,573	(5%)	$ 11,921	(1.7%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,387,207		$ 600,848	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 1,387,652		$ 522,685	
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)	$ 1,276,000		$ 379,730	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 2,663,652		$ 902,415	
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)	$ 4,291,464		$ 1,611,249	
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)	$ 19,123,790		$ 20,397,465	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 23,415,254		$ 22,008,714	

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 6,778,996	$ 6,061,488
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Social Services Block Grant (SSBG)	$ 286,668	$ 330,996
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 227,733	$ 33,540
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 126,944	$ 89,937
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 716,020	$ 0
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 245,626	$ 235,803
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 23,296	$ 17,484
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 197,203	$ 197,201
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Innovation Grants	$ 1,733,193	$ 1,260,910
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program	$ 587,797	$ 609,488
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vermont Cooperative Agreement for Public Health Crisis Response	$ 44,763	$ 0
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Integrated Community Systems for CSHCN	$ 42,296	$ 0

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Medicaid	$ 8,113,255	$ 7,984,938
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Overdose Data to Action		$ 319,297
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Preschool Development Grant Birth through Five		$ 376,898
Department of Health and Human Services (DHHS) > Other > Coronavirus Relief Fund		$ 572,765
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > ELC CARES		$ 265,063
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > ELC Enhancing Detection		$ 1,948,836
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Immunization COVID-19		$ 92,821

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Vermont anticipates this award will be fully obligated by the end of the FY20 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:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Vermont anticipates this award will be fully obligated by the end of the FY20 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:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Vermont anticipates this award will be fully obligated by the end of the FY20 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:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: The FY20 Administrative costs were low due to the ongoing public health emergency that started February 2020. Administrative costs are allocated on the basis of a program's direct salary costs. An unusually large portion of the health department salaries were charged to federal COVID-19 funds. Therefore a greater share of administrative costs were also funded by federal COVID-19 funds.	
5.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**

	Field Note: Vermont anticipates this award will be fully obligated by the end of the FY20 project period and the state match will be within 10% of budget.	
6.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: As noted in the FY20 budget narrative, there was an anticipated reduction in revenue from Medicaid billing in the transitioning 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 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 91,154	$ 56,509
2. Infants < 1 year	$ 77,301	$ 51,477
3. Children 1 through 21 Years	$ 902,832	$ 423,084
4. CSHCN	$ 493,184	$ 165,843
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 1,564,471	$ 696,913

IB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 61,006	$ 55,616
2. Infants < 1 year	$ 125,945	$ 50,665
3. Children 1 through 21 Years	$ 916,990	$ 416,404
4. CSHCN	$ 69,413	$ 0
5. All Others	$ 0	$ 0
Non-Federal Total of Individuals Served	$ 1,173,354	$ 522,685
Federal State MCH Block Grant Partnership Total	$ 2,737,825	$ 1,219,598

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 22 Application Budgeted	FY 20 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	$ 782,974	$ 339,852
3. Public Health Services and Systems	$ 850,086	$ 368,982
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	$ 1,633,060	$ 708,834

IIB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 67,007	$ 33,207
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	$ 67,007	$ 33,207
2. Enabling Services	$ 635,216	$ 314,794
3. Public Health Services and Systems	$ 689,664	$ 341,777
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		$ 33,207
Direct Services Line 4 Expended Total		$ 33,207
Non-Federal Total	$ 1,391,887	$ 689,778

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIB. - Other - Cystic Fibrosis and Nutrition Network**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**

Field Note:
he non-federal direct services category is comprised of support for Cystic Fibrosis and the CSHN Community Nutrition Network.

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

State: Vermont

Total Births by Occurrence: 5,184 **Data Source Year: 2019**

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	5,164 (99.6%)	269	14	14 (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	5,139 (99.1%)	44	17	17 (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:	**2020**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: 2020 metabolic data is not yet available for infants born in Vermont but screened in other states so 2019 calendar year data is reported here. In 2019, there were 5,193 births in Vermont but 9 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:	**2020**
	Column Name:	**Core RUSP Conditions**
	Field Note: 5,127 infants screened in Vermont, plus 37 screened out of state. All 20 cases not screened are confirmed parental refusals. No cases were lost to follow-up. Vermont screened for 33 conditions by dried bloodspot 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.	
3.	**Field Name:**	**Core RUSP Conditions - Total Number of Out-of-Range Results**
	Fiscal Year:	**2020**
	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:	**2020**
	Column Name:	**Core RUSP Conditions**
	Field Note: All conditions are in separate individuals. Screening conditions reported: 6 Congenital Hypothyroidism and 8 others (< 5 per condition) 2 lab results are listed as 'Pending'. Diagnostic workup for some conditions can take a very long time. These babies are in care, but it may be months/years before a definitive diagnosis is achieved.	
5.	**Field Name:**	**Newborn Hearing Screening - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2020**

	Column Name:	**Other Newborn**
	Field Note: We have chosen to report our Newborn Hearing Screening data separately because it comes from another program. There were 10 deaths before screening could be performed, so 99.2% 5,139/5,183) would also be an appropriate rate for this measure. In addition to the 10 deaths, there were 44 cases that were not screened. Of these, 16 were parental refusals, 27 were home births that did not respond to requests, and 1 families was non-resident or moved out of state.	
6.	**Field Name:**	**Newborn Hearing Screening - Total Number Confirmed Cases**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: Of the 27 presumptive positive screens that were not confirmed, all 27 had normal hearing results.	

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 2020

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	3,378	40.0	0.0	58.0	2.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	3,160	53.0	0.0	44.0	3.0	0.0
4. Others	0					
Total	3,378					

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	5,361	Yes	5,361	84.0	4,503	0
2. Infants < 1 Year of Age	5,193	No	5,579	93.0	5,188	0
3. Children 1 through 21 Years of Age	149,722	Yes	149,722	98.0	146,728	3,378
3a. Children with Special Health Care Needs 0 through 21 years of age^	32,147	Yes	32,147	98.0	31,504	3,160
4. Others	468,688	No	463,327	3.0	13,900	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:	**2020**
	Field Note: No direct services provided.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2020**
	Field Note: No direct services provided.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Numerator: There were 218 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 10/1/19 and 9/30/20, 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:	**2020**
	Field Note: In 2020, 3,160 CSHCN cases were reported: 550 Genetics consults 100 Nutrition consults 640 Care Coordination Program 20 High Tech 50 Palliative Care 1,800 Children's Personal Care Unfortunately, there is some duplication across programs that we have no simple way to account for.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**
	Field Note: No direct services provided.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2020**
	Field Note: Vermont-resident pregnant women with first trimester prenatal care receive public health messaging through MCH coordinators. Numerator: Vermont resident women receiving 1st trimester care. Denominator: VT resident women giving birth. Source: 2019 VT Vital Statistics/NVSS	
2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2020**
	Field Note: Numerator is the 5,185 Vermont-occurrent births who received services from our Newborn Metabolic Screening Program in 2019 Denominator: 2019 Census population estimate (5,579) for those aged less than 1 year. Data Sources: 2019 VT Vitals/2019 Census Population Estimates.	
3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: EPSDT Outreach and Informing/ School Health. Numerator: Assumed 98% reach. Denominator: 2019 Census population estimate (ages 1-21).	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: EPSDT Outreach and Informing/ School Health. Numerator: Assumed 98% reach. Denominator: 2018-19 NSCH rate (Ages 0-17) of 20.7% of the 2019 Census population estimate of 155,301 children ages 0-21.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**
	Field Note: Numerator: 15,724 Women's Health Initiative (WHI) patients attributed to WHI Specialty (WM) providers based on our Vermont Blueprint patient attributions used for Community Health Team (CHT) payments for 2020-Q3. Denominator: Number of people ages 22+, 2019 Census estimates, minus pregnant women to prevent double-counting. Source: 2019 Census, 2019 VT Vitals	

Data Alerts: None

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

State: Vermont

Annual Report Year 2020

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	5,193	4,160	163	224	25	143	2	124	352
Title V Served	5,185	4,152	163	224	25	143	2	124	352
Eligible for Title XIX	2,013	1,453	99	95	19	57	1	56	233
2. Total Infants in State	5,579	4,944	89	155	22	122	0	247	0
Title V Served	5,183	4,593	83	144	20	113	0	230	0
Eligible for Title XIX	2,924	1,379	56	7	6	16	0	0	1,460

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Data source is 2019 VT Vital Statistics births file	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2020**
	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 Program.	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Data source is the "Payer" field from the 2019 VT Vital Statistics births file.	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Data source for the total is the 2019 VT Census age, sex and race/ethnicity population estimates from J:\pop\data\POPxAGExRaceEth2019.xlsx.	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Assumed 92.9% Title V served due to newborn screening programs that serve VT occurrent births. (see Form 5 for calculation)	
6.	**Field Name:**	**2. Eligible for Title XIX**

Fiscal Year:	**2020**
Column Name:	**Total**

Field Note:
Data source is 2019 Medicaid claims data. 49.9% of unique IDs are missing race/ethnicity data. In addition, Asian race and Hispanic ethnicity data are not well tracked and underestimate the true rates . "Hawaiian/Pacific Islander" and "Multiple Race" categories are not tracked in VT claims data.

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Vermont

A. State MCH Toll-Free Telephone Lines	2022 Application Year	2020 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	2022 Application Year	2020 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"		1,629
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		310
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		500

Form Notes for Form 7:

None

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	Monica Ogelby
Title	CHSN Clinical Services Director
Address 1	108 Cherry St
Address 2	Suite 301
City/State/Zip	Burlington / VT / 05402
Telephone	(802) 863-7200
Extension	
Email	monica.ogelby@vermont.gov

3. State Family or Youth Leader (Optional)	
Name	Charlotte Safran
Title	Family Engagement Coordinator
Address 1	108 Cherry St
Address 2	Suite 301
City/State/Zip	Burlington / VT / 05402
Telephone	(802) 863-7338
Extension	
Email	Charlotte.Safran@partner.vermont.gov

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Vermont

Application Year 2022

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 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 Notes for Form 9:

None

Field Level Notes for Form 9:

None

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
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
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
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
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
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**
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
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
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
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
2018	3.1 ϟ	0.8 ϟ	17 ϟ	5,432 ϟ
2017	3.5	0.8	20	5,655
2016	1.9 ϟ	0.6 ϟ	11 ϟ	5,756 ϟ
2015	3.0 ϟ	0.7 ϟ	18 ϟ	5,903 ϟ
2014	3.4	0.8	21	6,130
2013	3.2 ϟ	0.7 ϟ	19 ϟ	5,975 ϟ
2012	2.5 ϟ	0.7 ϟ	15 ϟ	6,009 ϟ
2011	3.5	0.8	21	6,078
2010	2.2 ϟ	0.6 ϟ	14 ϟ	6,223 ϟ
2009	4.4	0.9	27	6,110

Legends:

⚑ Indicator has a numerator <10 and is not reportable

ϟ 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
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
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**
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**
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
2018	23.7	2.3	111	4,689
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
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
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**
2019	21.5 ϟ	5.4 ϟ	16 ϟ	74,274 ϟ
2018	23.7 ϟ	5.6 ϟ	18 ϟ	76,046 ϟ
2017	26.4	5.9	20	75,836
2016	27.4	6.0	21	76,634
2015	21.8 ϟ	5.3 ϟ	17 ϟ	78,028 ϟ
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 ϟ	5.2 ϟ	19 ϟ	83,649 ϟ
2009	29.4	5.9	25	85,023

Legends:

Indicator has a numerator <10 and is not reportable

ϟ 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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	90	91	91	92	92
Annual Indicator	84.5	81.9	89.3	89.9	90.2
Numerator	4,599	4,748	4,773	4,919	4,650
Denominator	5,445	5,797	5,345	5,471	5,154
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	92.0	93.0	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)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	38	38	40	42	45
Annual Indicator	31.3	27.7	38.0	37.2	36.8
Numerator	1,629	1,560	1,976	1,946	1,811
Denominator	5,203	5,637	5,195	5,227	4,926
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	45.0	45.0	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)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			60	70	75
Annual Indicator		39.7	37.0	45.3	57.8
Numerator		5,111	5,399	6,939	7,281
Denominator		12,865	14,604	15,303	12,592
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	75.0	75.0	80.0	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**
Annual Objective			40	42
Annual Indicator	39.7	32.4	29.9	34.1
Numerator	14,153	12,528	11,872	12,757
Denominator	35,688	38,672	39,659	37,374
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year	2016	2016_2017	2017_2018	2018_2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	44.0	46.0	50.0	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)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			93	94	95
Annual Indicator		88.0	87.4	87.4	88.0
Numerator		40,460	35,604	35,604	38,754
Denominator		46,004	40,737	40,737	44,020
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017	2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			93	94	95
Annual Indicator	88				
Numerator	41,007				
Denominator	46,622				
Data Source	NSCH				
Data Source Year	2016				
Provisional or Final ?	Final				

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	95.0	95.0	95.0	95.0	95.0	95.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Significantly higher than the US rate of 78.9%.

Of note, Vermont's rate of adolescents who receive care alone is 73.5%, compared to 49% nationally. Vermont has worked very hard with adolescent care providers to message the importance of this.

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**
Annual Objective			25	25
Annual Indicator	21.8	20.4	25.1	27.6
Numerator	2,189	1,808	2,162	3,016
Denominator	10,050	8,853	8,632	10,947
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	30.0	30.0	35.0	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)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			92	92	95
Annual Indicator		87.4	85.7	83.3	84.3
Numerator		98,305	95,571	91,502	92,788
Denominator		112,465	111,490	109,884	110,125
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			92	92	95
Annual Indicator	87.3				
Numerator	98,226				
Denominator	112,487				
Data Source	NSCH				
Data Source Year	2016				
Provisional or Final ?	Final				

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	95.0	95.0	95.0	95.0	95.0	95.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Significantly higher than the US rate of 78.7%.

NPM 14.1 - Percent of women who smoke during pregnancy

Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	15	12	10	10	8.5
Annual Indicator	16.6	15.5	15.5	14.2	13.2
Numerator	965	881	868	758	697
Denominator	5,825	5,676	5,587	5,348	5,284
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	8.5	8.5	7.0	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
Annual Objective	83	84	86	88
Annual Indicator	67.6	67.6	86.7	83.2
Numerator	22,213	24,152	31,277	28,178
Denominator	32,842	35,708	36,090	33,879
Data Source	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016-17	2018	2018-19
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	90.0	90.0	90.0	90.0	90.0	90.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	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:**	**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.	
3.	**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.	
4.	**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.	
5.	**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.	

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

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		55	58	60	63
Annual Indicator	50.5	60.5	60.5	58.2	58.2
Numerator	13,258	16,108	16,108	14,285	14,285
Denominator	26,270	26,614	26,614	24,524	24,524
Data Source	YRBS	YRBS	YRBS	YRBS	YRBS
Data Source Year	2015	2017	2017	2019	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	65.0	65.0	66.0	66.0	66.0	66.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: This is a state-specific question not found on the national YRBS.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: This is a state-specific question not found on the national YRBS.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: This is a state-specific question not found on the national YRBS.	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: This is a state-specific question not found on the national YRBS.	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: This is a state-specific question not found on the national YRBS.	

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
Annual Objective			85	87
Annual Indicator	83.6	85.1	83.5	83.5
Numerator	4,596	4,587	4,321	4,321
Denominator	5,499	5,388	5,176	5,176
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2016	2017	2018	2018
Provisional or Final ?	Final	Final	Final	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	90.0	90.0	90.0	90.0	90.0	90.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Due to diversions of workforce for COVID pandemic response, 2019 PRAMS data is still being reviewed by the PRAMS data team. The 2018 data is repeated here as provisional data.

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

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	8.0	7.0	7.0	7.0	7.0	7.0

Field Level Notes for Form 10 SPMs:

None

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

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	90.0	90.0	100.0	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

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					
	2016	2017	2018	2019	2020
Annual Objective		16.7	25	33.3	33.3
Annual Indicator	16.7	16.7	16.7	18.2	18.2
Numerator	2	2	2	2	2
Denominator	12	12	12	11	11
Data Source	Program-level data	Program-level data	Program-level data	Program-level data	Program-level data
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	41.7	50.0	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
Annual Objective			150	100
Annual Indicator			352	224
Numerator				
Denominator				
Data Source			Program Data	Program Data
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	50.0	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.	

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
Annual Objective			12	12
Annual Indicator			9	4
Numerator				
Denominator				
Data Source			Program Data	Program Data
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	12.0	12.0	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.

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
Annual Objective			5	10
Annual Indicator			0	0
Numerator				
Denominator				
Data Source			Program Data	Program Data
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	15.0	25.0	35.0	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.

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

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			30	50
Annual Indicator			38	38
Numerator				
Denominator				
Data Source			Program Data	Program Data
Data Source Year			2019	2019
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	70.0	80.0	90.0	90.0	90.0	90.0

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.

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					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective				3,000	3,100
Annual Indicator	1,751	1,606	1,422	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	2015-16	2016-17	2017-18	2018-19	2018-19
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	3,300.0	3,400.0	3,500.0	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.	

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

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		5	5	7	7
Annual Indicator	3.4	2.5	2.4	6.2	6.3
Numerator	29	19	16	37	35
Denominator	865	769	654	599	556
Data Source	QuitLine and Vital Statistics	QuitLine and Vital Statistics	QuitLine and VT Vital Statistics	QuitLine and VT Vital Statistics	QuitLine and VT Vital Statistics
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	10.0	10.0	10.0	10.0	10.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Revised with 2016 data 6/21/2018.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: 2018 VT Vital Statistics data is not yet available.	
3.	**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	
4.	**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	

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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Promote protective factors and resiliency among Vermont’s families.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>% of children 6 month to 5 years who meet all 4 flourishing items</td></tr>
<tr><td>Denominator:</td><td># of children 6 month to 5 years</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data source: National Survey of Children's Health</td></tr>
<tr><td>Significance:</td><td>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</td></tr>
</table>

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:	Active
Goal:	Achieve a comprehensive, coordinated, and integrated state and community system of services for children.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of CSHCN who receive transition meetings before their 18th birthday. **Denominator:** Number of CSHCN turning 18
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 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 2020

	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