

***Draft Criteria for Health and Well Being Workgroup Recommendations:***

- Can it be scaled up?
- Is it considered a best practice?
- Is there existing support?
- And does it have the potential for significant impact?
- Are there legislative, regulatory or policy changes required?
- Will it require additional funding?

**CCCS Health and Well Being Workgroup  
January 15, 2015 1pm**

Patrick Henry Building, Conference Room #3  
1111 East Broad Street Richmond, VA 23219

- I. Welcome and Introductions
- II. Health Department Presentation (Dr Levine)
  - Infant Mortality in Virginia
  - Racial disparities and perinatal periods of risk
- III. Poverty in Virginia (Catherine Hancock)
- IV. Ongoing Discussion on Priorities and Additional Information Needed
- V. Planning for Additional Meetings

*Next CCCS Meeting:* January 15, 2015 at 3pm in East Reading Room of the Patrick Henry Building



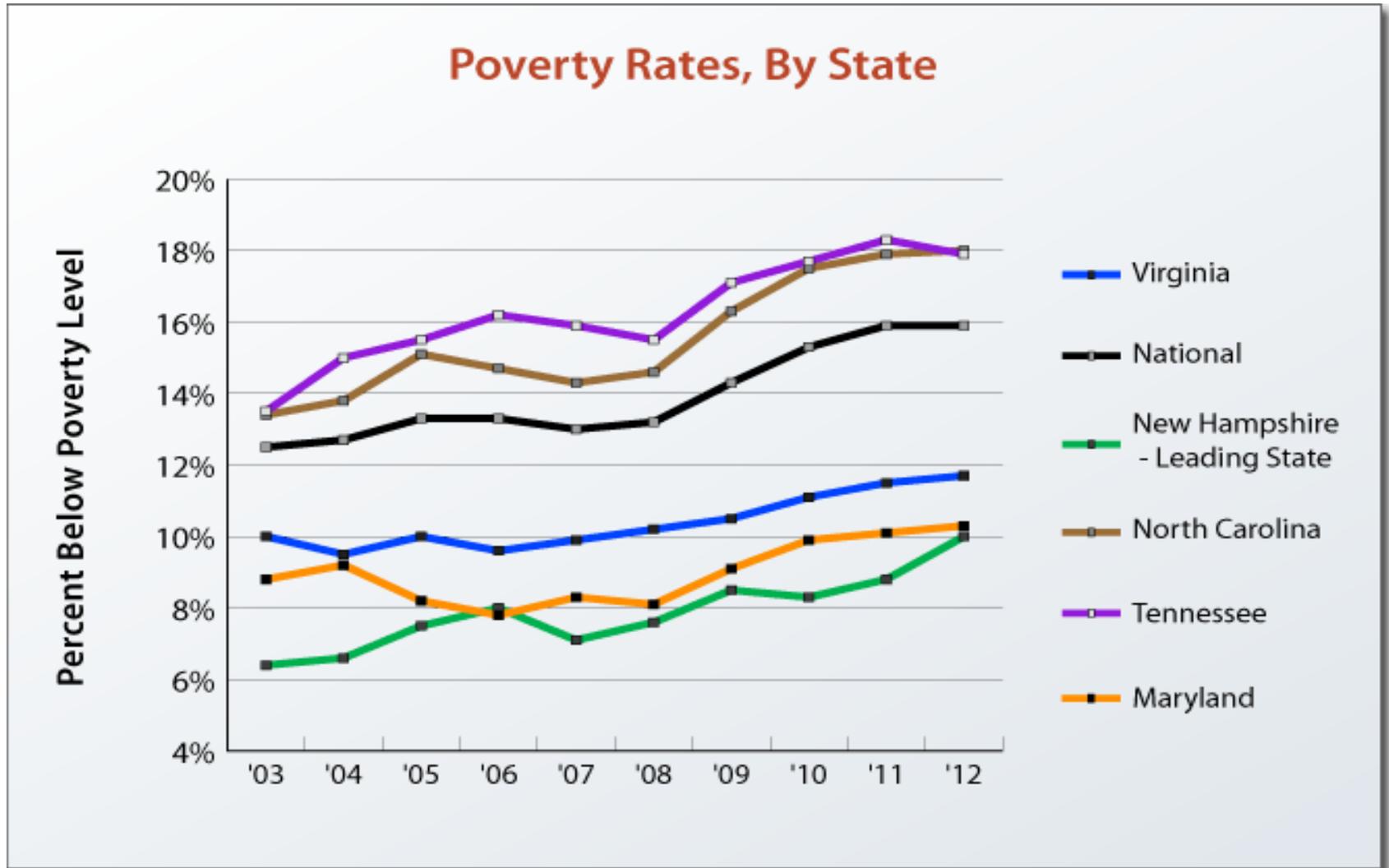
Virginia Department of  
Behavioral Health &  
Developmental Services

# Poverty in Virginia

January 15, 2015

**DBHDS Vision: A life of possibilities for all Virginians**

# Percentage of Citizens Below the Poverty Level by State 2003-2012

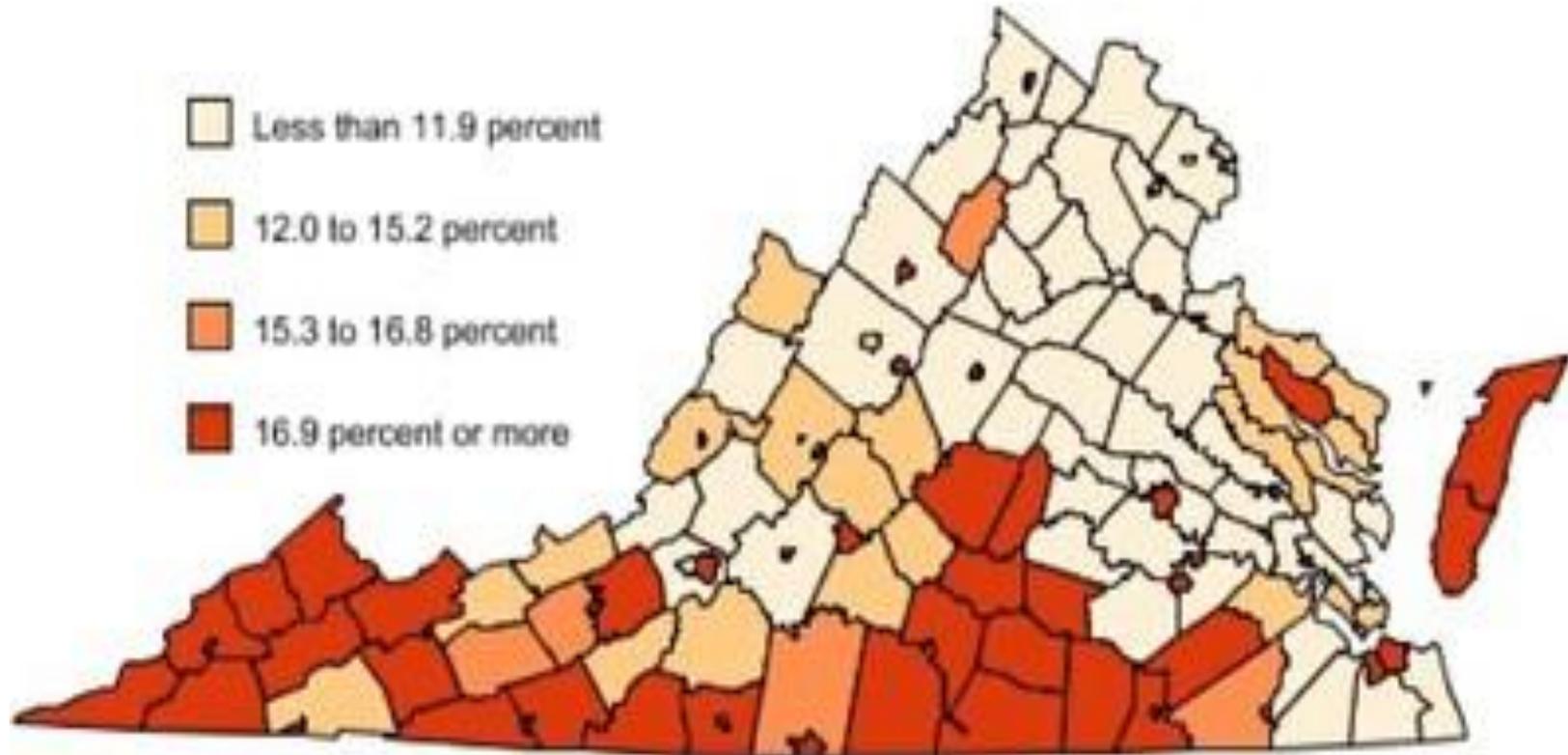


Virginia Performs, Council on Virginia's Future, November 2014

<http://vaperforms.virginia.gov/indicators/economy/poverty.php>

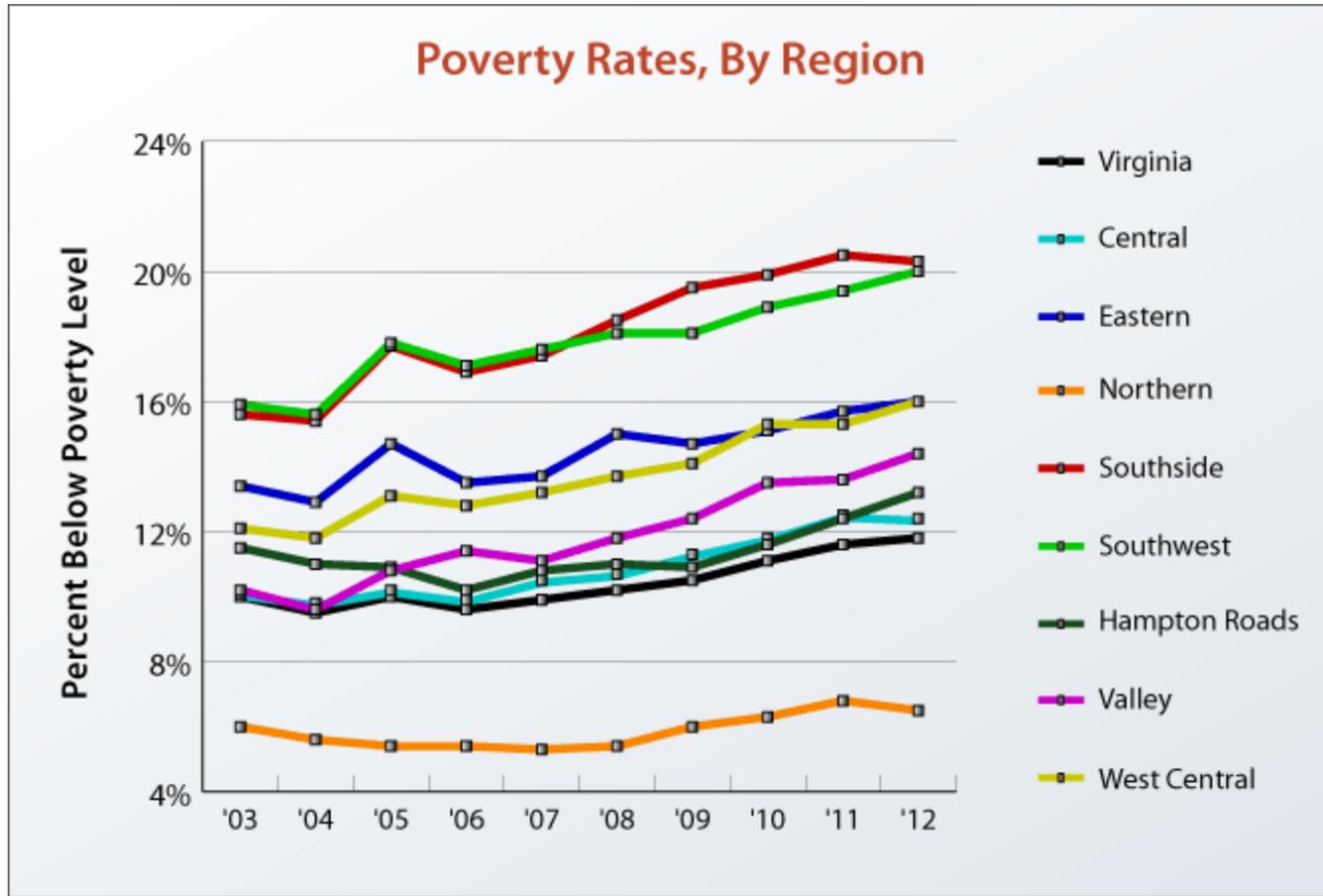
# Poverty By County

Percent of Total Population in Poverty in Virginia Counties, 2010



US Census Bureau

# Virginia Regional Comparisons



Virginia Performs, Council on Virginia's Future, November 2014

<http://vaperforms.virginia.gov/indicators/economy/poverty.php>

# Virginia and US Poverty Rates Are Still High

- More Virginians and Americans are in poverty now than at the end of the great recession in 2009, according to census figures.
- About one-of-three Americans and one-of-four Virginians live below twice the federal poverty line.
- The data shows continuing weakness in wages, the amount of work available and in job security.
- [Public News Service - VA September 2014](#)

# Children in Poverty



## Child Poverty in Virginia

- Number of poor children (and percent poor) 264,601 (14.5%)
- Number of children living in extreme poverty (and percent in extreme poverty) 114,051 (6.2%)
- Number of adults and children receiving cash assistance from Temporary Assistance for Needy Families (TANF) 74,264
- Maximum monthly TANF cash assistance for a family of three \$320

<http://www.childrensdefense.org/library/data/state-data-repository/cits/2013/2013-virginia-children-in-the-states.pdf>

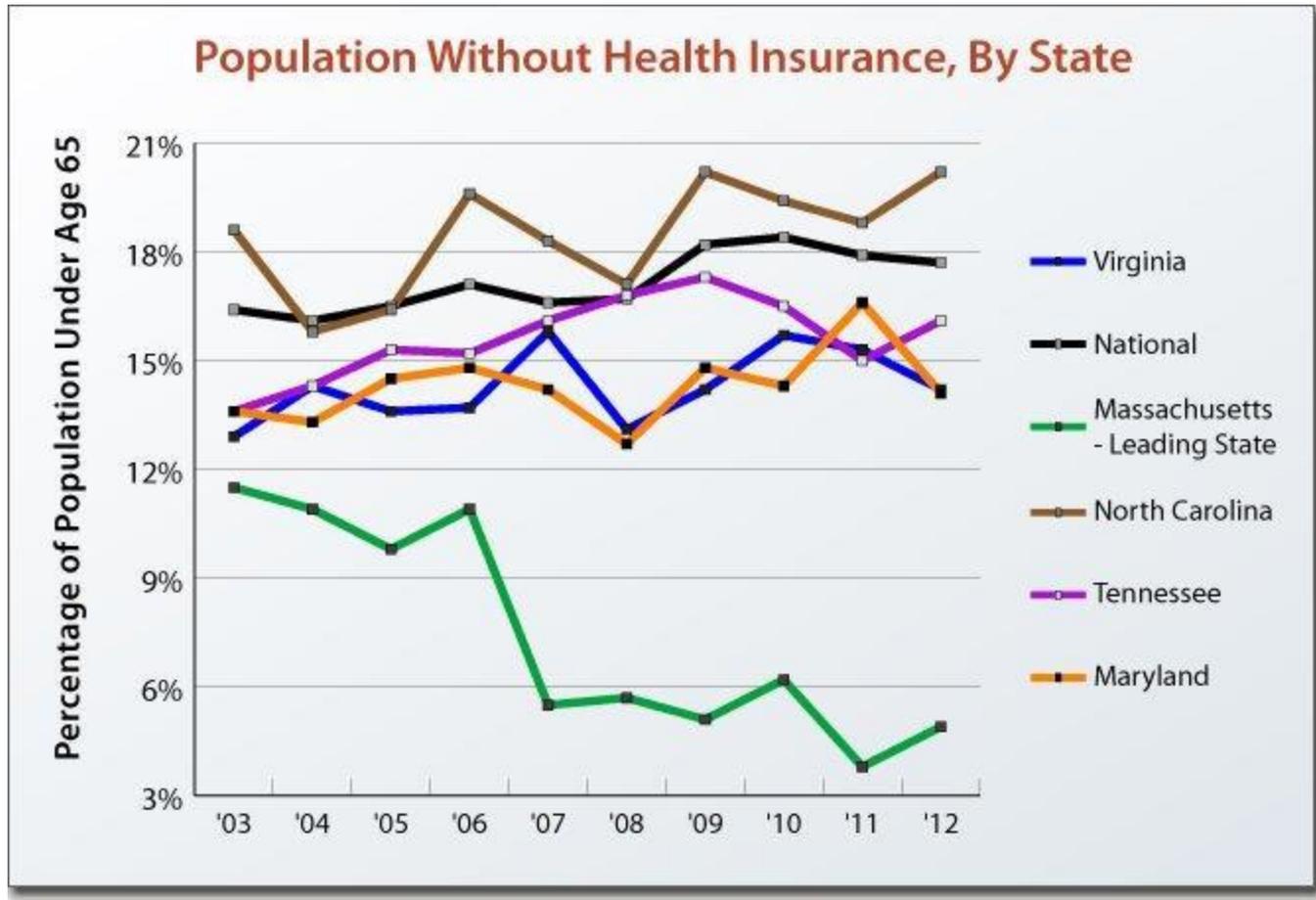
# Early Brain Development has Lifelong Consequences

Research from human and animal studies alike suggests that a high-stress early childhood in poverty changes the physical brain in subtle ways that impair educational performance and life outcomes.

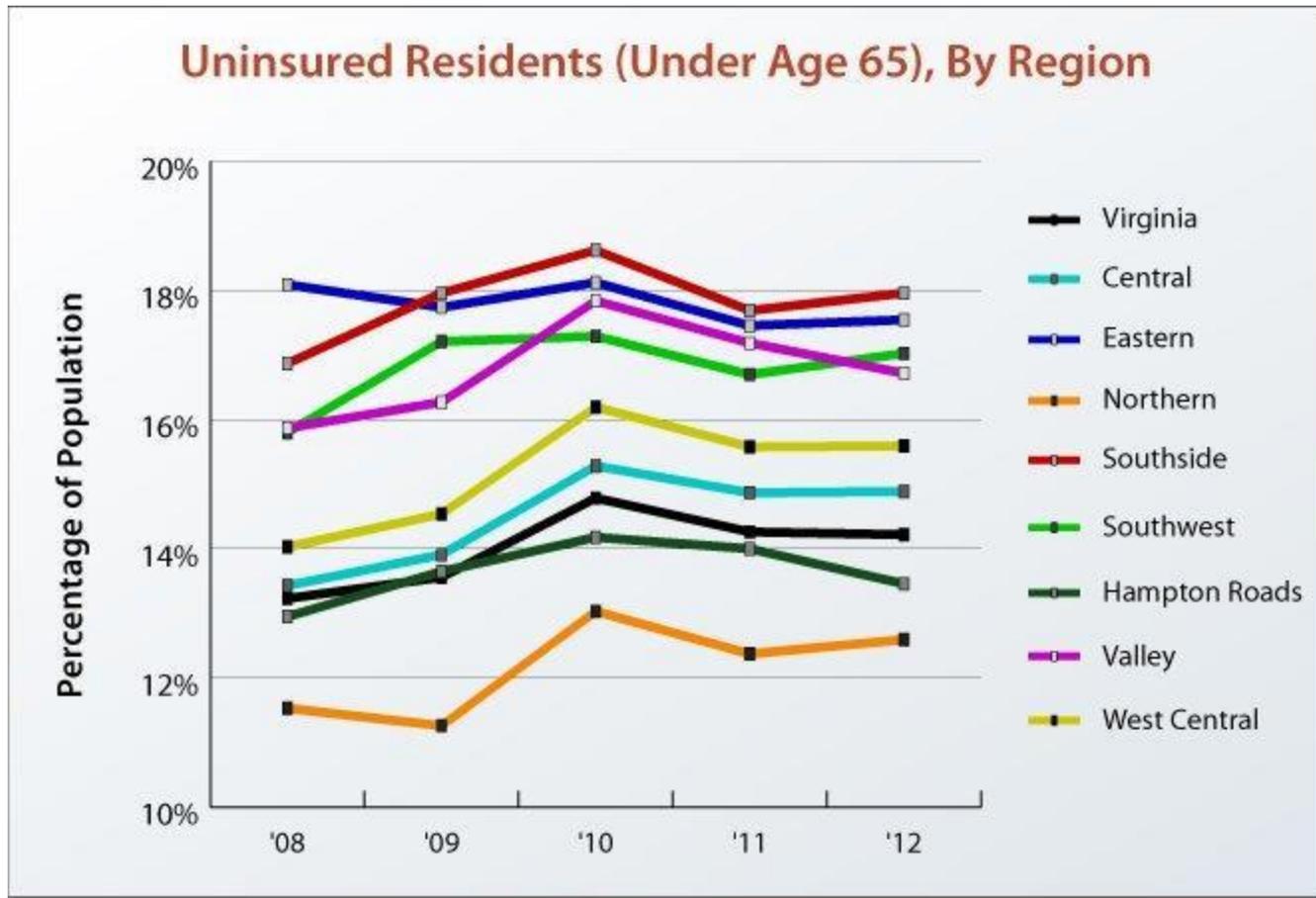


<http://www.ncbi.nlm.nih.gov/pubmed/24165922>

# Virginia's Uninsured Rate



# Uninsured Rates Vary by Region



# Children & Health Insurance



## Child Health in Virginia

- Number of children without health insurance (and percent uninsured) 157,488 (8.4%)
- Number of children enrolled in the Children's Health Insurance Program (CHIP) 173,515
- CHIP eligibility: 200 percent of federal poverty (\$46,100 for a family of four)
- Number of children enrolled in Medicaid 621,799 in SFY 13
- Children as a percent of total Medicaid enrollment 54.0%
- Children in Medicaid and CHIP constitute 54% of enrollees but account for only 23% of total Medicaid expenditures
- Percent of two-year-olds not fully immunized 30.5%

<http://www.childrensdefense.org/library/data/state-data-repository/cits/2013/2013-virginia-children-in-the-states.pdf>

[http://www.dmas.virginia.gov/Content\\_atchs/atchs/va-medprg.pdf](http://www.dmas.virginia.gov/Content_atchs/atchs/va-medprg.pdf)

# Supplemental Food Programs



- Number of children who receive SNAP (food stamps) 344,000
- Percent of eligible persons who receive SNAP (food stamps) 63%
- Number of children in the School Lunch Program 755,481
- Number of children in the Summer Food Service Program 58,107
- Number of women and children receiving WIC (Supplemental Nutrition Program for Women, Infants, and Children) 156,085

<http://www.childrensdefense.org/library/data/state-data-repository/cits/2013/2013-virginia-children-in-the-states.pdf>

Type of Health Issue	Report Name	Relevant Recommendations (Primary, Secondary, Tertiary) (Data)	Status
Autism	JLARC Report on Services for Virginians with Autism Spectrum Disorders 2009	VA does not have a publicly-funded comprehensive system of care which serve individuals with ASDs, thus children are diagnosed later, schools lack training and tools needed to meet the needs of students, and adults with ASDs require ongoing services and support not widely available in VA. DMAS should develop and implement a plan for educating Virginians with ASDs and their families. Role of other public and private sources could also be explored to share the cost. Increase consisten and standardized ASD screening through training, expedite access to diagnosis by increasing capacity, develop new early intervention programs and improve access to Medicaid programs.	VA needs public investments in comprehensive system
Behavioral Health	1in5kids: Voices for VA's children presentation to the behavioral healthcare subcommittee of the joint commission on health care 2014	The funding the General Assembly allocated during the last three sessions has greatly improved the ability of some communities to stabilize children in psychiatric crisis with[out] hospitalizing them. It has improved access to child psychiatry for children in crisis and in rural areas allowing for proper diagnosis and medication. Funding has allowed increased capacity, collaboration, sharing of resources, and expertise among community service boards in each region. Partnerships among public/private providers and families have been positive due to the impact of this funding	Increased funding has helped kids in criss without hospitalization. Additional funding needed for mobile crisis stabilization units

<p>Behavioural Health</p>	<p>DBHDS (2011): A Plan for Community-Based Children's Behavioral Health Services in VA</p>	<p>1) Define and promote through DBHDS the full comprehensive service array as the goal for children's behavioral health services in every community; this would allow for children across Virginia communities to be served closer to home; <b>earlier interventions would lessen the severity of conditions and strengthen community and family supports, as well as create better collaboration between other agencies that also provide services.</b> 2) Expand the array and capacity of services to assure a consistent base level of services for children and families statewide; <b>consider having contracts or private entities who could provided: mobile child crisis response services, in-home crisis stabilization support services, emergency respite care placement services and/or crisis stabilization unit(s) for children; create funding for Case Management and Intensive Care Coordination;</b> increase/ have greater availability in psychiatric services and in-home services. 3) Establish a children's behavioral health workforce development initiative to be organized by DBHDS. 4) <b>Continue the current role of the Commonwealth Center for Children and Adolescents (CCCA) for the foreseeable future, and until more adequate community-based services are in place.</b> 5) Establish quality management mechanism to improve access and quality in behavioral health services for children and families; improve quality and accountability in the provision of Medicaid services- DBHDS should continue active involvement with DMAS.</p>	<p>Shift to investing in early interventions still very much needed. New DBHDS Commissioner and internal transformation teams provide opportunity for those changes</p>
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Behavioural Health	Early Childhood Mental Health Policy Summit Recommendations (2012)	<p>1) Integrating Early Childhood mental health into the children's mental health "system of care" in Virginia: 1- Universal screening and earlier interventions, certification/endorsement in mental health in part C and other early childhood programs, a single point of entry for early childhood mental health. 2) Financing and sustaining the early childhood mental health system in Virginia, 1: review available data to inform work, results from CSB ECMH survey, review JMU fiscal analysis, 2: do a comprehensive financial scan of ECMH, decide on format of financial document (simple, integrity), 3: consider social emotional component in VSQI, 4: embed social emotional component in other areas, 5: training on social emotional topic, 6: Medicaid and insurance providers, look at ways insurance providers and Medicaid can support more services such as a prevention model in addition to treatment, need a continuum of service delivery and reimbursement options to support ECMH. 3) Supporting the family and the parent/child/provider relationships in Virginia, 1: universal strategy, information and screening/assessment on social emotional development for all parents, 2: targeted strategies, mental health screening in home visiting program, emphasize social emotional goals in part C and other early childhood program services, educate part C and other early childhood providers on how to identify and serve social emotional needs.</p>	No single point of entry for children's mental health, or long term sustained funding strategy.
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Behavioural Health	Voices for VA's Children (2011): Children's Mental Health in VA: System Deficiencies and Unknown Outcomes	1) Overall better data collection in regards to children's mental health needs with a focus on children's outcomes- there being no systematic effort currently in place to determine whether children receiving mental health treatment across the various systems are achieving positive outcomes is something that needs to be addressed as well. 3) Addressing ways to inconsistent use of research-based best practices. 4) more localities developing state-of-the-art systems of care for children with mental health disorders. 5) improving data collections a key element to analyzing system gaps and inefficiencies and working towards improved outcomes for children.	Better data collection and analysis needed
Behavioural Health	Voices for VA's Children (2012): Intensive In-Home Services for Children's Mental Health in VA: Time to Focus on Quality	1) improve the consistency and quality of intensive in-home services in VA-- by developing VA's practice models and replicating existing models of excellence, 2) in addition, improving the quality of in-home services must be part of developing a more robust array of services to reduce over-reliance on IHS. 3) to ensure the services are leading to positive outcomes for kids and families, VA must develop outcome measure on well-being of youth served. 4) Finally, VA must be vigilant to ensure access to services through the transition to Medicaid care coordination.	
Child Abuse	Prevent Child Abuse VA (2012) Healthy Families VA: Statewide Evaluation	1) Restore the almost \$200,000 dollar funding cuts that the Healthy Families Virginia initiative experienced during FY2011-FY2012 2) Foster high-quality programs that are capable of producing strong outcomes by providing full-time funding for all of the technical assistance/quality assurance staff 3) Strengthen families by connecting and reconnecting father with their children to promote safe, stable, and successful families. 4) Conduct an epidemiological study to estimate the number of participating mothers who are experiencing depression and begin to understand the impact of depression on parenting and home visiting service delivery.	Funding restored; but continuous need for sustained funding to make investments in prevention

Chronic Disease	Joint Commission on Health Care (2010) Opportunities for Early Identification and Preventive Care for Chronic Diseases	1) Department of Medical assistance services report to JCHC regarding recommended options for addressing the chronic care needs of Virginia's Medicaid and FAMIS enrollees. 2) Request that the Department of Human Resources Management report to JCHC regarding the costs and benefits of the recently implemented COVA Connect pilot program for State programs.	
Developmental Health	The Report to the General Assembly on Early Intervention Part C	<p>With the additional state funds allocated for early intervention in FY2013 and FY2014, local systems resumed child find efforts and the number of children served in early intervention rose 4.8% from FY2013 to FY2014. Unless funding stays apace with growth, Virginia runs the risk of falling back into noncompliance, which puts federal Part C funding at risk and results in children and families not getting the supports and services they need in a timely and effective manner.</p> <p>No financial data for Part C services is collected through ITOTS, resulting in a burdensome paper process for collection and reporting of comprehensive and reliable data related to the cost of providing services and the revenue sources that are accessed in providing services. Local systems incur additional costs as ITOTS cannot accept data from local information systems. Additional time is spent preparing manual or Excel reports. ITOTS data reports are limited in scope and, therefore, the analysis of the available data does not allow analysis of outcomes.</p>	Achieving a stable and sustainable fiscal structure for Virginia's early intervention system remains a top priority; Data not integrated for analysis of long term outcomes

Disabilities	Virginia Board for People with Disabilities (2014): Assessment of the Disability Services System in Virginia	<p>1) Early intervention: to provide front-loaded supports that maximize positive outcomes for infant and toddlers and offer the highest potential for long-range cost avoidance, Virginia's early intervention services must be delivered at the earliest juncture possible. 2) Crisis intervention system that ensures service access regardless of diagnosis(as), type of disability, age, or locality of residence; crisis services for children should be developed and implemented without delay. 3) Develop a strategy to eliminate the institutionalization of individuals under the age of 21 and task the DMAS and the DBHDS with the responsibility to develop processes that ensure adequate service are provided to these youth and their families.</p>	<p>Shift to early interventions and away from institutionalizations is very much relevant and needed. Scheduled closing of training centers is part of this process.</p>
Health	VDH 2015 Maternal and Child Health Block Grant	<p>Conduct a statewide needs assessment every five years that shows the need for 1) preventive and primary care services for pregnant women, mothers and infants; 2) preventive and primary care services for children; and 3) family-centered, community-based services for children with special health care needs and their families. Maintain or make available a state toll-free number to provide parents with information about health care providers who provide services under Title XIX and other relevant health related information.</p>	All outstanding requests at this point
Health	2015 Early Childhood Unified Agenda	<p>Fully fund comprehensive home visiting programs, CHIP of Virginia and Healthy Families. Despite successes helping families gain employment and meet children's developmental needs, our statewide home visiting network only reaches 12% of need. Fully fund early intervention (IDEA Part C) for infants and toddlers with developmental delays. Each year local systems must balance budget decisions with providing timely access to developmental therapies.</p>	All outstanding requests at this point

Home Visiting	Joint Commission on Health Care (2013) Annual Report	JCHC Members were briefed on CHIP's activities and funding, as a result JCHC members introduced budget amendments to restore \$900,0000 in state funding to CHIP that had been eliminated	
Home Visiting	CHIP of VA 2013: Improving Health Outcomes, Reducing Medicaid Costs: Prenatal and Early Childhood Home Visiting	Home-visiting for families who are pregnant or have children under 6yrs and low income (Medicaid). HV model must match the family's needs. 3 core elements are access to a medical home, health supervision, and family support	Recent state and federal HV funding; but only a fraction of eligible families are being served
Behavioral Health	DBHDS Recent Improvements in the Delivery of Services to Children and Families 2009	Availability of MH services varies widely among communities, thus DBHDS lead an interagency process. Every CSB have a single point of leadership for children. CSB case-related involvement with and collaboration with other agencies was mostly limited or did not occur, hence CSBs with more comprehensive systems of services share factors of their success with other CSBs. CSBs should assess children with mental health or intellectual disabilities for substance abuse to assure integrated care.	

<p>Health, Behavioral Health</p>	<p>Early Childhood Advisory Council (2013) Family Support and Wellness Task Force</p>	<p>4. Promote and utilize service delivery improvements which maximize resources and minimize overlap in administrative costs.  a. Examples- Central referral/intake for home visiting; Expand the service area of existing programs into unserved geographic areas in lieu of creating brand new programs  5. Enhance family/child level information sharing across agencies and programs for referrals and initiating services.  a. Create a workgroup to identify points of entry, gaps in service provision, lack of interconnectedness  b. Identify strategies to improve documentation/data sharing across agencies and programs (ex. require standard core application/enrollment form for all state funded services)  6. Incorporate cross-disciplinary education around physical, social/emotional, and behavioral health for medical and oral health care students, as well as in-service training for currently licensed health care providers.  7. Integrate Early Childhood Mental Health Initiative &amp; Infant Mental Health Competencies into the Children’s Mental Health System of Care Plan, including universal screening and earlier interventions, certification/endorsement in Mental Health in Part C and other programs and single point of entry for early childhood mental health. 8. Review opportunities to integrate children’s mental health data with other data systems, collaborate to identify a consistent set of key early childhood mental health data indicators and identify means of implementing integrated data collection.</p>	
<p>Nutrition</p>	<p>Breakfast After the Bell: Tackling Childhood Hunger in our Schools</p>	<p>Students who do not eat breakfast show poor academic performance. Barriers to school breakfast include transportation, schedules, peer pressure, stigma. Implementing "Breakfast after the Bell" programs will remove such barriers and provide the opportunity for more students to participate. Three options included are breakfast in the classroom (for k-5), Grab n' Go, and second chance breakfast for (8-12)</p>	<p>Campaign for schools to take advantage of community eligibility for breakfast in schools; New nutrition council led by Dorothy McAuliffe</p>

Obesity	VT Policy Recommendations: Childhood Obesity 2010	Require nutrition standards for beverages sold in schools. Require every student in K-8 participate in daily physical education for the entire school year, including those with disabling conditions and in alternative education programs. Require school wellness policies to contain language that "requires" policies in the following areas: School funds, Physical Education, Physical Activity, Nutrition Education, and School Wellness	
Obesity	Institute of Medicine's Local Government Actions to Prevent and Reduce Childhood Obesity	Goals: <b>Improve access to and consumption of healthy, safe affordable food; reduce access to and consumption of calorie-dense nutrient-poor foods; raise awareness about the importance of health eating to prevent childhood obesity; encourage physical activity; decrease sedentary behavior; raise awareness of the importance of increasing physical activity;</b>	VFHY and Y's promoting healthy living; GA debates around physical activity; New nutrition council led by Dorothy McAuliffe
Shaken Baby	Joint Commission on Health Care (2012) Shaken Baby Syndrome and Abusive Head Trauma	1) Departments of Health, Social Services, Behavioral Health & Developmental Services, Rehabilitation Services and Education collaborate with other public and private sector stakeholders to identify current best practices, state-wide programs, <b>surveillance and data, initiatives and interventions dedicated to addressing infant mortality in Virginia.</b>	Through they've come down dramatically in recent years; Infant mortality is still high in VA; and focus of VDH

Shaken Baby	Joint Commission on Health Care:Study of Shaken Baby Syndrome and Abusive Head Trauma 2011	Policy Action 1) take no action 2) Introduce budget amendments to allow VDH to contract(or undertake) a hospital-based prevention program 3) Introduce budget amendments to allow VDH to contract (or undertake) a pediatric office-based prevention program to provide staff training and video presentations on dangers of shaking infants 4) Request by letter of chairman that all public and private agencies develop a more comprehensive SBS prevention initiative 5) Introduce a joint resolution to establish the third week of April as Shaken Baby Awareness Week 6)Include in the 2012 work plan for the Behavioral Health Care Subcommittee, continuation of the study for a second year to consider definitional and medical coding issues	
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# Creating Opportunities for Virginia's Infants to Thrive

Marissa J. Levine, MD, MPH, FAAFP  
Virginia State Health Commissioner  
January 15, 2015

# VISION: VIRGINIA IS THE HEALTHIEST STATE IN THE NATION

**WHAT:** Thriving Infants is a national and state initiative to improve birth outcomes for all babies

**HOW:** Coordinate and integrated statewide actions including Thriving Infants

## Thriving infants (TI) short term priorities by 2016

### 1. **Preconception/Interconception Health:**

Action plan: Long Acting Reversible Contraception (LARC)

Action plan: Behavioral health

Action plan: Tobacco

Action plan: Obesity

### 2. **SIDS/SUIDS/Safe Sleep**

Action plan: Hospital based

### 3. **Breastfeeding**

Action plan: 5 star program

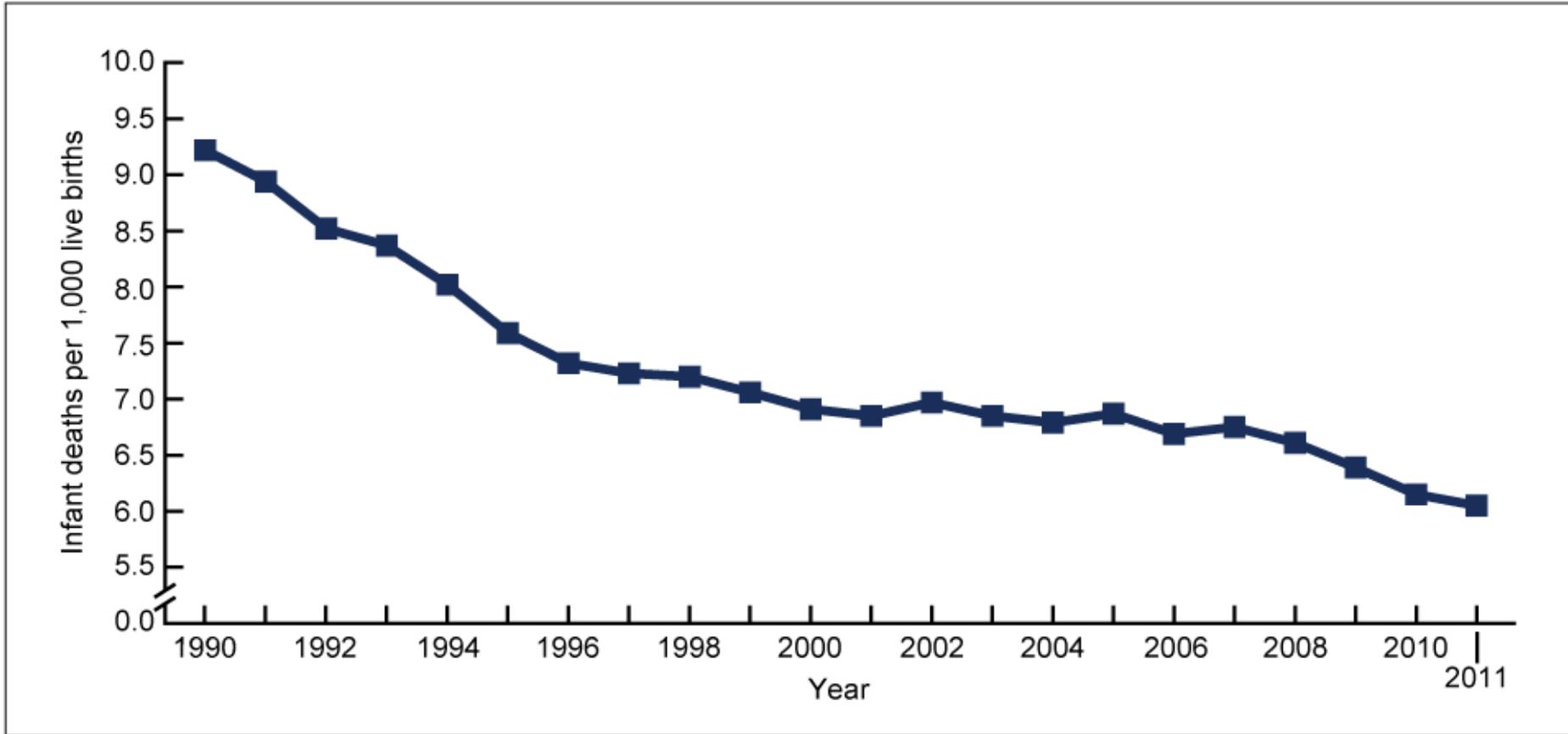
### 4. **Overarching action plan for all 3 priorities: Home Visiting**

## TI long term goals by 2018

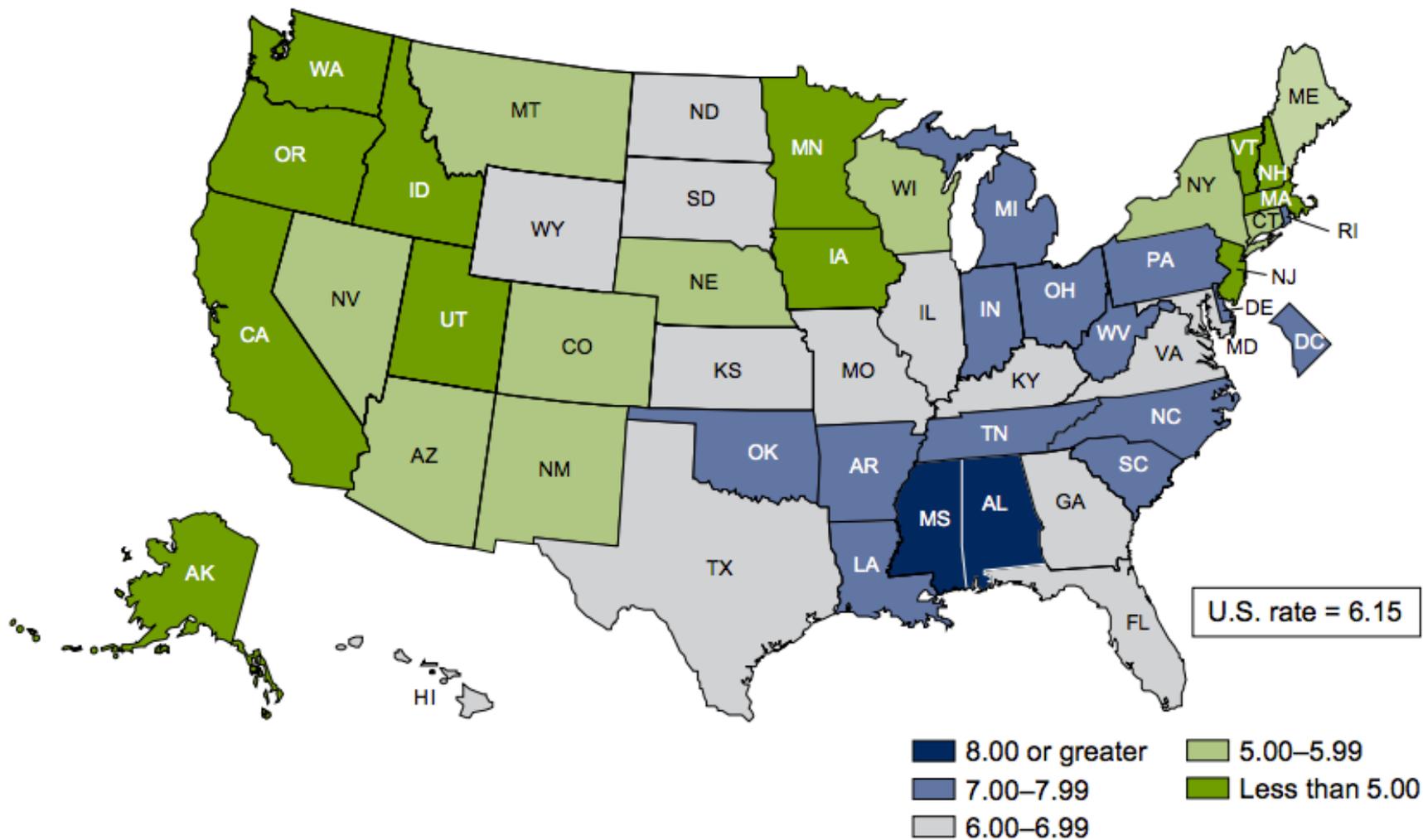
1. **IMR:** Reduce the IMR from 6.7 to 5.7

2. **Disparities:** Eliminate disparities related to birth outcomes

Figure 5. Infant mortality rates: United States, 1990–2010 final and preliminary 2011

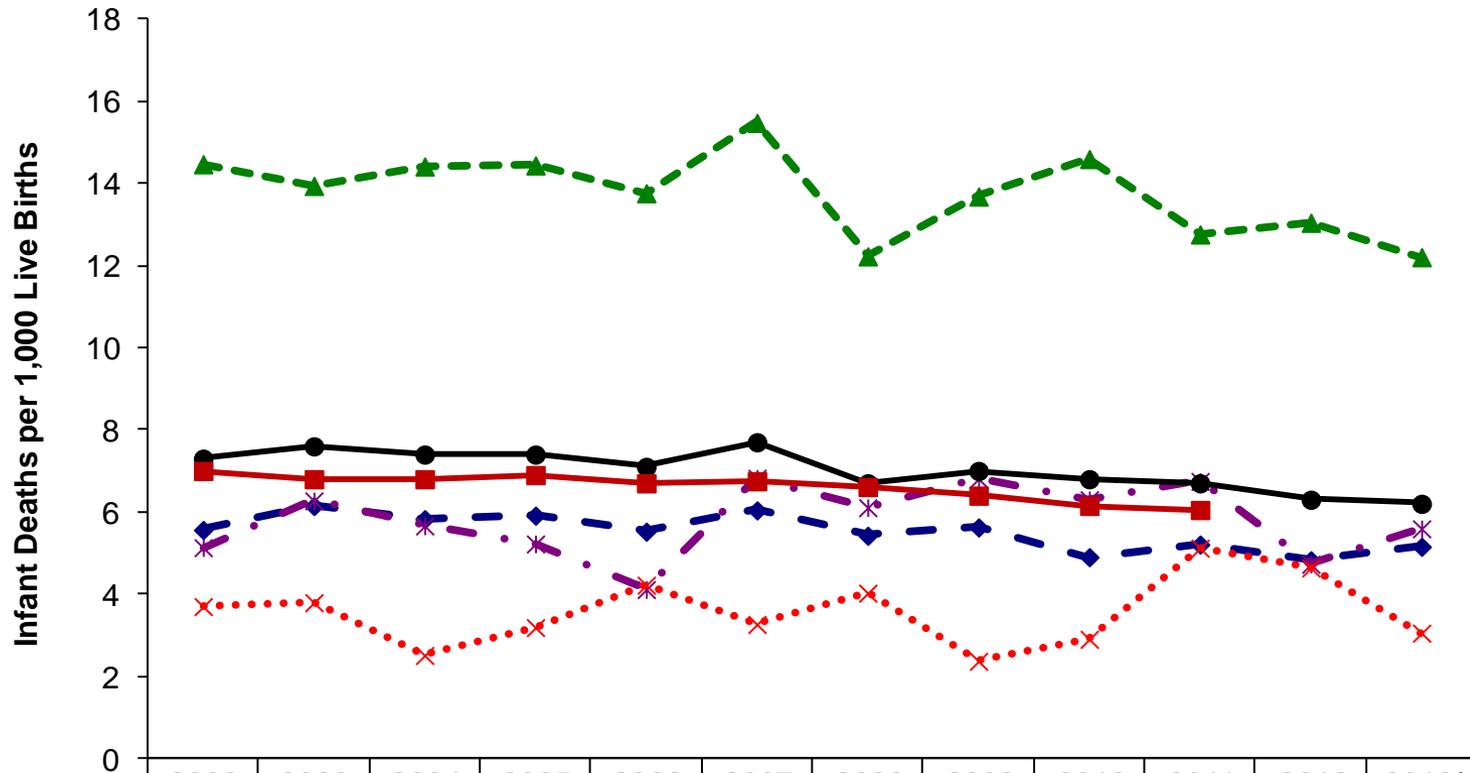


SOURCE: National Vital Statistics System, Mortality.



Infant mortality rates, by state: United States, 2010 (CDC)

## Resident Infant (>1 year of age) Death Rates By Race/Ethnicity, Virginia and U.S. Rate, 2002-2013\*

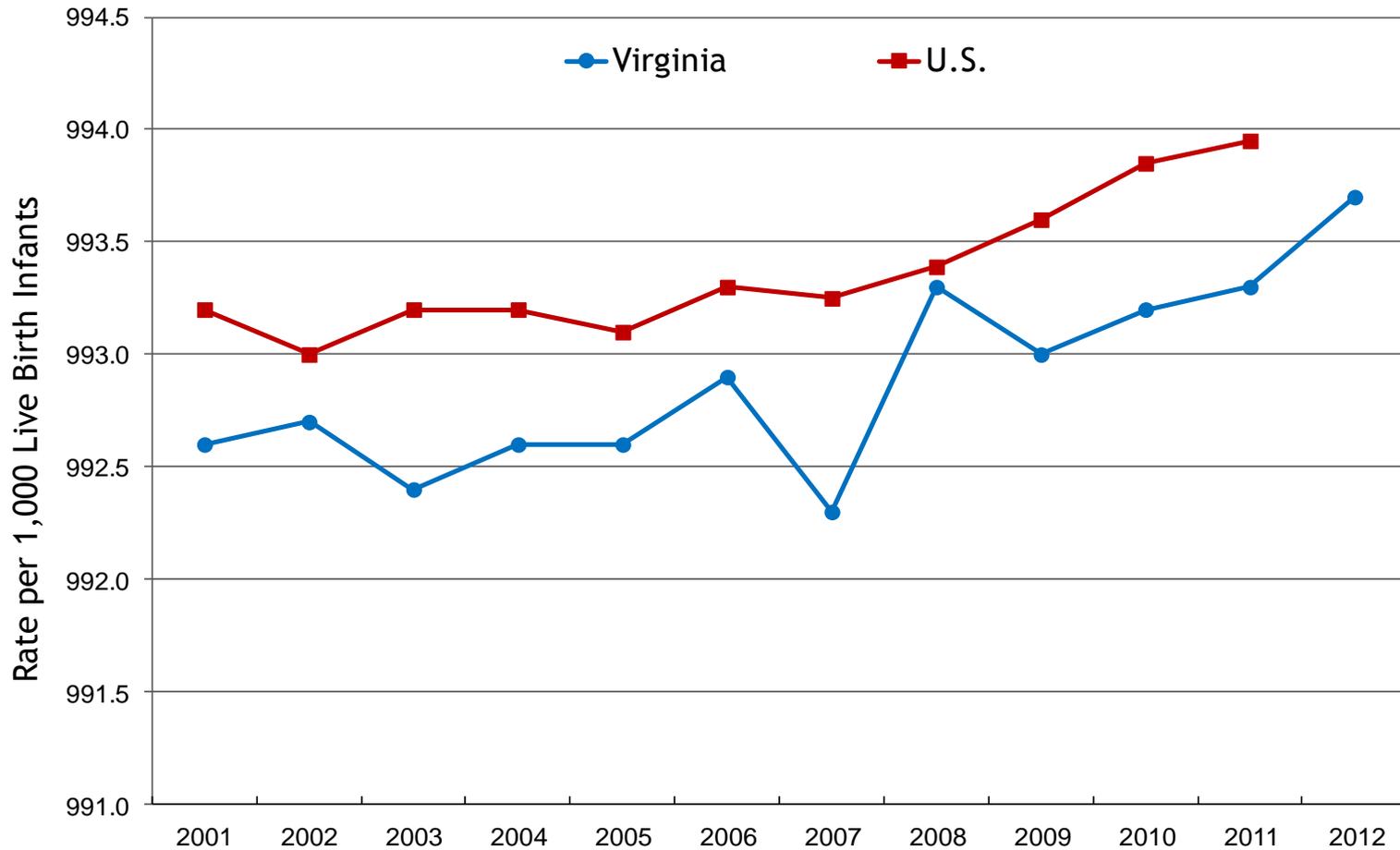


	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013*
White	5.6	6.1	5.8	5.9	5.5	6.0	5.4	5.6	4.9	5.2	4.8	5.2
Black	14.5	13.9	14.4	14.4	13.8	15.5	12.2	13.7	14.6	12.8	13.0	12.2
Hispanic	5.1	6.3	5.7	5.2	4.1	6.8	6.1	6.8	6.3	6.7	4.7	5.6
Asian	3.7	3.8	2.5	3.2	4.2	3.3	4.0	2.4	2.9	5.1	4.6	3.0
Virginia	7.3	7.6	7.4	7.4	7.1	7.7	6.7	7.0	6.8	6.7	6.3	6.2
U.S.	7.0	6.8	6.8	6.9	6.7	6.8	6.6	6.4	6.2	6.1		

Source: VDH Division of Health Statistics, compiled by the Division of Policy & Evaluation, Office of Family Health Services

\* Data for 2013 is provisional as of 01/05/2015.

# Increase In Infants Surviving



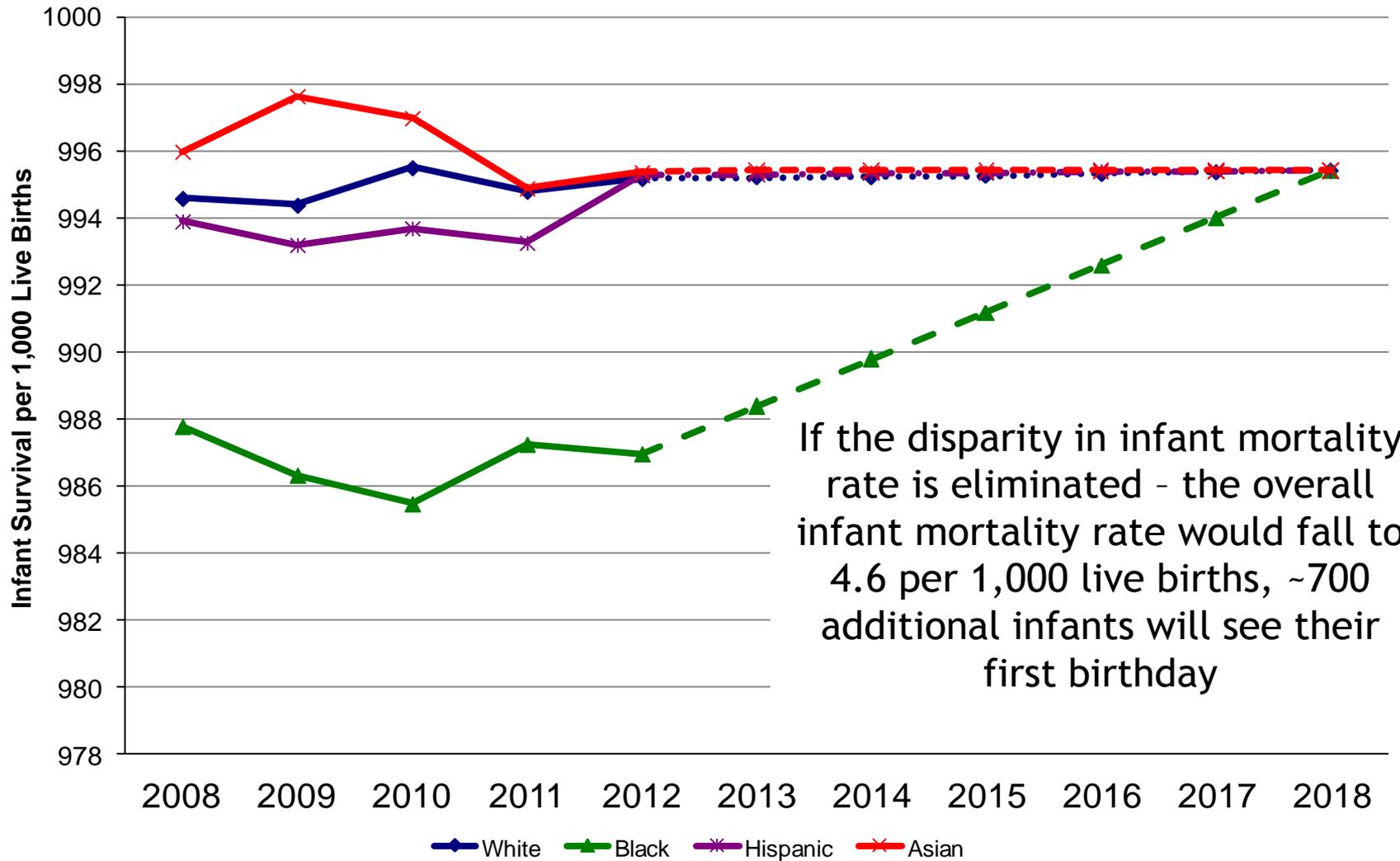
Source: VDH Division of Health Statistics, compiled by the Division of Policy & Evaluation, Office of Family Health Services

# Virginia's Infant ~~Mortality~~ Strategic Plan THRIVING

*994 thriving infants per 1000 live births*



# Resident Infant (>1 year of age) Survival Rates By Race/Ethnicity, Virginia 2008-2018



If the disparity in infant mortality rate is eliminated - the overall infant mortality rate would fall to 4.6 per 1,000 live births, ~700 additional infants will see their first birthday

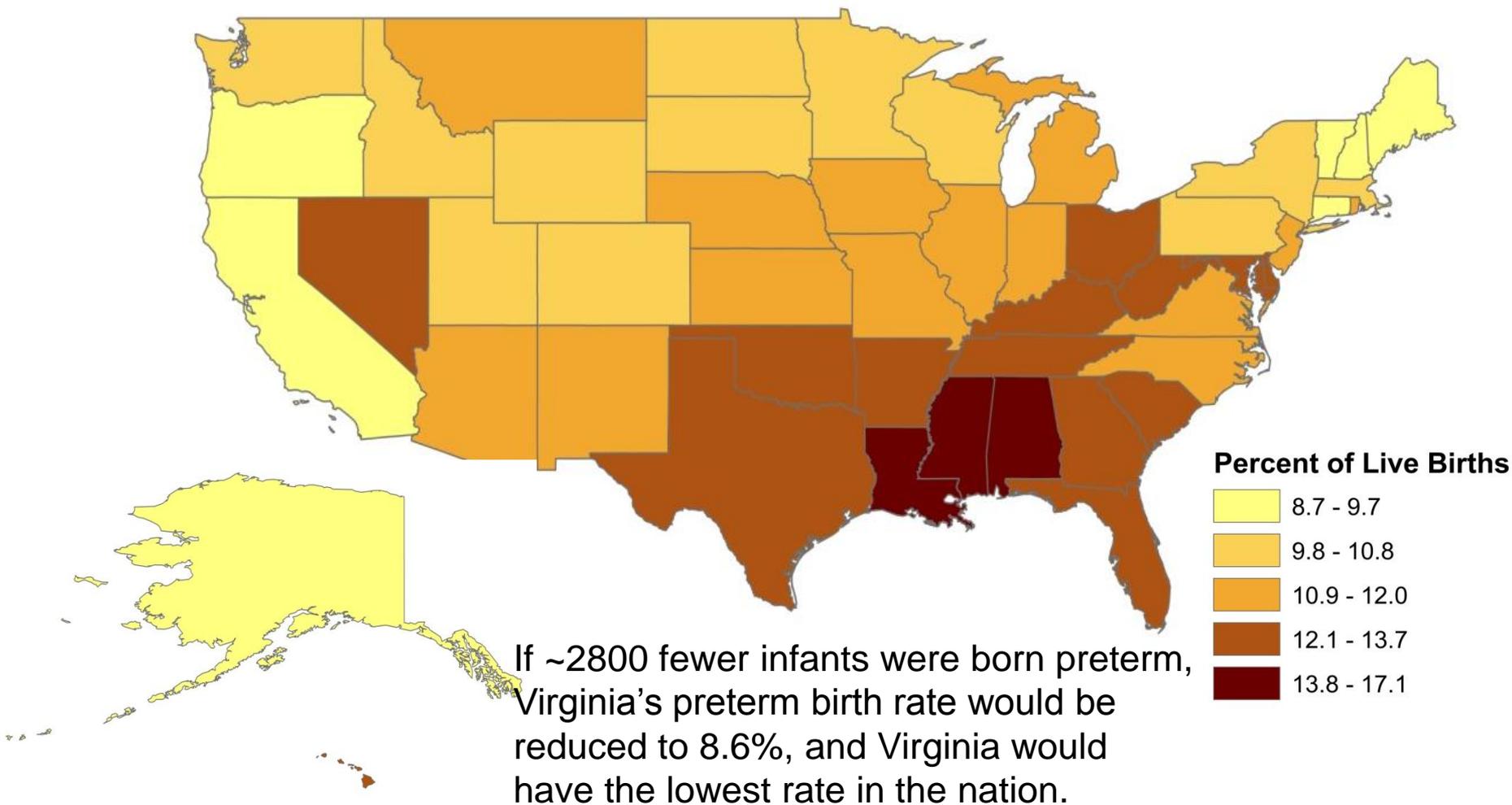
# Perinatal Risk Factors & Behaviors

- Alcohol Use During Pregnancy
- Breastfeeding
- Impaired Fertility & Infertility Services
- Intimate Partner Violence
- Maternal Age
- Preconception Health
- Pregnancy Spacing
- Safe Sleep Behaviors
- Smoking During Pregnancy
- Stress During Pregnancy
- Unintended Pregnancy and Contraception Use
- Weight Gain During Pregnancy

# 2011 Top 5 Causes of Infant Mortality

- Born too small and too early (i.e. preterm birth, birth before 37 weeks gestation)
  - Adequate birth spacing
  - No early elective delivery
  - Preconception health (clean air, normal weight)
- Born with a serious birth defect - **Folic Acid**
- Victims of Sudden Infant Death Syndrome (SIDS)-
  - **Safe Sleep**
- Affected by maternal complications of pregnancy
  - **Early and regular prenatal care**
  - **Preconception health**
- Victims of injuries (e.g. suffocation) -
  - **Domestic violence prevention**

# Preterm (<37 completed wks) Birth Across the Nation, 2012



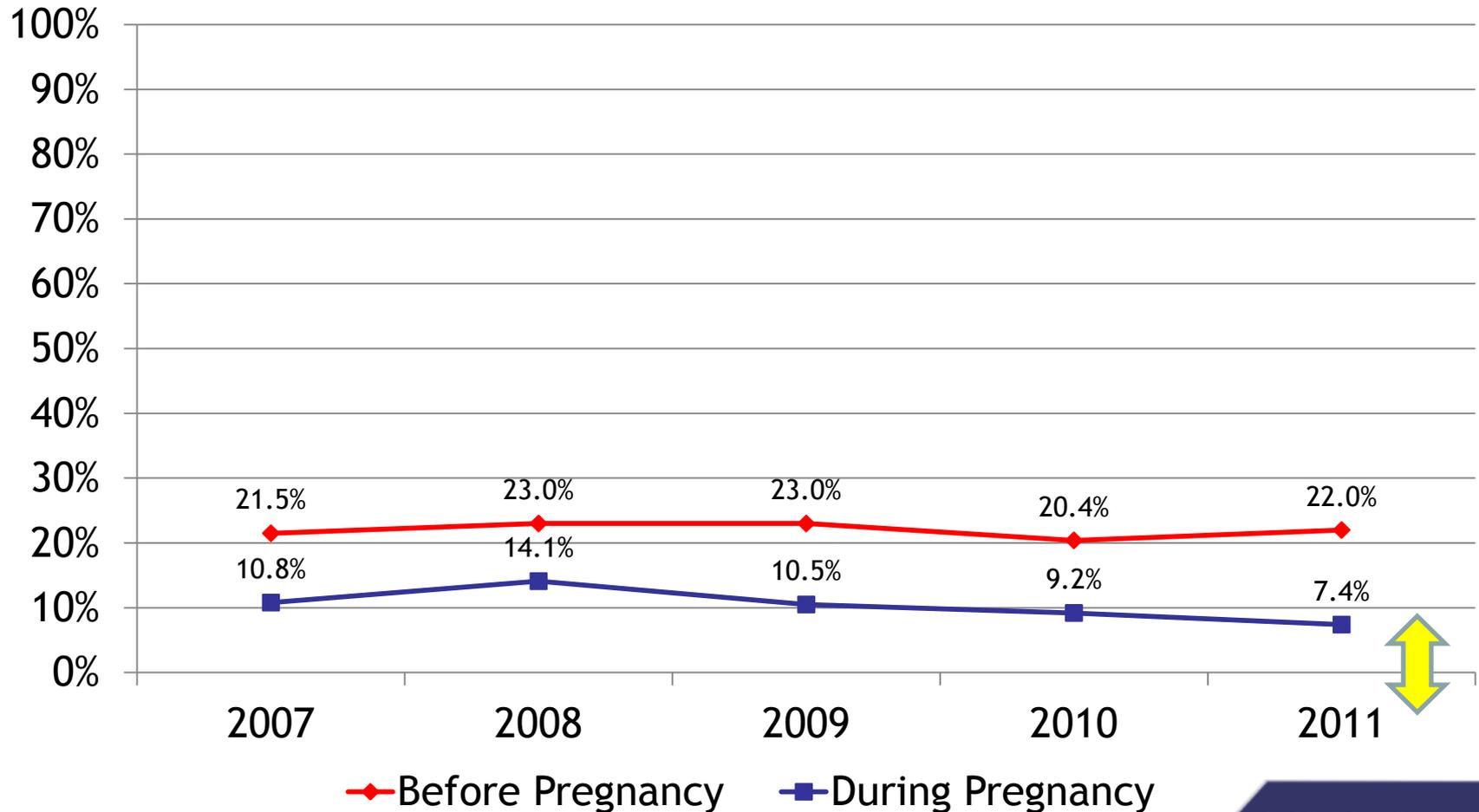
# Virginia's Goal: The best term rate in the nation

Improving pre-conception health could take Virginia more than two thirds (82.0%) of the way to our goal of having the best term rates in the country, with 2,295 more infants born at full-term.

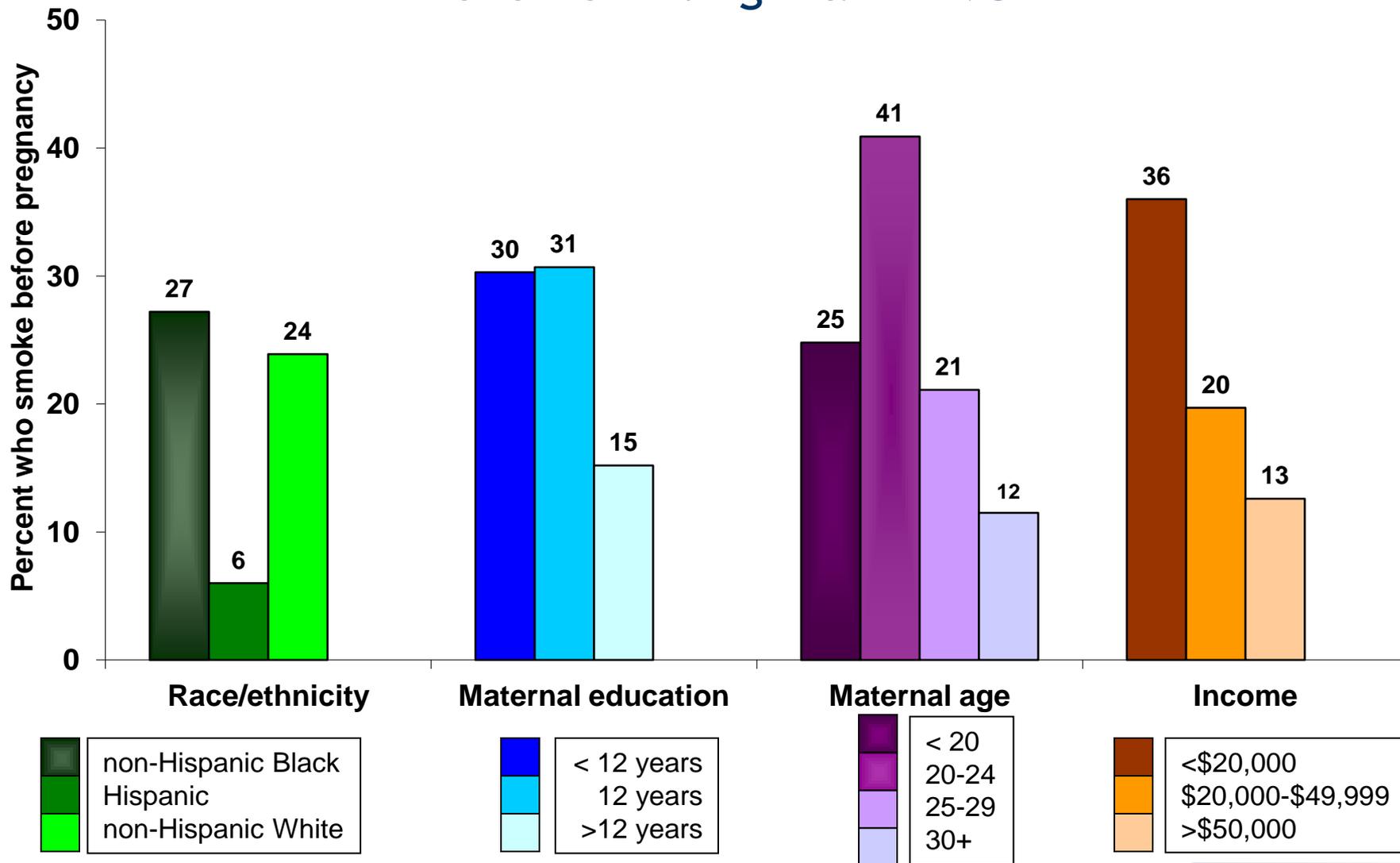
Risk Factor Among Pregnant Women	Additional Infants Born Full-term
Smoking	1548
Diabetes	275
Chronic hypertension	190
Risks from prior preterm birth	179
Anemia	103

# Maternal Smoking

Percent of women having a live birth who reported smoking before or during their most recent pregnancy, Virginia 2007-2011



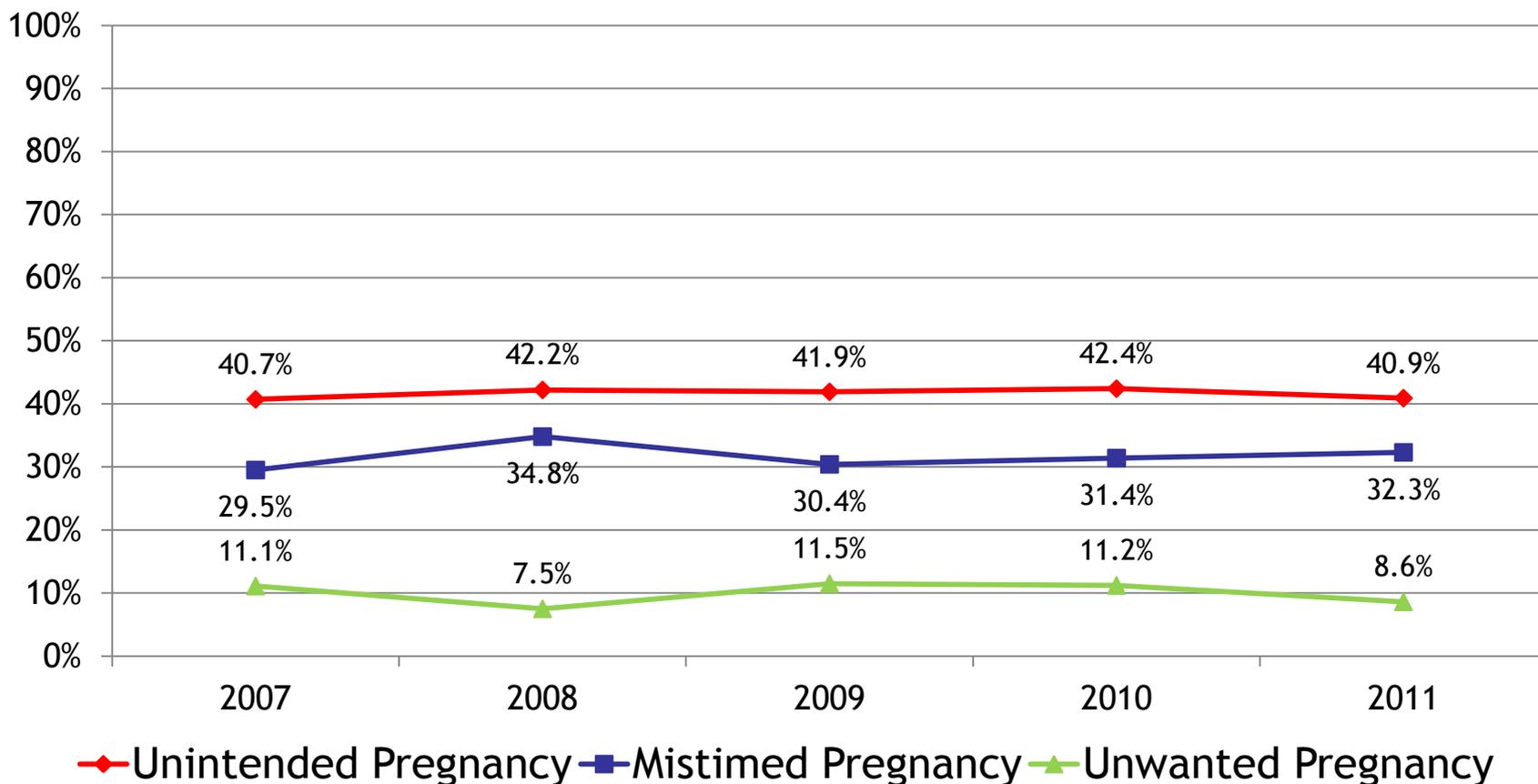
# Percent of women who smoked before pregnancy, 2010-2011 Virginia PRAMS



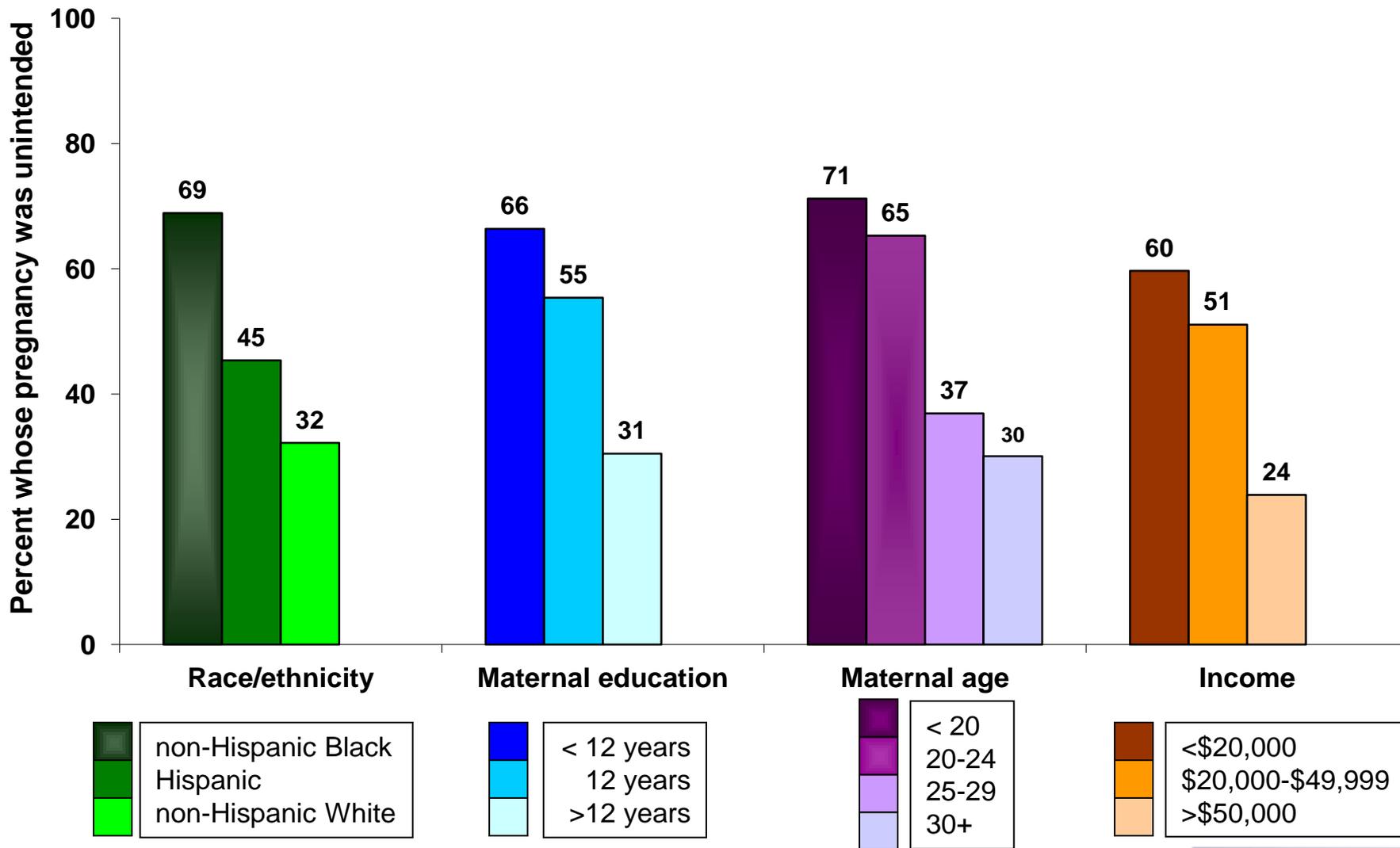
Source: Virginia Department of Health, Pregnancy Risk Assessment Monitoring System, 2010-11.

# Pregnancy Intention

Percent of women having a live birth who reported their most recent pregnancy was Unintended [Mistimed or Unwanted], Virginia 2007-2011

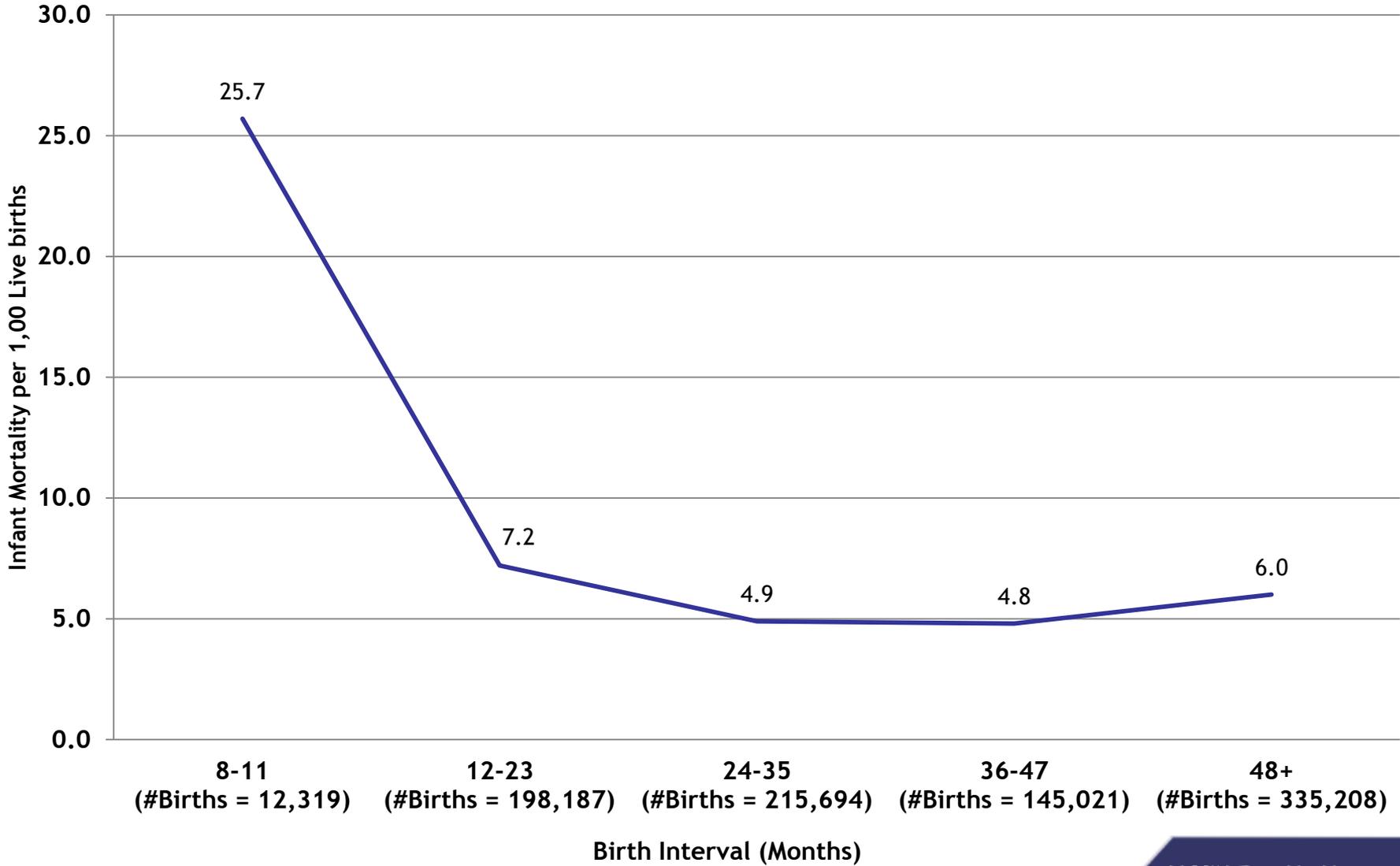


# Percent of mothers who had an unintended pregnancy 2010-2011 Virginia PRAMS



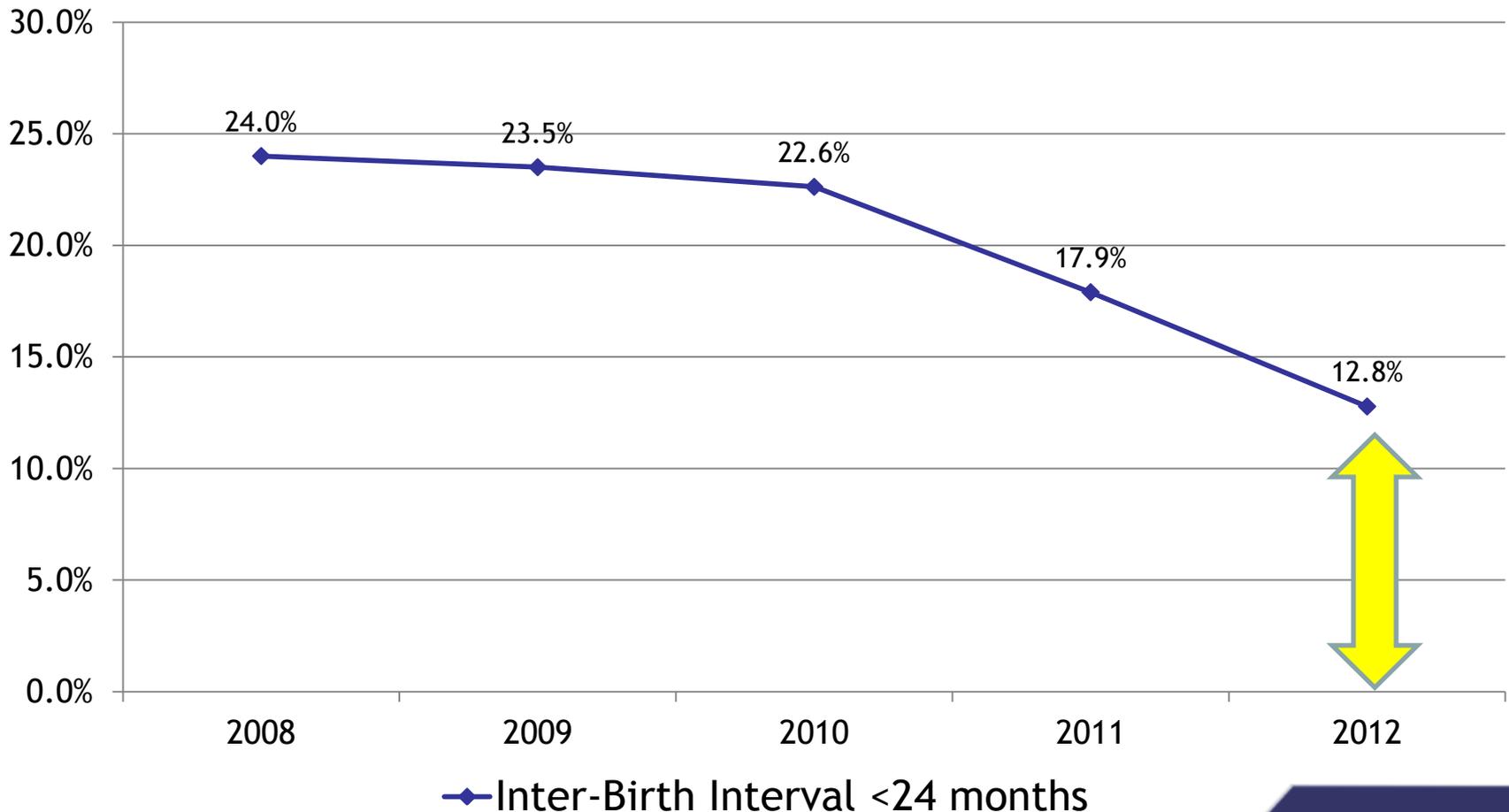
Source: Virginia Department of Health, Pregnancy Risk Assessment Monitoring System, 2010-11.

# Infant Mortality Rate by Preceding Birth Interval, Virginia 1993-2009



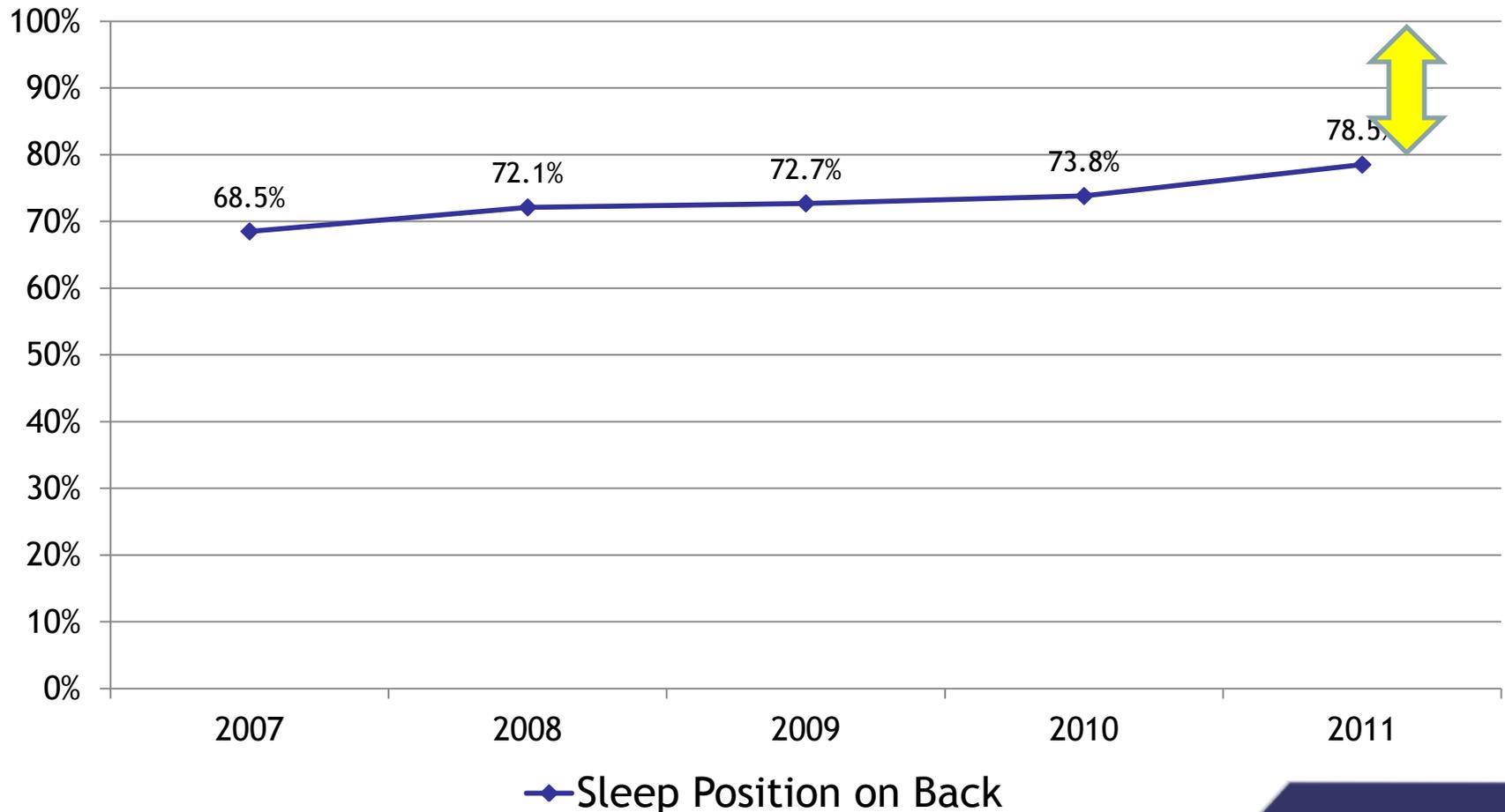
# Inter-Birth Interval

Percent of women having an inter-birth Interval less than 24 months since their last live birth, Virginia 2008-2012



# Infant Safe Sleep

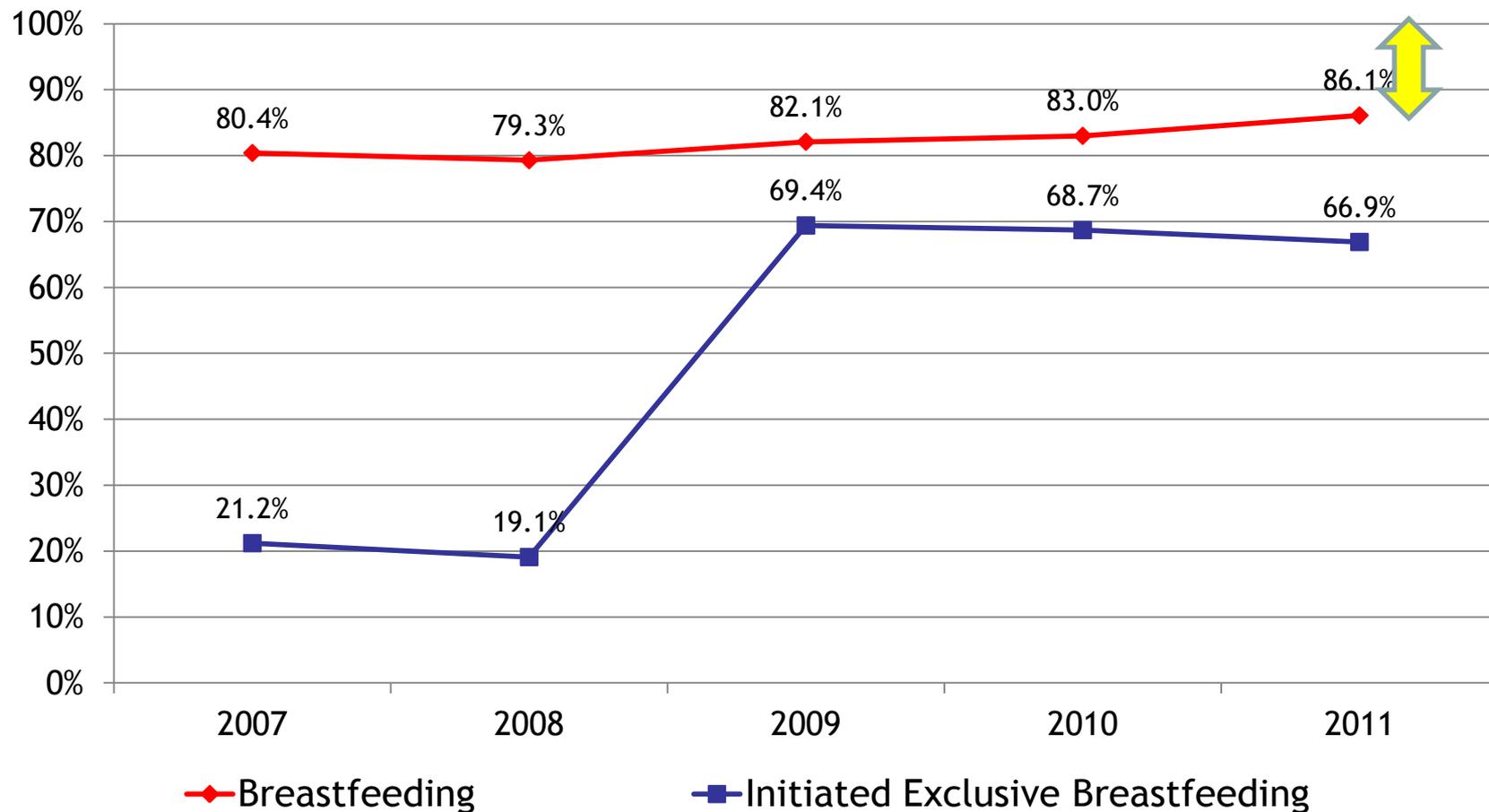
Percent of women having a live birth who reported Always or Almost Always places their infant to sleep on its back, Virginia 2007-2011



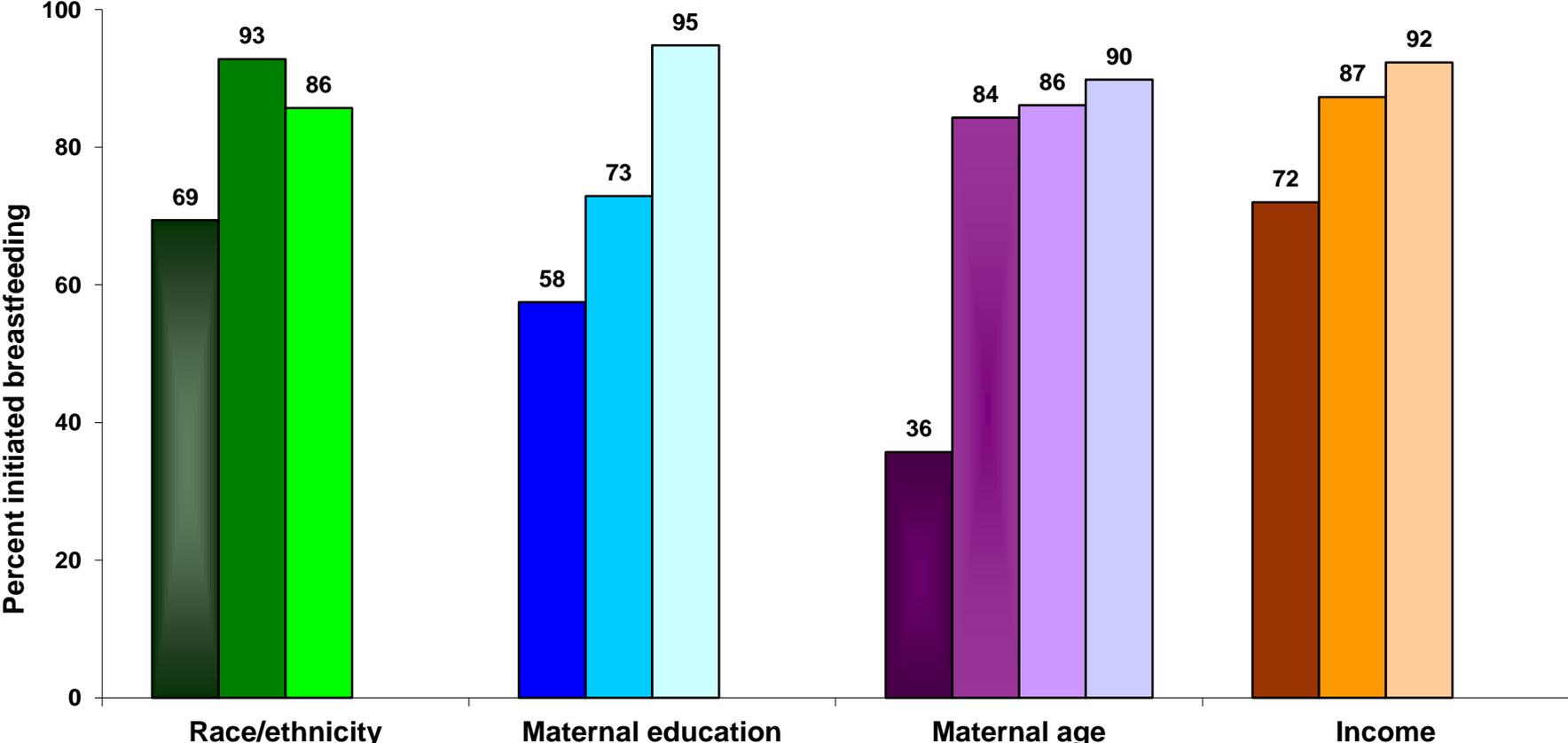
Source: Virginia Department of Health, Pregnancy Risk Assessment Monitoring System, 2007-2011

# Breastfeeding Initiation

Percent of women having a live birth who reported initiation of breastfeeding, Virginia 2007-2011



# Percent of women who initiated breastfeeding 2010-2011 Virginia PRAMS



non-Hispanic Black  
 Hispanic  
 non-Hispanic White

< 12 years  
 12 years  
 >12 years

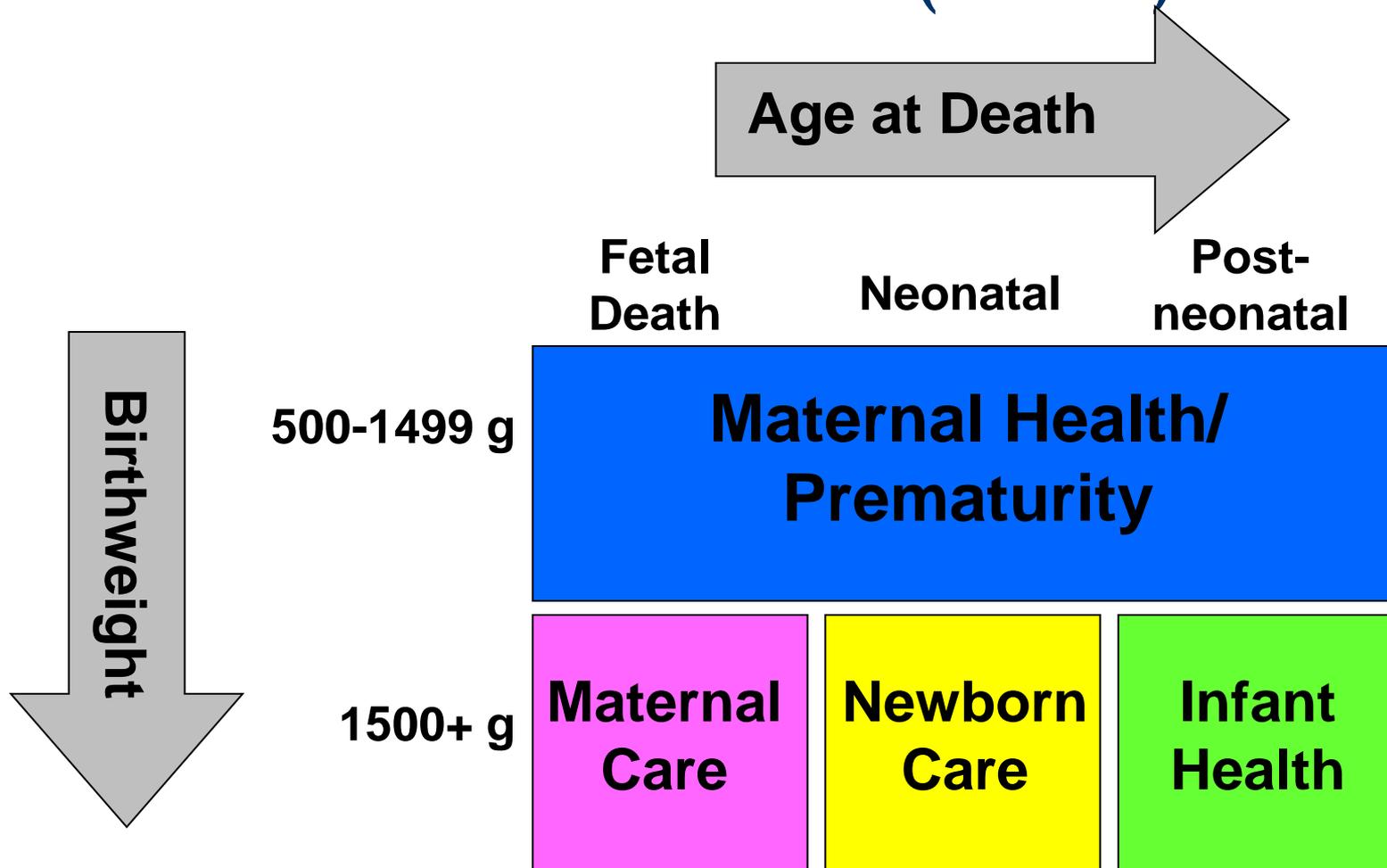
< 20  
 20-24  
 25-29  
 30+

<\$20,000  
 \$20,000-\$49,999  
 ≥\$50,000

Source: Virginia Department of Health, Pregnancy Risk Assessment Monitoring System, 2010-11.



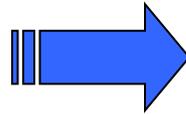
# Perinatal Periods of Risk (PPOR)



Magda Peck , Sappenfield W, Skala J. Perinatal Periods of Risk: A Community Approach for Using Data to Improve Women and Infants' Health . *Matern Child Health J* (2010) 14:864–874

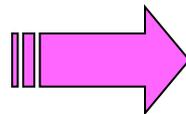
# PPOR Example Potential Actions

**Maternal Health/  
Prematurity**



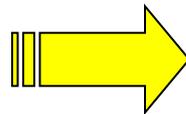
Preconception Health  
Health Behaviors  
Perinatal Care

**Maternal Care**



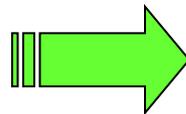
Prenatal Care  
High Risk Referral  
Obstetric Care

**Newborn Care**



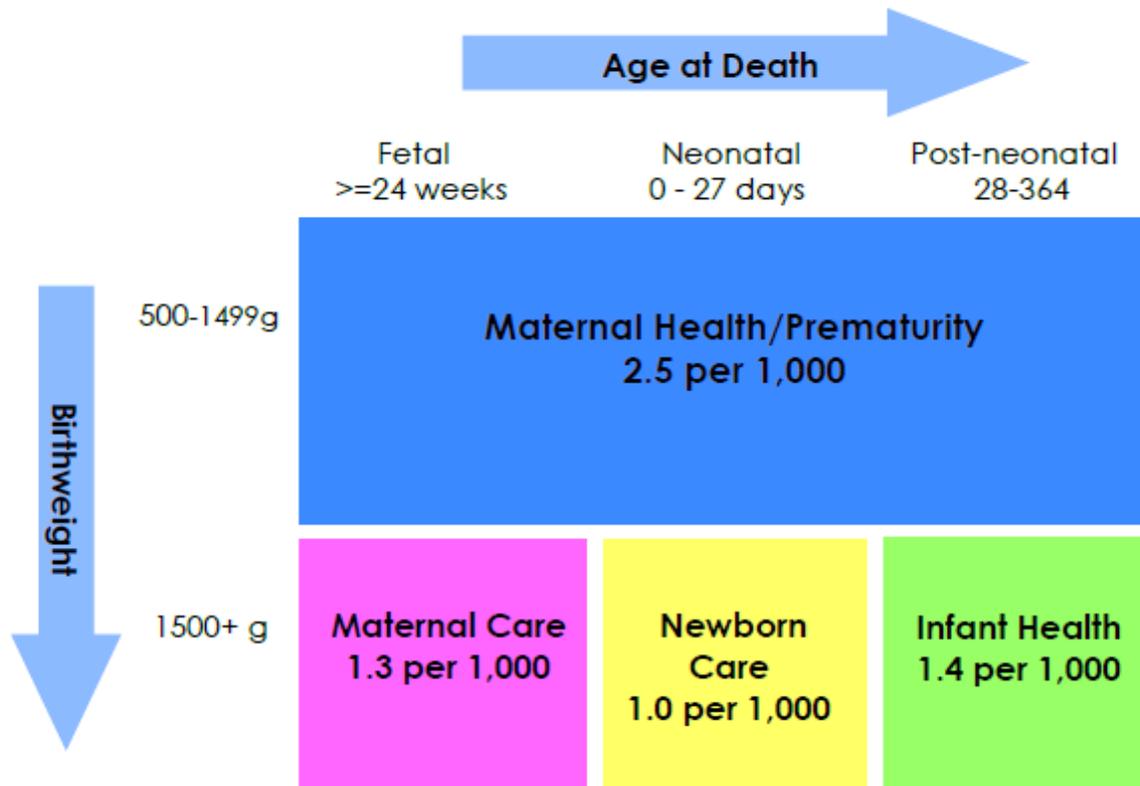
Perinatal Management  
Neonatal Care  
Pediatric Surgery

**Infant Health**



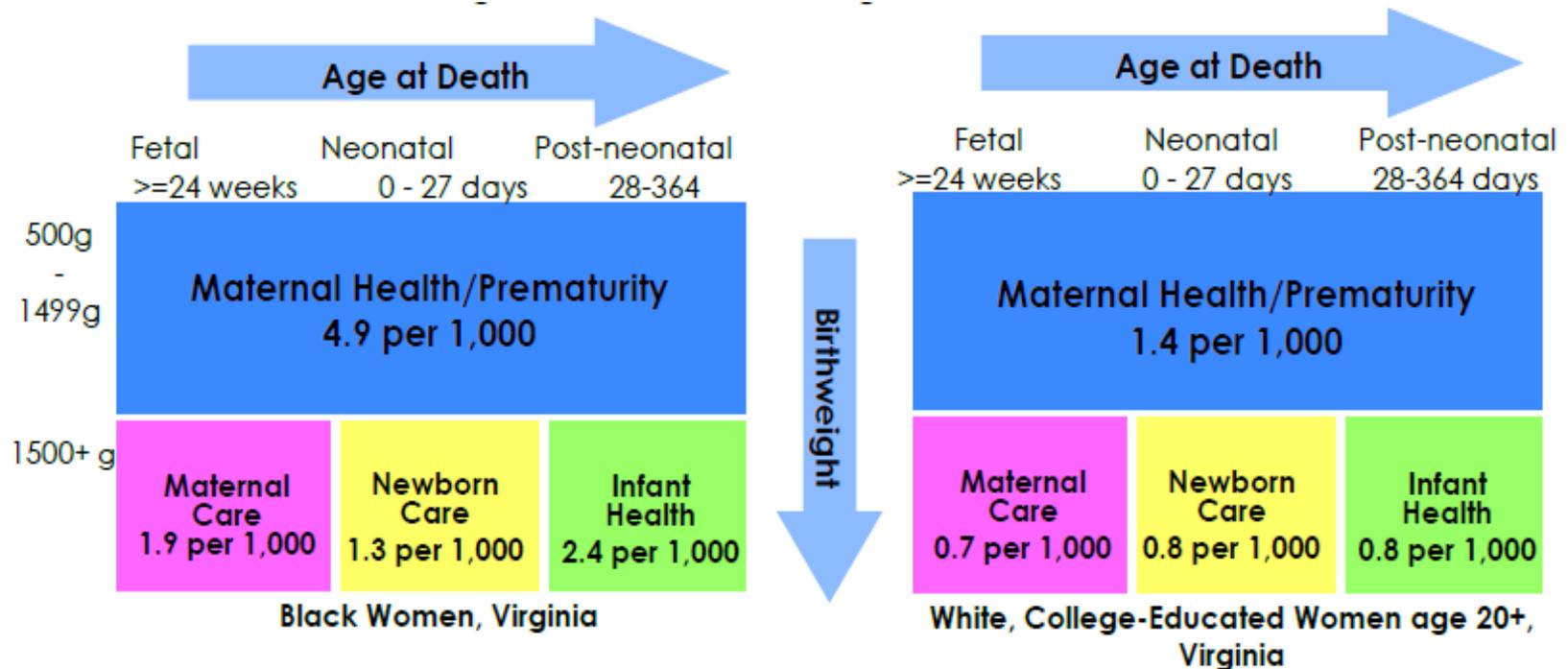
Sleep Position  
Breast Feeding  
Injury Prevention

# Virginia - Statewide Data



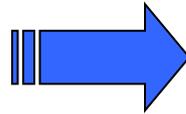
Virginia State, Feto-Infant Overall Mortality  
PPOR Map

# Virginia - Race Disparity



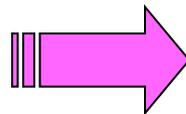
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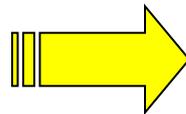
Preconception Health  
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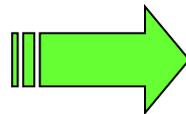
Prenatal Care  
High Risk Referral  
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**Newborn Care**



Perinatal Management  
Neonatal Care  
Pediatric Surgery

**Infant Health**



Sleep Position  
Breast Feeding  
Injury Prevention

# VISION: VIRGINIA IS THE HEALTHIEST STATE IN THE NATION

**WHAT:** Thriving Infants is a national and state initiative to improve birth outcomes for all babies

**HOW:** Coordinate and integrated statewide actions including Thriving Infants

## Thriving infants (TI) short term priorities by 2016

- 1. Preconception/Interconception Health:**
  - Action plan: Long Acting Reversible Contraception (LARC)
  - Action plan: Behavioral health
  - Action plan: Tobacco
  - Action plan: Obesity
- 2. SIDS/SUIDS/Safe Sleep**
  - Action plan: Hospital based
- 3. Breastfeeding**
  - Action plan: 5 star program
- 4. Overarching action plan for all 3 priorities: Home Visiting**

## TI long term goals by 2018

- 1. IMR:** Reduce the IMR from 6.7 to 5.7
- 2. Disparities:** Eliminate disparities related to birth outcomes

# VIRGINIA THRIVING INFANTS PARTNERS and CHAMPIONS

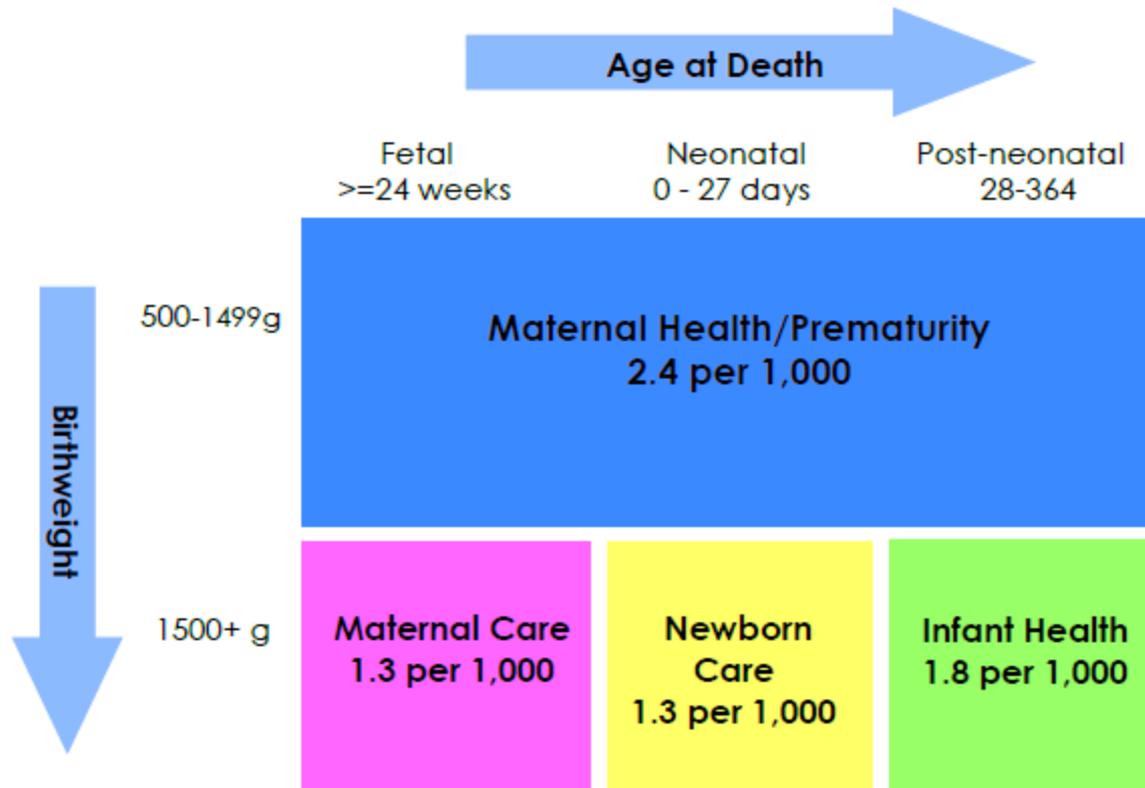


# Questions?



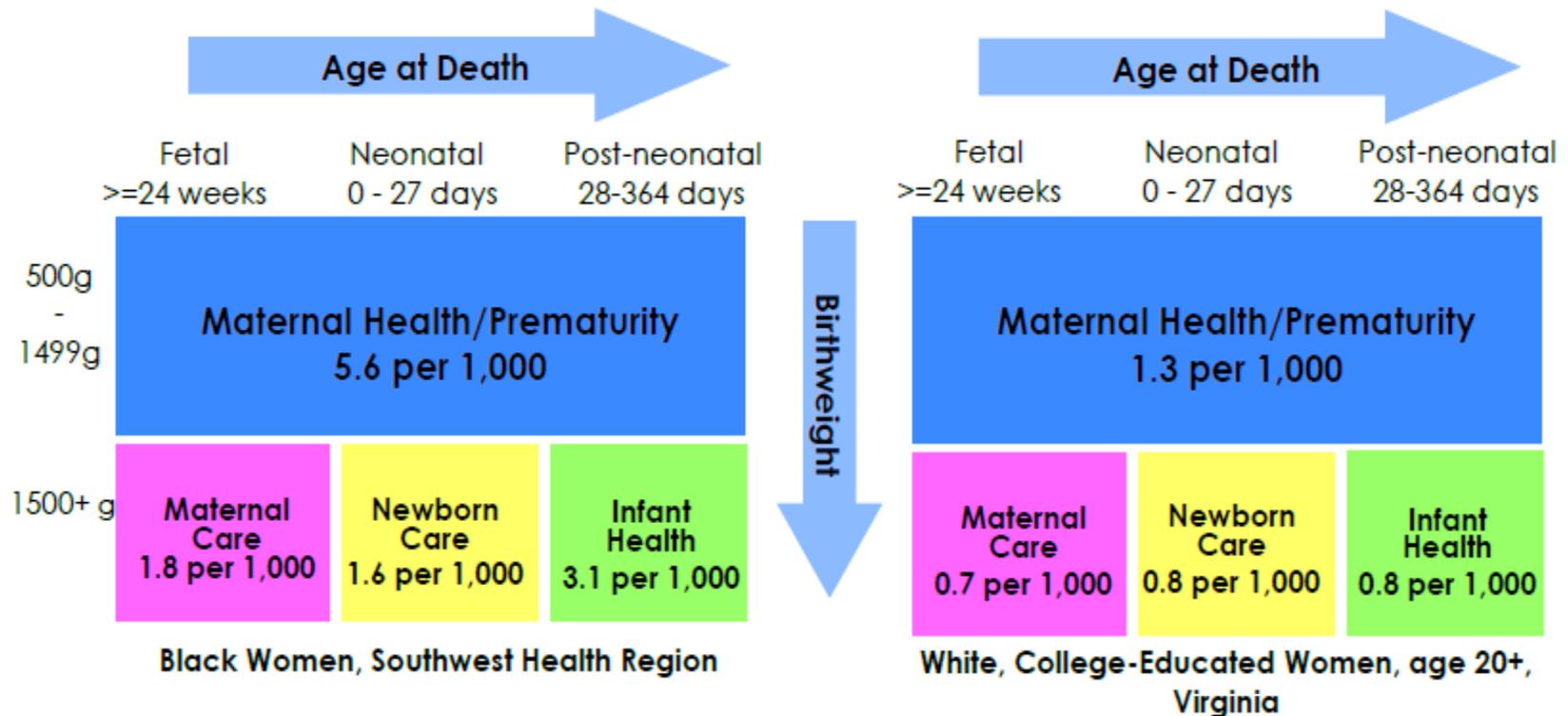
# Additional Reference Slides

# Southwest Region

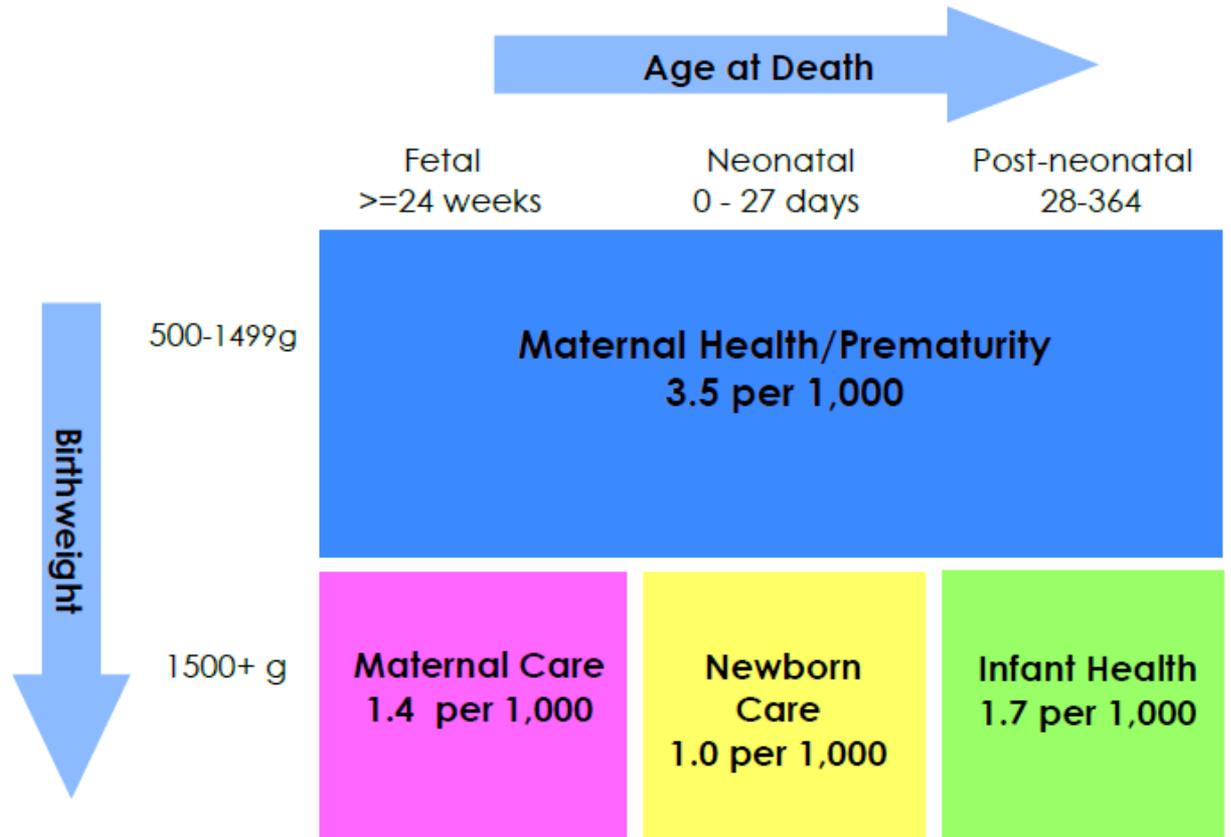


Southwest Health Region, Feto-Infant Overall Mortality  
PPOR Map

# Southwest Region - Racial Disparity

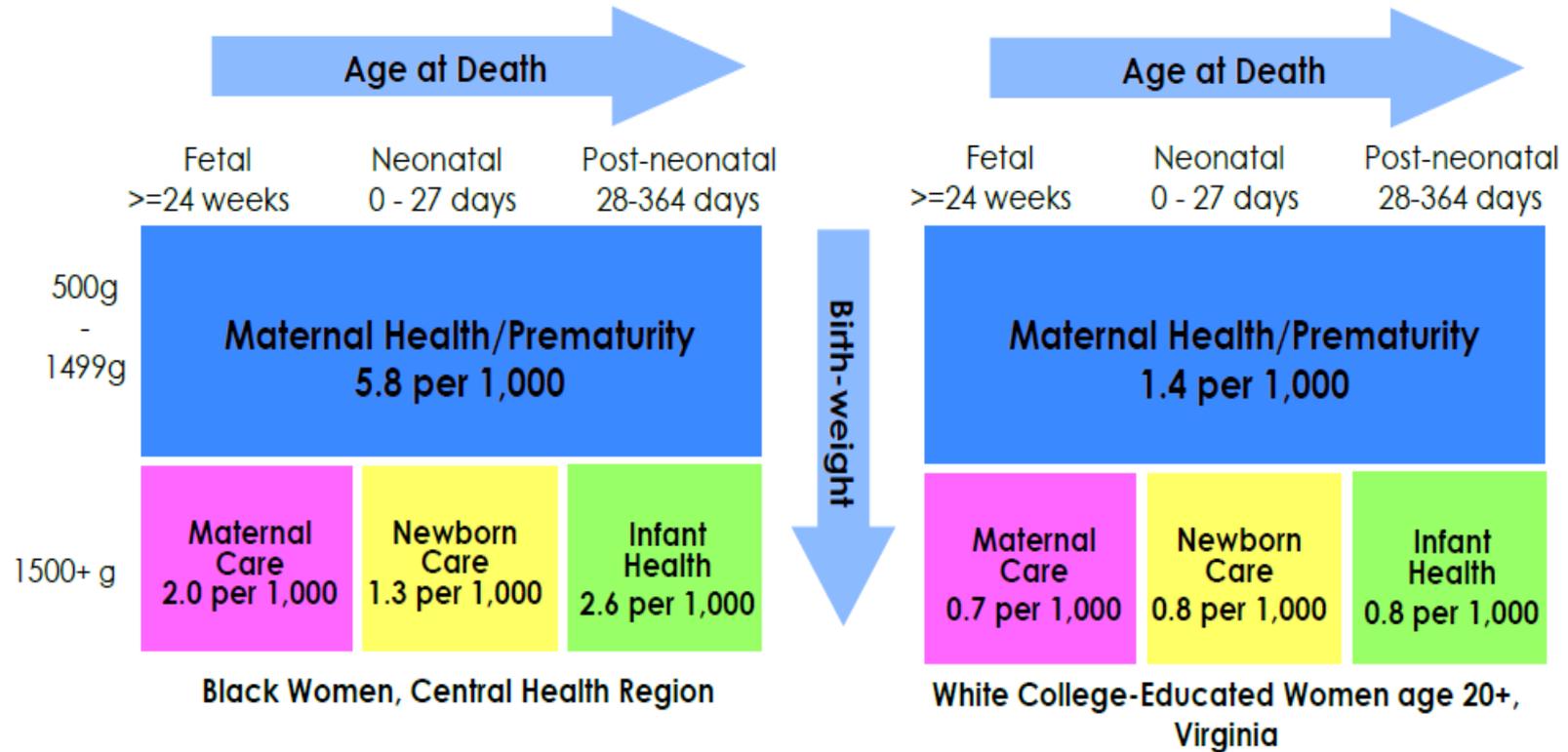


# Central Region

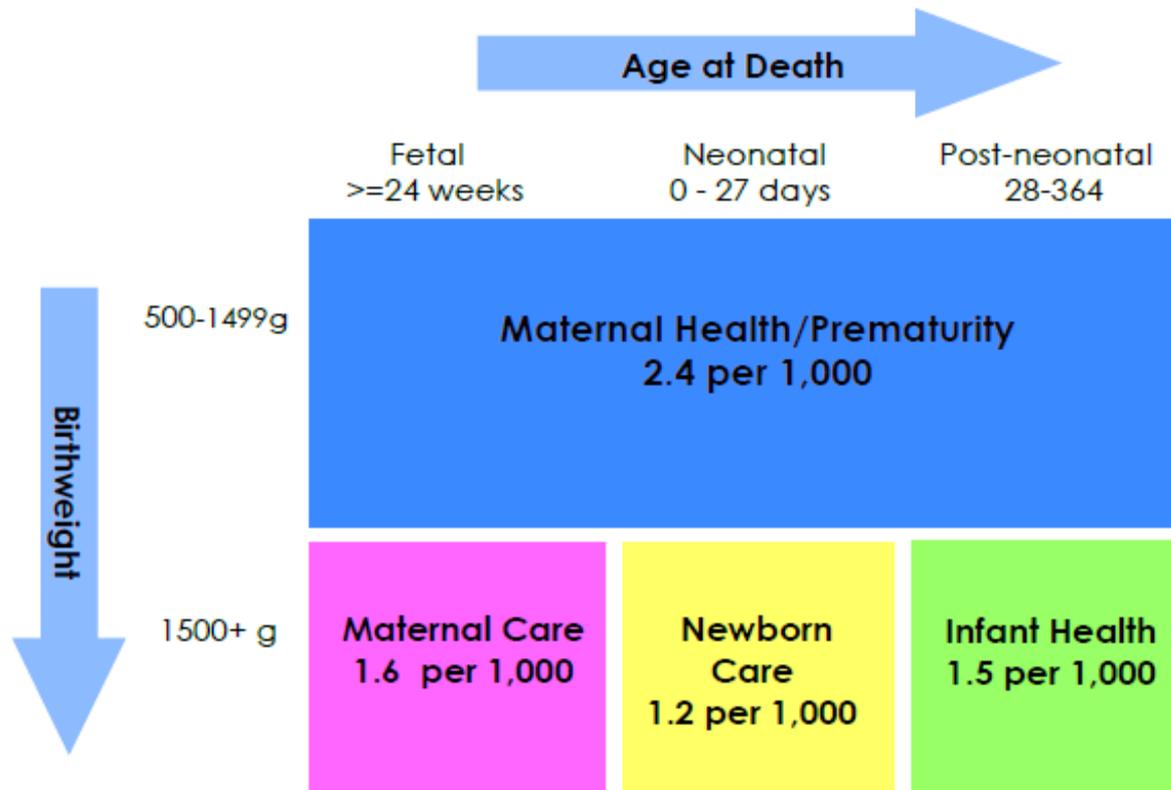


Central Health Region , Feto-Infant Overall Mortality  
PPOR Map

# Central Region - Race Disparity

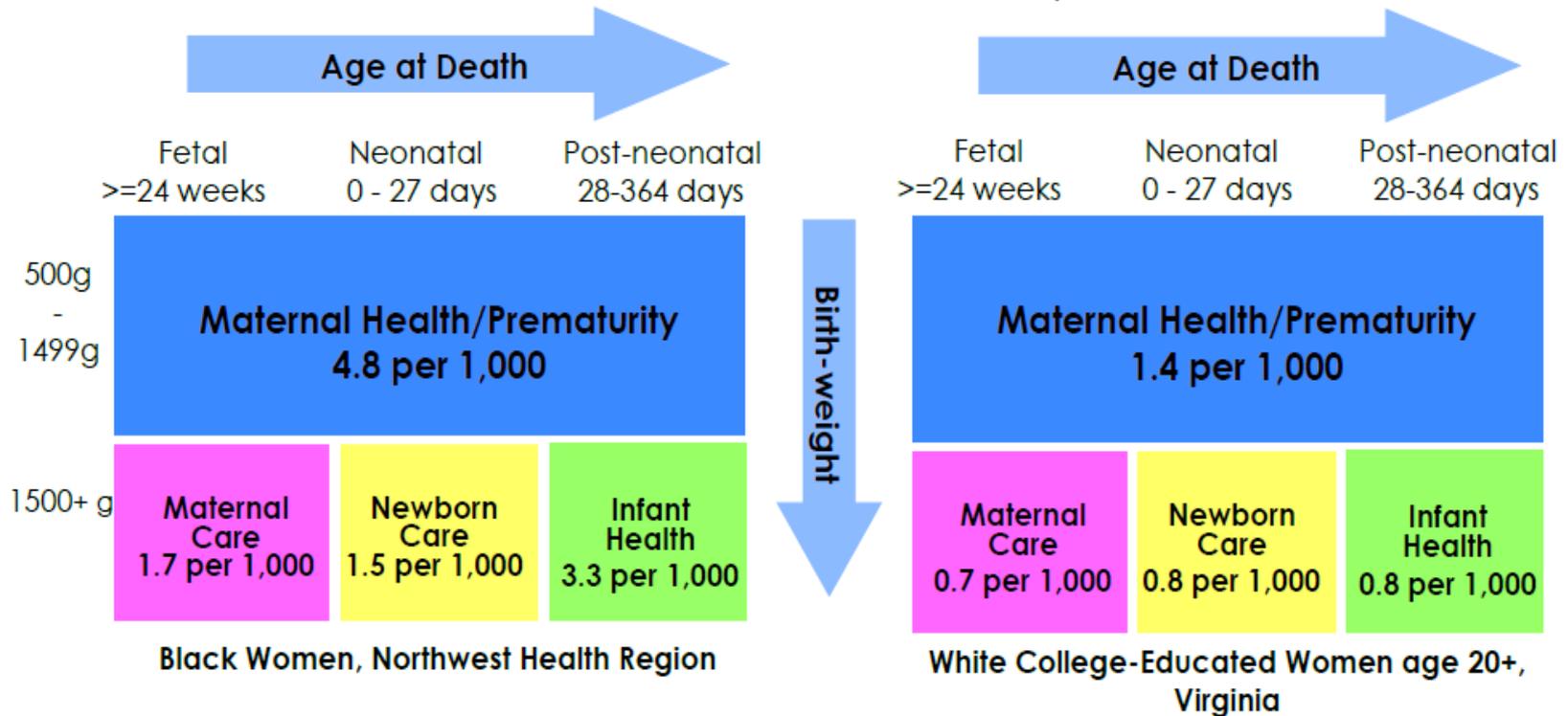


# Northwest Region

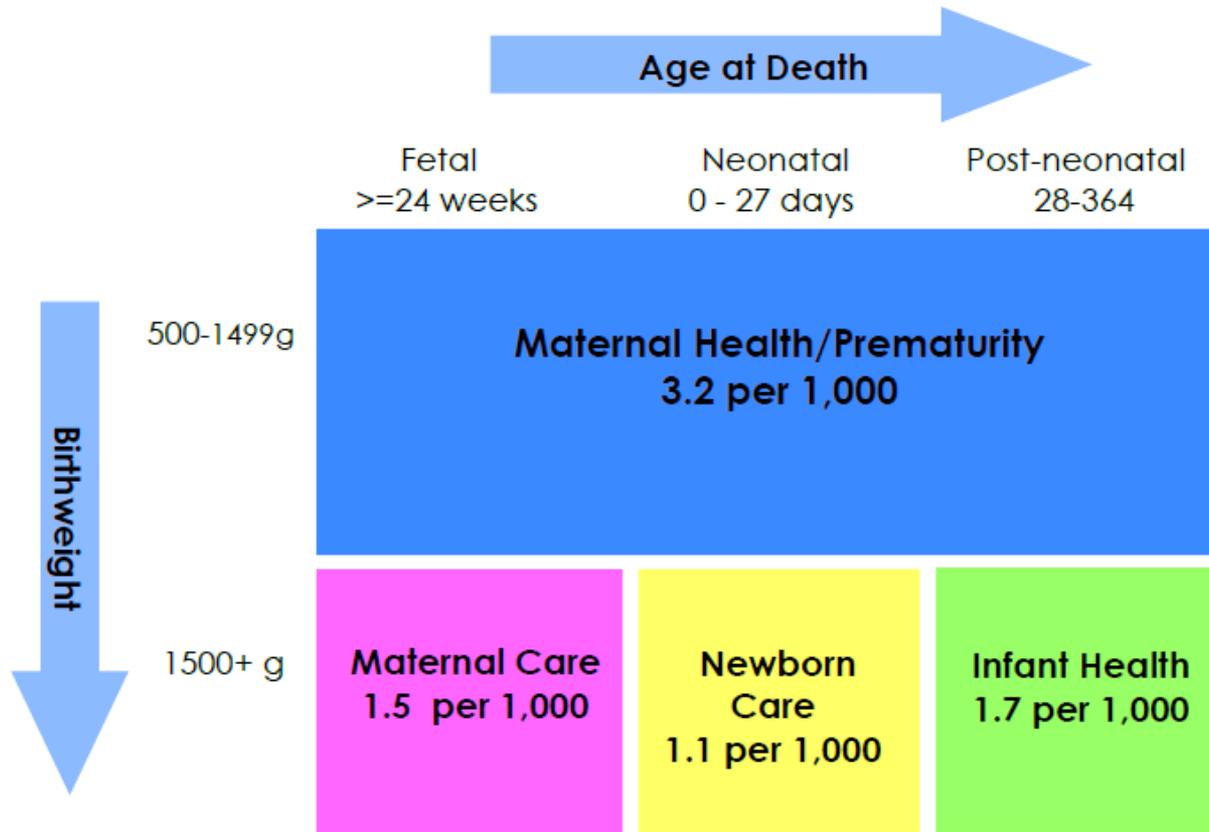


Northwest Health Region , Feto-Infant Overall Mortality

# Northwest Region - Race Disparity

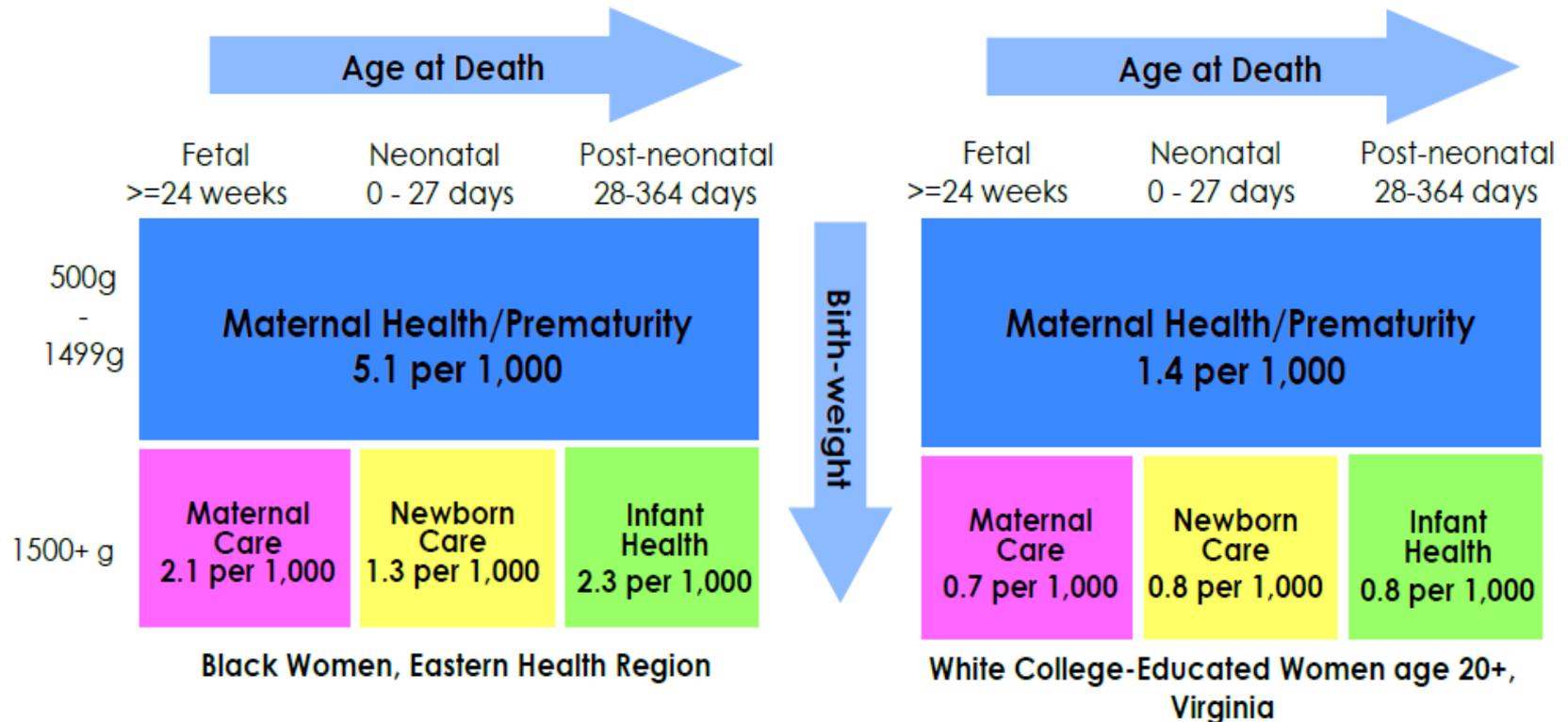


# Eastern Region



Eastern Health Region , Feto-Infant Overall Mortality

# Eastern Region - Race Disparity



# National Infant Mortality CoIN

- A Collaborative Improvement & Innovation Network
- A national strategy to reduce infant mortality and improve birth outcomes
- Began in HHS Regions IV, V, and VI and now being implemented nationally
- Is a state-driven initiative, with focus on a learning collaborative, local, state, and federal collaboration and strong federal technical support
- Designed to accelerate improvement by uniting key state stakeholders in infant mortality reduction

# Virginia's State Infant Mortality CoIN Team

- Virginia's State Team: First Regional Summit in July, 2014
  - Expanded team from 11 to 25 key organizations and their champion representatives for additional expertise around strategies
  - Working sessions completed to identify key state priorities, strategies, and evidence based, data driven action plans
  - Moving from action planning to implementation in 2015

# What Prevention Strategies are Working to Improve Birth Outcomes in Virginia?



Reducing the Early Elective Deliveries without a medical indication (<39 weeks)

Reducing the percentage of uninsured women of child-bearing age

Lowered percentage of pregnant women who smoke

Lowering the Preterm birth rate (<37 weeks) and late preterm (34-36 weeks)

\*Reduction in preterm rates in blacks and whites

Increase in breastfeeding initiation

# Moving Forward in Virginia with the Thriving Infants' Strategic Initiative

- Actionable strategic priorities with measurable objectives with a focus on health equity and a life course framework
- Build upon the enhanced collaborative relationships across Virginia
- Maximizing engagement of stakeholders and resources
- Implementation at state, regional, local levels
- Short, intermediate, and long term outcomes

# Why is Infant Mortality *Important*?

- Indicator to measure the health/well-being of a nation, state, and community.
- Broad range of factors affect the health
- Changes in infant mortality rates are a signal that factors are changing
- Causes and rates of mortality can vary at different times during the first year of life
  - Impacts type of evidence-based strategies to focus on

# What is Infant Mortality & Infant Mortality Rate?

- The Centers for Disease Control and Prevention (CDC, 2014) defines infant mortality as “a death of a baby before his/her first birthday.”
- Infant Mortality rate “is an estimate of the number of infant deaths for every 1,000 live births” (CDC, 2014)

Accessed at <http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/InfantMortality.htm>