

**Virginia State Plan for FFY 2009
Preventive Health and Health Services
Block Grant**

Work Plan

Original Work Plan for Fiscal Year 2009

Submitted by: Virginia

DUNS: 014584150

Printed: 8/24/2009 11:49 AM

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CDC Work Plan ID: VA 2009 V0 R1

Created on: 6/8/2009

Submitted on: 7/1/2009

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Executive Summary

This Virginia State Plan is the Preventive Health and Health Services Block Grant (PHHSBG) application for Federal Fiscal Year 2009 (FFY09). The Centers for Disease Control and Prevention (CDC) administers PHHSBG funds in accordance with the Public Health Services Act, Sections 1901-1907, as amended in October 1992, and Section 1910A, as amended in October 1996 and 2000. The Virginia Department of Health (VDH), Office of Family Health Services (OFHS) has administrative responsibility for the PHHSBG for the Commonwealth of Virginia.

PHHS Block Grant dollars are allocated to those priority health areas that have no other source of state or federal funds or wherein combined state and federal funds are insufficient to address the extent of mortality or morbidity that result from health problems. The programs funded by the PHHSBG address the following national health status objectives from Healthy People 2010:

- 7-10: Increase the proportion of tribal and local health service areas or jurisdictions that have established a community health promotion program that addresses multiple Healthy People 2010 focus areas;
- 15-13: Reduce deaths caused by unintentional injury;
- 15-35: Reduce the annual rate of rape or attempted rape;
- 19-2: Reduce the proportion of adults who are obese;
- 19-3: Reduce the proportion of children and adolescents who are overweight or obese;
- 21-1: Reduce the proportion of children and adolescents who have dental caries experience in their primary or permanent teeth;
- 21-8: Increase the proportion of children who have received dental sealants on their molar teeth;
- 21-9: Increase the proportion of U.S. population served by community water systems with optimally fluoridated water; and
- 23-5: Increase the proportion of leading health indicators, health status indicators, and priority data needs for which data are available at the tribal, state, and local levels.

In accordance with PHHSBG legislation, the PHHS Advisory Committee makes recommendations regarding funding priorities and the development of the Virginia State Plan.

Funding Assumptions

The FY09 application is based on the assumption that the funding level will be at least equal to the FY08 grant award of \$1,981,709. The programs funded by the PHHSBG will operate on the federal fiscal year. Any PHHSBG funding changes will be made under the advisement of the PHHS Advisory Committee and in full compliance with applicable state and federal law. Implementation of Virginia's FFY09 prevention programs that are funded with PHHSBG will be contingent upon receipt of level funding for FFY09.

Funding Rationale: Under or Unfunded, Data Trend

Statutory Information

Advisory Committee Member Representation:

College and/or university, Community health center, Community resident, County and/or local health department, Dental organization, Faith-based organization, Hospital or health system, State health department, State or local government, Transportation organization, Youth serving organization

Dates:

Public Hearing Date(s):

11/20/2008

Advisory Committee Date(s):

6/3/2008

11/20/2008

Current Forms signed and attached to work plan:

Certifications: Yes

Certifications and Assurances: Yes

Budget Detail for VA 2009 V0 R1

Total Award (1+6)	\$2,072,317
A. Current Year Annual Basic	
1. Annual Basic Amount	\$1,898,978
2. Annual Basic Admin Cost	(\$180,837)
3. Direct Assistance	\$0
4. Transfer Amount	\$0
(5). Sub-Total Annual Basic	\$1,718,141
B. Current Year Sex Offense Dollars (HO 15-35)	
6. Mandated Sex Offense Set Aside	\$173,339
7. Sex Offense Admin Cost	(\$17,333)
(8.) Sub-Total Sex Offense Set Aside	\$156,006
(9.) Total Current Year Available Amount (5+8)	\$1,874,147
C. Prior Year Dollars	
10. Annual Basic	\$0
11. Sex Offense Set Aside (HO 15-35)	\$0
(12.) Total Prior Year	\$0
13. Total Available for Allocation (5+8+12)	\$1,874,147

Summary of Funds Available for Allocation	
A. PHHSBG \$'s Current Year:	
Annual Basic	\$1,718,141
Sex Offense Set Aside	\$156,006
Available Current Year PHHSBG Dollars	\$1,874,147
B. PHHSBG \$'s Prior Year:	
Annual Basic	\$0
Sex Offense Set Aside	\$0
Available Prior Year PHHSBG Dollars	\$0
C. Total Funds Available for Allocation	\$1,874,147

Summary of Allocations by Program and Healthy People 2010 Objective

Program Title	Health Objective	Current Year PHHSBG \$'s	Prior Year PHHSBG \$'s	TOTAL Year PHHSBG \$'s
Adult and Older Adult Dental Program	21-2 Untreated dental decay	\$110,000	\$0	\$110,000
Sub-Total		\$110,000	\$0	\$110,000
CHAMPION	19-2 Obesity in adults	\$175,000	\$0	\$175,000
	19-3 Overweight or obesity in children and adolescents	\$175,000	\$0	\$175,000
Sub-Total		\$350,000	\$0	\$350,000
Chronic Disease Prevention and Control for Healthy Communities	7-10 Community health promotion programs	\$325,000	\$0	\$325,000
Sub-Total		\$325,000	\$0	\$325,000
Chronic Disease Self-Management Program	7-10 Community health promotion programs	\$70,000	\$0	\$70,000
Sub-Total		\$70,000	\$0	\$70,000
Community Water Fluoridation	21-9 Community water fluoridation	\$25,000	\$0	\$25,000
Sub-Total		\$25,000	\$0	\$25,000
Dental Disease Reduction Program	21-1 Dental caries experience	\$245,000	\$0	\$245,000
Sub-Total		\$245,000	\$0	\$245,000
Dental Sealant Project	21-8 Dental sealants	\$50,000	\$0	\$50,000
Sub-Total		\$50,000	\$0	\$50,000
Injury Prevention	15-13 Unintentional injury deaths	\$350,000	\$0	\$350,000
Sub-Total		\$350,000	\$0	\$350,000
OFHS Research and Analysis - Surveillance Program	23-5 Data and Information systems	\$103,141	\$0	\$103,141
Sub-Total		\$103,141	\$0	\$103,141
Sexual Assault Intervention and Education Program	15-35 Rape or attempted rape	\$156,006	\$0	\$156,006
Sub-Total		\$156,006	\$0	\$156,006
Virginia Suicide Prevention Program	18-1 Suicide	\$90,000	\$0	\$90,000
Sub-Total		\$90,000	\$0	\$90,000
Grand Total		\$1,874,147	\$0	\$1,874,147

State Program Title: Adult and Older Adult Dental Program

State Program Strategy:

Program Goal: The Adult and Older Adult Dental Program is designed to improve access to dental services for the adult and older adult, especially those adults who are indigent or in nursing homes.

Program Health Priority: Priority dental public health concerns include the prevalence and severity of oral diseases and disorders, their potential impact on general health and well-being, and the significant disparities related to health and health care. Oral health data collection and reporting, and access enhancement efforts, have focused primarily on children. However, profound oral health and oral health care access disparities also exist for adult minority, low income and low education populations, and individuals who are physically and medically impaired, elderly, homeless or homebound. Adults who suffer from poor oral health are more likely to experience poor overall health with a reduced quality of life compared to adults who maintain good oral health. There also appears to be a link between periodontal disease and increased risk of preterm birth and low birthweight.

Primary Strategic Partners: The partnerships that are critical for these projects to succeed include those with other agencies, internal and external, that deal with the oral health issues of the elderly. Those partners include the Virginia Association of Area Agencies on Aging, local nursing home facilities that will pilot these projects, Richmond City Health Department, Department of Juvenile Justice, Vernon J. Harris Community Health Center, Richmond Redevelopment and Housing Authority, and the Virginia Dental Association (VDA). The Office of Family Health Services Research and Evaluation Team will be a partner in the assessment and evaluation portion of this project.

Evaluation Methodology: Survey questions will be reviewed by the OFHS Research and Evaluation Team, as well as through technical assistance from the Association of State and Territorial Dental Directors (ASTDD). Response rates will be used to help determine the validity of the survey results.

In preparation for the development of training materials, including a video for nursing staff, trainings from other states have been studied, in addition to conducting focus groups at three nursing homes. The proposed training packet will contain goals and objectives, and a pre and post test will be required.

The oral health aide project will be evaluated through surveying the facility regarding a number of short term outcome measures including the number of residents with improved oral health care, improved patient and family satisfaction, and a decrease in emergency room visits to assess dental issues. Prior to commencing the project, a clinical survey of a sample of residents will be conducted using the Oral Hygiene Index (OHI), a method for classifying the oral hygiene status of a patient. The OHI can be used over time to monitor progress in corrective interventions, and will be conducted at the end of the pilot. Finally, health professionals (physicians and dentists) who work with specific nursing homes will also be surveyed as to the effectiveness of the training and aide program and how it has benefited their patients.

State Program Setting:

Senior residence or center

FTE's (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Title: Dental Assistant

State-Level: 0% Local: 50% Other: 0% Total: 50%

Position Title: Dentist

State-Level: 0% Local: 20% Other: 0% Total: 20%

Position Title: Nurses Aide

State-Level: 0% Local: 80% Other: 0% Total: 80%

Total Number of Positions Funded: 3

Total FTE's Funded: 1.50

National Health Objective: HO 21-2 Untreated dental decay

State Health Objective(s):

Between 10/2008 and 09/2009, increase the number of nursing home residents receiving dental services by 1,000.

Baseline:

According to the most recent national survey data, 27% of adults aged 35 to 44 years had untreated dental decay in 1998–2004. According to the National Nursing Home Survey, only 19% of all nursing home residents received dental services in 1997.

Data Source:

National nursing home survey

State Health Problem:

Health Burden:

Throughout the past decades, there have been significant improvements in the oral health status of American adults. Through the implementation of community fluoridation and prevention efforts, the prevalence of dental disease has declined among the adult population. Compared to previous generations, a higher percentage of adults are maintaining their natural teeth, especially among older adults. In fact, the prevalence of complete tooth loss (edentulism) has significantly decreased during the past twenty years from 33% to 20% among 55-64 year old adults and from 2% to 0.4% among younger adults 18-34 years. Despite these successes in adult oral health, not all adults have benefited from advances in oral health care and dental disease prevention efforts. As a result, adverse oral health outcomes continue to persist in the adult population, creating additional challenges for further reducing the prevalence of dental disease for all adults. Furthermore, adults who suffer from poor oral health are also more likely to experience decrements to their overall health with a reduced quality of life compared to adults who maintain good oral health. Therefore, public health strategies need to identify and address health disparities among the population in order to effectively improve the oral health needs of all adults.

According to the 2000 Surgeon General report, most U.S. adults experience signs of gum disease and untreated tooth decay, which persists predominantly among adults of low-socioeconomic (SES) status. Oral health is an integral component of total wellness. The importance of oral health was spotlighted with the release of *Oral Health in America: A Report of the Surgeon General*, in 2000. This report focused on the oral health of all Americans and was the first of its kind to show the mouth as the "mirror for general health and well-being". The report reminded us all that oral health meant more than just sound teeth and that "Ignoring oral health problems can lead to needless pain and suffering, complications that can devastate well-being and financial and social costs that significantly diminish quality of life and burden American society". In recent years, researchers have found more and more evidence linking bacteria in the mouth to many systemic conditions. For example, while the direct link between oral bacteria and heart disease and stroke is unknown, people with gum disease are twice as likely to have certain types of heart disease and people diagnosed with acute cerebrovascular ischemia were found more likely to have an oral infection when

compared to those in control groups. People with diabetes are more likely to have periodontal disease than people without diabetes. In fact, periodontal disease is often considered the sixth complication of diabetes, causing bone and tissue loss at a greater rate and making the diabetic condition harder to control.

While slightly less than two-thirds of American adults reported visiting a dentist within the past year, adults of lower SES status were even less likely to receive an annual dental visit compared to adults of higher SES. As a result, low SES populations are less likely to benefit from the early detection of oral health problems and prophylaxis treatment. These findings are consistent with those of the Virginia BRFSS.

Dental insurance status is perhaps the most salient predictor of oral health care access, including annual visits to the dentist. However, the percentage of adults with dental coverage is lower compared to the proportion of adults who receive medical insurance. Socioeconomic status and race/ethnicity are significant factors related to dental care access among American adults. Adults with low educational attainment (less than a high school education) and those living below the poverty level were least likely to visit the dentist within the previous year. Gender and race/ethnicity were also important factors related to dental care access as females and white, non-Hispanic adults were more likely to report an annual dental visit compared to adult males and minorities.

Age is affiliated with utilization of dental services. With increasing age, there is a decline in the percentage of older adults who access dental services. This is despite the demonstrated need for care among the elderly. In fact, as the U.S. population has aged, there has been a resultant increase in the decay rate in older adults such that persons aged 65 years and older have more decay than children less than 14 years who live in an area with nonfluoridated water. Furthermore, the elderly are more likely to experience oral health complications that require extensive treatment compared to younger adults.

Additionally, in the most recent national survey (NHANES III), nearly half of all individuals aged 75 years or older had root caries on one or more teeth. A comparison of NHANES I and NHANES III—for which data were collected in 1971–1974 and 1988–1994, respectively—reveals that the percentage of teeth with caries (treated or untreated) decreased for individuals between the ages 18 and 54 years but increased for those between the ages of 55 and 74 years. The progression of root caries in an individual with little or no saliva can be quite rapid, and the restoration of these lesions is often technically challenging.

“A State of Decay - The Oral Health of Older Americans”, released in 2003 by Oral Health America, provides evidence of a crisis among the elderly with regard to oral health. In this report, Virginia received a failing grade of “F” for dental coverage of older Americans, highlighting the need for increased access to oral health services for these individuals. Other reports, such as the Centers for Disease Control and Prevention (CDC) “The Oral Health of Older Americans,” document the unmet oral health needs of older adults nationally.

Oral health problems in older adults can affect overall well being, ability to eat, nutritional status, and the incidence of certain systemic infections such as aspiration pneumonia. Residents of institutions face additional barriers to obtaining dental services. Often, residents have multiple chronic diseases, take medications that affect their oral health, or have diseases or disabilities that make brushing and flossing their teeth difficult or impossible. Virginia BRFSS data shows an increase in the prevalence and severity of tooth loss with increasing age. While approximately 10% of 18 to 24 year old adults reported at least one missing tooth as a result of tooth decay or gum disease, 80% of adults over the age of 64 years had experienced tooth loss. As anticipated, loss of all teeth was predominately concentrated among the elderly population.

Nearly 17% of all Virginia adults restrict foods because of the condition of their teeth. This problem becomes more prevalent in the elderly whose nutritional status is of vital importance to maintaining overall health.

Target Population:

Number: 886,574

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: Yes

Disparate Population:

Number: 32,000

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: Yes

Location: Entire state

Target and Disparate Data Sources: U.S. Census Bureau

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: Best practices from the Association of State and Territorial Dental Directors

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$110,000

Total Prior Year Funds Allocated to Health Objective: \$0

Funds Allocated to Disparate Populations: \$110,000

Funds to Local Entities: \$110,000

Role of Block Grant Dollars: No other existing federal or state funds

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

100% - Total source of funding

ESSENTIAL SERVICES –OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Essential Service 7 – Link people to services**Objective 1:****Increase access to oral health services**

Between 10/2008 and 09/2009, Dental Division staff will increase the number of adults and older adults that have access to oral health services from 19% to 25%.

Annual Activities:**1. Complete development of a training DVD and provide training**

Between 12/2008 and 09/2009, Dental Division staff will complete development of a training DVD targeted at approximately 300 nursing homes statewide to improve oral health assessment and care for the residents of

those facilities. Staff will provide training for nursing home staff at targeted facilities (30) in addition to the DVD to compare utilization of training information and evaluate.

2. Nursing aide project

Between 12/2008 and 09/2009, Dental Division staff will continue nursing aide project at Lucy Corr Nursing Home for 150 residents. Add one additional nursing home in a rural area to the program. Complete evaluations and open mouth surveys.

3. Develop pilot denture program.

Between 07/2009 and 09/2009, Develop pilot denture programs for edentulous low-income seniors without insurance in two health districts.

4. Provide dental visits.

Between 07/2009 and 09/2009, Provide 50 dental visits for seniors who qualify for the pilot program for complete dentures.

State Program Title: CHAMPION

State Program Strategy:

Program Goal(s): CHAMPION's program goals include the following:

1. Prevention and control of obesity and other related risk factors through Virginians making healthy food choices and increasing physical activity;
2. Promotion of policy and environmental changes that support obesity prevention;
3. The reduction in prevalence and incidence of overweight and obesity levels among Virginians reached through increasing community lead interventions and programs; and
4. The promotion of breastfeeding as a proven obesity prevention strategy.

Program Health Priority: The obesity epidemic continues to be one of the most urgent health problems facing Virginia today. The prevalence of overweight and obesity in the Commonwealth has increased steadily. Data from the Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System (BRFSS) reveals that from 1996 to 2007 the percentage of Virginia adults who were considered obese went from 15.9 percent in 1996 to 25.3 percent in 2007. Presently, nearly 62 percent of Virginia adults are considered either overweight or obese.

Health behavior is complex and is influenced by a variety of factors. Interventions that address individual behavior along with social and physical environments can have population-wide impact. The key to prevention and treatment of obesity in Virginia will be to bring changes from many directions, at multiple levels, and through collaboration within and between many groups. This social-ecological approach encompasses multiple levels of risk factors and health determinants: individuals, families and social networks, cultural characteristics including social and cultural norms and cultural differences, communities, systems of services, the built and natural environments, laws and political processes, and the interactions and reciprocal influences among them.

The Department of Health and the Division of WIC and Community Nutrition Services (DWCNS) has embarked on a community-driven approach to address the growing overweight and obesity problem in Virginia through the creation of the Commonwealth's Healthy Approach and Mobilization Plan for Inactivity, Obesity and Nutrition (CHAMPION). CHAMPION is a unique strategy that concentrates on encouraging and supporting individual and community empowerment and ownership of overweight and obesity prevention. In 2005, approximately 900 Virginians participated in nine separate regional and issue-specific meetings. The regional meetings were a forum for participants to provide input on community strategies and ideas for combating the obesity epidemic in their communities. The CHAMPION Report, a state summary of the CHAMPION Regional meetings, was released by Governor Kaine in October 2006. National, state, and local nutrition and physical activity campaigns, programs, and policy options have been researched for consideration in the CHAMPION Obesity Prevention Plan. Currently, a draft of the CHAMPION Obesity Prevention Plan is completed and is being reviewed at the office level.

It is the intent of CHAMPION Obesity Prevention Plan to equally target adults and children through obesity-focused programs and initiatives. The completion CHAMPION Obesity Prevention Plan will determine the number of adult-focused and children-focused obesity programs. Also, with CHAMPION's community-driven approach, communities throughout the Commonwealth will determine the age-focus of their obesity prevention efforts. The current list of recommended obesity prevention programs includes programs targeting children and adolescents as well as adults and seniors to ensure that all age groups are included in the CHAMPION Obesity Prevention Plan. Based on the number of adult-focused and children-focused programs recommended, it is estimated that approximately 60% of the budget allocated for

local entities will be targeted toward childhood obesity and approximately 40% will be targeted toward adult obesity.

Program Primary Strategic Partners: The Division of WIC and Community Nutrition Services (DWCNS), which houses CHAMPION, has fostered a number of collaborative relationships and strategic partnerships both internally and externally. CHAMPION's primary strategic partnerships include the Maternal Child Health Block Grant (MCH), Preventive Health and Health Services Block Grant (PHHS), Virginia Women, Infants and Children (WIC) Program, and Governor Kaine's *Healthy Virginians* initiative.

Program Evaluation Methodology: The CDC Framework for Program Evaluation will be used to evaluate the implementation of the CHAMPION Obesity Prevention initiative. Surveillance data from the CDC Behavioral Risk Factor Surveillance System (BRFSS), The Pediatric Nutrition Surveillance System (PedNSS), CDC Pregnancy Risk Assessment Monitoring System (PRAMS) and WIC will be used to evaluate the programs progress towards the overall program goal of the prevention and control of overweight and obesity in Virginia. CHAMPION recommended programs include a program evaluation instrument for communities to assess outcomes at the community level. Funded and non-funded participating communities will be required to submit an evaluation summary report to DWCNS, allowing opportunity for aggregated data collection of local projects.

State Program Setting:

Business, corporation or industry, Child care center, Community based organization, Community health center, Faith based organization, Home, Local health department, Medical or clinical site, Parks or playgrounds, Schools or school district, Senior residence or center, State health department, Tribal nation or area, University or college, Work site

FTE's (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

- Position Title:** Obesity Prevention Coordinator
State-Level: 50% Local: 0% Other: 0% Total: 50%
- Position Title:** Obesity Prevention Dietitian
State-Level: 0% Local: 50% Other: 0% Total: 50%
- Position Title:** Physical Activity Coordinator
State-Level: 50% Local: 0% Other: 0% Total: 50%
- Position Title:** Division Director
State-Level: 10% Local: 0% Other: 0% Total: 10%
- Position Title:** Nutrition Services Manager
State-Level: 10% Local: 0% Other: 0% Total: 10%
- Position Title:** Technology Manager
State-Level: 10% Local: 0% Other: 0% Total: 10%
- Position Title:** Policy Analyst
State-Level: 20% Local: 0% Other: 0% Total: 20%

Total Number of Positions Funded: 7

Total FTE's Funded: 2.00

National Health Objective: HO 19-2 Obesity in adults

State Health Objective(s):

Between 10/2008 and 06/2010, reduce the rate of obese adults to 20% and rate of overweight adults to 30%.

Baseline:

Data from the CDC BRFSS reveals that 62 percent of Virginia adults are considered either overweight or obese with 36.6% of Virginia adults being obese and 25.3% of Virginia adults being overweight.

Data Source:

Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System (BRFSS)

State Health Problem:

Health Burden:

Obesity is considered an individual clinical condition; however it is now recognized as a public health threat because of its detrimental health impact on American communities. Obesity and overweight have been shown to increase an individual's risk of many diseases and health conditions, including hypertension, osteoarthritis, high cholesterol, type 2 diabetes, coronary heart disease, stroke, gallbladder disease, sleep apnea, respiratory problems and some cancers.

Overweight and obesity rates in Virginia have increased significantly among adults over the last two decades. Poor diet and physical inactivity are the two most important contributing factors. In addition to increasing rates of overweight and obesity, disparities continue to exist. When analyzed by race and ethnicity, BRFSS data reveals that 37.3 percent of Black, Non-Hispanic Virginians and 25.3 percent of Hispanic Virginians are considered obese¹. When examining Virginia obesity trends by gender, data indicates 26 percent of males are considered obese and 24.5 percent of adult females are considered obese¹. Data also reveals that in Virginia, 43.9 percent of males are considered overweight and 29.4 percent of adult females are considered overweight¹.

A 2003 VDH study revealed that 50.6% of Virginians reported that they are not getting the daily allotment of recommended physical activity and 22.1% reported not engaging in any physical activity in the past month. Additionally, 74.2% of Virginians reported that they consumed less than five servings of fruits and vegetables a day.

In 2006, Virginia received a C grade in our efforts to control obesity from the University of Baltimore Obesity Report Card. This was an improvement from receiving a D grade in obesity control. Virginia is moving in the right direction addressing our obesity problem; however there is much more work to be done. Continuing programs that promote healthy eating and physical activity is essential in reducing overweight and obesity in Virginia.

Target Population:

Number: 5,340,253

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Disparate Population:

Number: 1,649,027

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Specific Counties
Target and Disparate Data Sources: 2000 Census Bureau, bridged race population estimates; 2005 National Center for Health Statistics

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

CDC Recommends: The Prevention Guidelines System (Centers for Disease Control and Prevention)
Guide to Community Preventive Services (Task Force on Community Preventive Services)
MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

Other: Healthy People 2010

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$175,000
Total Prior Year Funds Allocated to Health Objective: \$0
Funds Allocated to Disparate Populations: \$7,285
Funds to Local Entities: \$60,000
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
75-99% - Primary source of funding

ESSENTIAL SERVICES –OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Essential Service 4 – Mobilize Partnerships

Objective 1:

Develop community reengagement conferences

Between 10/2008 and 09/2009, the Division of WIC and Community Nutrition Services, Obesity Prevention Team will develop 2 community reengagement conferences to promote the CHAMPION obesity prevention plan.

Annual Activities:

1. Hold reengagement conferences

Between 10/2008 and 09/2009, hold reengagement conferences to discuss community specific recommendations. At the conclusion of the conferences, attendees will be able to determine which programs to pursue for implementation in their communities through mini-grant funding.

Objective 2:

Provide 10 community mini-grants

Between 10/2008 and 09/2009, the Division of WIC and Community Nutrition Service, Obesity Prevention Team will increase the number of programs focused on obesity prevention implemented in communities through the CHAMPION obesity prevention program from 0 programs to 10 programs.

Annual Activities:

1. Completion of program evaluations and data collection for the mini-grant cycle

Between 10/2008 and 09/2009, provide training and technical assistance that focus on program areas, data collection, and program evaluation to mini-grant recipients.

National Health Objective: HO 19-3 Overweight or obesity in children and adolescents

State Health Objective(s):

Between 10/2008 and 06/2010, reduce the rate of overweight children to 12% and children at risk for becoming overweight to 15%.

Baseline:

Data from PedNSS reveals for Virginia 17% of children are considered overweight. According to data based on the July 2008 enrollment in the Virginia WIC program, 19 percent of children ages 2-5 who participate in the program are overweight and 15% are “at risk” for overweight.

Data Source:

Pediatric Nutrition Surveillance System (PedNSS), 2008 Virginia Department of Health WICNet Data

State Health Problem:

Health Burden:

Obesity is associated with significant health problems in the pediatric age group and is an early risk factor for adult morbidity and mortality. Overweight and obesity rates in Virginia have increased significantly among children over the last two decades.

For Virginia, PedNSS data reveals that 17 percent of children ages 2-5 are considered overweight. According to data based on the July 2008 enrollment in the Virginia WIC program, 19 percent of children ages 2-5 who participate in the program are overweight and 15 percent are “at risk” for overweight. A 2003 VDH study revealed that 46-48% of children reported not participating in physical education or recess. Additionally, 74.2% of Virginians reported that they consumed less than five servings of fruits and vegetables a day.

In 2006, Virginia received a C grade in our efforts to control childhood overweight prevalence from the University of Baltimore Obesity Report Card. This was an improvement from receiving an F grade in 2004 for childhood overweight. Virginia is moving in the right direction addressing our obesity problem; however there is much more work to be done. Nutrition and physical activity habits established early in life impact the risk of developing obesity in childhood and adulthood. Continuing programs that promote healthy eating and physical activity is essential in reducing overweight and obesity in Virginia.

Target Population:

Number: 1,738,262

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Disparate Population:

Number: 537,634

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Specific Counties
Target and Disparate Data Sources: 2000 U.S. Census Bureau, bridged race population estimates; 2005 National Center for Health Statistics

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

CDC Recommends: The Prevention Guidelines System (Centers for Disease Control and Prevention)
Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)
MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

Other: Healthy People 2010

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$175,000
Total Prior Year Funds Allocated to Health Objective: \$0
Funds Allocated to Disparate Populations: \$7,285
Funds to Local Entities: \$90,000
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
75-99% - Primary source of funding

ESSENTIAL SERVICES –OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Essential Service 4 – Mobilize Partnerships

Objective 1:

Community reengagement conferences

Between 10/2008 and 09/2009, the Division of WIC and Community Nutrition Services, Obesity Prevention Team will develop 2 reengagement conferences to promote the CHAMPION obesity prevention plan.

Annual Activities:

1. Hold reengagement conferences

Between 10/2008 and 09/2009, hold reengagement conferences to discuss community specific recommendations. At the conclusion of the conferences, attendees will be able to determine which programs to pursue for implementation in their communities through mini-grant funding.

Objective 2:

Fund up to 10 community programs

Between 10/2008 and 09/2009, the Division of WIC and Community Nutrition Services, Obesity Prevention Team will increase the number of programs focused on obesity prevention implemented in communities through the CHAMPION obesity prevention program from 0 to 10.

Annual Activities:

1. Completion of program evaluations and data collection

Between 10/2008 and 09/2009, provide training and technical assistance that focus on program areas, data collection, and program evaluation to mini-grant recipients.

State Program Title: Chronic Disease Prevention and Control for Healthy Communities

State Program Strategy:

Program Goal: To reduce occurrences, disabilities, and deaths due to chronic diseases in Virginia.

Program Health Priority: Chronic diseases are a major contributor to the premature death and disability of American adults. Not only does chronic diseases account for 70 percent of all deaths in the United States but more than 90 million Americans (about 30 percent of the U.S. population) live with chronic illnesses. An estimated 2.2 million Virginians live with a chronic disease.

Modifiable behaviors that contribute to the development and/or complications of major chronic diseases include: physical inactivity, healthy weight maintenance, and use of tobacco products. In addition, improper care of an existing health condition such as high blood pressure or diabetes can lead to co-morbidity of chronic diseases.

The Division of Chronic Disease Prevention and Control will provide resources, public and professional education, consultation, and public health leadership related to the reduction of the burden of chronic diseases. This assistance will be provided to health districts, community agencies, and other health care professionals in Virginia.

Initiatives focus on improved health status for those at high risk for development of chronic diseases. Activities include conducting community assessments; developing behavior change strategies for risk reduction (nutrition, physical inactivity, and smoking); and providing professional education and training in support of risk reduction activities. A strong chronic disease prevention program supports promoting healthy behaviors, expanding the use of early detection practices, providing health education in community, school and worksite settings, and working to develop healthy communities

Program Primary Strategic Partners:

Internal - Asthma Control Project; Comprehensive Cancer Control Project; Heart Disease and Stroke Prevention Project; Diabetes Prevention and Control Project; Virginia Cancer Registry; Tobacco Use Control Project; Virginia Chronic Disease Self Management Program; Office of Minority Health and Health Policy.

External - Health Pathways Coalition; Virginia Diabetes Council; Local Tobacco Control Coalitions; Virginia Cancer Plan Action Coalition Virginia Asthma Coalition; local health districts; private, non-profits health agencies.

Program Evaluation Methodology: The division follow CDC's format for program evaluation, using formative evaluation including needs assessments, monitoring processes such as process indicators, reports, and surveys, and tracking short-term (e.g. adoption of policies, environmental changes) and long term outcomes using data sources such as the Behavioral Risk Factor Surveillance System (BRFSS), hospital discharge and morbidity data.

State Program Setting:

Business, corporation or industry, Community based organization, Faith based organization, State health department

FTE's (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHS Block Grant funds.

Position Title: Division Director
State-Level: 55% Local: 5% Other: 0% Total: 60%
Position Title: Program Supervisor
State-Level: 18% Local: 2% Other: 0% Total: 20%
Position Title: Special Project Manager
State-Level: 45% Local: 5% Other: 0% Total: 50%
Position Title: Health Disparities Specialist
State-Level: 18% Local: 2% Other: 0% Total: 20%
Position Title: Administrative Specialist
State-Level: 90% Local: 10% Other: 0% Total: 100%

Total Number of Positions Funded: 5
Total FTE's Funded: 2.50

National Health Objective: HO 7-10 Community health promotion programs

State Health Objective(s):

Between 10/2008 and 09/2009, maintain the capacity of the Virginia Department of Health, local health districts, community agencies, and health partner agencies to conduct chronic disease prevention activities aimed at reducing the burden of chronic diseases.

Baseline:

The division currently serves 120 partner agencies (including coalitions workgroups, non-governmental groups), 158 cancer-reporting facilities, and 20 health districts.

Data Source:

Chronic Disease projects' reports; Virginia Cancer Registry; and contact tracking system.

State Health Problem:

Health Burden:

In Virginia, heart disease, cancer, and stroke are the top three leading causes of death and diabetes is the sixth leading cause of death as cited in the Virginia Vital Statistics Report. These chronic diseases form the cornerstone for a comprehensive chronic disease prevention program

Results from the 2006 Behavioral Risk Factor Surveillance Survey show that 61.8 percent of respondents would be at risk for health problems related to being overweight or obese; 21.7 percent of respondents had not participated in any physical activity during the past month; and 19.3 percent smoke.

The cost of people with chronic diseases account for more than 75 percent of the nation's medical-care costs and chronic diseases account for one third of the years of potential life lost before age 65. For Virginia, the costs of chronic disease exceed \$24.6 billion.

Target Population:

Number: 1,003,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:

Number: 9,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: U.S. Census Bureau

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

CDC Recommends: The Prevention Guidelines System (Centers for Disease Control and Prevention) Guide to Community Preventive Services (Task Force on Community Preventive Services)
MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

Other: Recommendations by the National Association of Chronic Disease Directors

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$325,000
Total Prior Year Funds Allocated to Health Objective: \$0
Funds Allocated to Disparate Populations: \$100,000
Funds to Local Entities: \$0
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

ESSENTIAL SERVICES –OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Essential Service 3 – Inform and Educate

Objective 1:

Maintain community partners/coalitions

Between 10/2008 and 09/2009, the Division of Chronic Disease Prevention and Control staff will maintain 6 community partners/coalitions working to increase healthy behaviors (including early screening and /or self management for chronic diseases) in the areas of physical activity, tobacco use control, and healthy weight through planned, coordinated, evidence-based, and community-based practices.

Annual Activities:

1. Conduct research for local health districts

Between 10/2008 and 09/2009, conduct research and coordinate obtaining educational and implementation resources for local health districts and partner agencies.

2. Develop surveillance data

Between 10/2008 and 09/2009, initiate the development of a list of accessible surveillance data and evaluation sources and identify system gaps.

3. Update health indicators

Between 10/2008 and 09/2009, update and distribute chronic disease health indicators by health district.

4. Chronic disease report

Between 10/2008 and 09/2009, develop a plan for analysis, writing, and distributing a 2009 chronic disease issue highlight report.

5. Partner to expand chronic disease interventions

Between 10/2008 and 09/2009, partner with categorical funded projects to coordinate and expand chronic disease interventions into Virginia worksites.

Objective 2:

Provide key chronic disease prevention and control messages

Between 10/2008 and 09/2009, the Division of Chronic Disease Prevention and Control staff will increase the number of health districts and partner agencies routinely using division resources for chronic disease education and interventions from 4 health districts and 6 partner agencies to 5 health districts and 10 partner agencies.

Annual Activities:

1. Develop marketing strategies

Between 10/2008 and 09/2009, continue to develop marketing strategies to coordinate chronic disease resources and key messages.

2. Promote chronic disease prevention message

Between 10/2008 and 09/2009, continue to promote the message, "Chronic Disease Prevention: You Can", through web-based technology and media outlets in Virginia.

3. Develop outreach materials

Between 10/2008 and 09/2009, continue to develop outreach materials for health disparate populations including older adults regarding risks for chronic diseases and healthy aging.

4. Publish report

Between 10/2008 and 09/2009, the Division's *What's Happening Report* is published and distributed on a quarterly basis.

5. Promote resources

Between 10/2008 and 09/2009, continue to promote the Division as a resource using the theme "You Can... contact us."

Essential Service 4 – Mobilize Partnerships

Objective 1:

Continue the development of partnerships within VDH and with other organizations

Between 10/2008 and 09/2009, the Division of Chronic Disease Control and Prevention staff will maintain 6 partnerships within VDH and with other organizations that support the reduction of chronic disease in Virginia.

Annual Activities:

1. Implement ManyOne partnership activity

Between 10/2008 and 09/2009, based on the findings of the partnership survey, the ManyOne Partnership Team will continue to implement at least one activity designed to increase understanding of and opportunities for internal partnering within the division.

2. Promote chronic disease self management

Between 10/2008 and 09/2009, explore ways to promote chronic disease self-management and living healthy lives with chronic conditions among partner agencies.

Essential Service 8 – Assure competent workforce

Objective 1:

Increase the number of partner agencies using evidence-based strategies

Between 10/2008 and 09/2009, the Division of Chronic Disease and Control staff will increase the number of local health district staff, central office staff, and community partners using evidence-based strategies and best practices in chronic disease reduction from six partner agencies to twelve partner agencies.

Annual Activities:

1. Update web site

Between 10/2008 and 09/2009, update web site with Chronic Disease Prevention and Control Program Guides and Best Practices reports.

2. Chronic disease prevention and control training

Between 10/2008 and 09/2009, plan, conduct, and evaluate state chronic disease prevention and control training for community project coordinators and partner agencies with a projected audience of at least 75 professionals.

3. Promote use of evidence-based curriculums

Between 10/2008 and 09/2009, the ManyOne training team will begin to identify and promote use of evidence-based, chronic disease prevention training curriculums.

Objective 2:

Increase knowledge, skills, and abilities of health promotion staff

Between 10/2008 and 09/2009, the Division of Chronic Disease Control and Prevention staff will increase the number of programs and people participating in educational opportunities working in the field of health promotion and chronic disease prevention and control from 6 programs/252 people to 6 programs/350 people.

Annual Activities:

1. Professional education and continuing education units

Between 10/2008 and 09/2009, continue to provide support for professional education opportunities and continuing education units for certified health education specialists (CHES) within the state.

2. Participation in ASTHO and ASTDHPPE

Between 10/2008 and 09/2009, continue to participate in the activities/events of the Association of State and Territorial Health Officials (ASTHO) and the Association of State and Territorial Directors of Health Promotion and Public Health Education (ASTDHPPE), which provides information and linkages to funding sources, national directives for chronic disease and health promotion, and guidance on emerging issues for these areas.

3. Support and document the division's collaborative model

Between 10/2008 and 09/2009, provide support and documentation of the Division's collaborative model to other states and organizations to assist in improving collaborative processes.

Essential Service 9 – Evaluate health programs

Objective 1:

Provide consultation, educational strategies, and resources

Between 10/2008 and 09/2009, the Division of Chronic Disease Prevention and Control staff will maintain 6 state coalitions and 22 local coalitions of Virginia health professionals that use chronic disease data reports.

Annual Activities:

1. Provide consultation and technical assistance

Between 10/2008 and 09/2009, continue to provide consultation and technical assistance to health districts and community agencies to improve project implementation, cultural competency skills, and evaluation of services that focus on risk reduction for chronic disease in Virginia.

2. Strategic plan implementation

Between 10/2008 and 09/2009, begin implementation of state chronic disease prevention and control strategic plan.

3. Upgrade chronic disease prevention data

Between 10/2008 and 09/2009, continue to upgrade the chronic disease prevention data and evaluation collection systems and work with local health districts in utilizing data from this system.

4. Update statistical sources

Between 10/2008 and 09/2009, review current statistical sources (BRFSS, mortality and hospital discharge) and update statistics used by chronic disease prevention project areas to reflect currently available data sources.

State Program Title: Chronic Disease Self-Management Program

State Program Strategy:

Program Goal: To implement the CDSMP in the Commonwealth based on identified need, by training personnel in interested health districts and other agencies/organizations who work with populations of adults living with a chronic disease.

Program Health Priority: The CDSMP has three main priorities: 1) to assist adults who are living with a chronic disease in managing the day-to-day issues of the disease; 2) to assist patients in taking responsibility for the management of their disease; and 3) to increase knowledge and skills of patients living with a chronic disease to improve overall health and decrease utilization of health care resources.

Program Primary Strategic Partners: Stanford University, Virginia Diabetes Council, Health Promotion for People with Disabilities Task Force, Carilion Health System, Healthy Pathways Coalition, Virginia Arthritis Action Coalition, Virginia Asthma Coalition, Cancer Plan Action Coalition, local health districts, Area Agencies of Aging, Virginia Department on Aging.

Program Evaluation Methodology: The Division of Family and Community Medicine in the School of Medicine at Stanford University conducted the initial evaluation of the program through a randomized controlled trial. The study was completed in 1996, and has been replicated in Maryland, Florida, Vermont, Alaska and New York. Over 1,000 people with heart disease, lung disease, stroke or arthritis participated in a randomized, controlled test of the program, and were followed for up to three years. The following key components of effective condition management were assessed among program participants: health status (disability, social/role limitations, pain and physical discomfort, energy/fatigue, shortness of breath, psychological well-being/distress, depression, health distress, self-rated general health), health care utilization (visits to physicians, visits to emergency departments, hospital stays, and nights in hospital), self-efficacy (confidence to perform self-management behaviors, confidence to manage disease in general, confidence to achieve outcomes), and self-management behaviors (exercise, cognitive symptom management, mental stress management/relaxation, use of community resources, communication with physician, and advance directives).

The Division of Chronic Disease Prevention and Control utilizes the evaluation forms developed by Stanford University for the CDSMP. The coordinator will collect data from the different programs pre and post implementation to note successes. The coordinator will conduct site visits to the local programs to document program successes and barriers, and to assure program implementation fidelity.

State Program Setting:

Community based organization, Community health center, Faith based organization, Medical or clinical site, Senior residence or center, Tribal nation or area

FTE's (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Title: Chronic Disease Self Mgmt Program Coordinator
State-Level: 100% Local: 0% Other: 0% Total: 100%

Total Number of Positions Funded: 1

Total FTE's Funded: 1.00

National Health Objective: HO 7-10 Community health promotion programs

State Health Objective(s):

Between 10/2008 and 12/2010, increase the number of health districts that have an established community health promotion program that addresses multiple Healthy People 2010 focus area to eight.

Baseline:

Four health districts

Data Source:

Division of Chronic Disease Prevention and Control, Virginia Department of Health

State Health Problem:

Health Burden:

Chronic diseases are defined by the Centers for Disease Control and Prevention (CDC) as those diseases that are prolonged, do not resolve spontaneously, and for which a complete recovery is rarely achieved. Heart disease, cerebrovascular disease (also called stroke), cancer, asthma, diabetes, and arthritis, some of which are among the top ten leading causes of death in Virginia. All of these leading causes of death are impacted by risk factors such as lack of physical activity, improper nutrition, lack of physical activity, and stress. All of these risk factors are discussed in the CDSMP, with sessions devoted to information and resources needed to develop skills to reduce the risk and increase healthy lifestyle behaviors.

Chronic disease conditions are the major cause of illness, disabilities, and death in the United States. Approximately 90 million, or 30 percent, of the U.S. population has a chronic disease. This translates to an estimated 2.2 million Virginians living with a chronic disease. Chronic disease accounts for approximately 75 percent of the nation's \$1.4 trillion health care costs each year; for Virginia this would be approximately \$24.6 billion.

The 2006 Chronic Disease Data Report reveals:

- In Virginia, the estimated cost associated with arthritis-related hospitalization is over \$426 million.
- There were 29,934 hospitalizations in Virginia due to cancer in 2003, for total charges of \$704 billion. The average charge per stay was over \$27,000.
- Cardiovascular disease is the most costly chronic disease based on total hospitalization charges. In 2003, there were 111,933 hospitalizations with a primary diagnosis of a cardiovascular-related condition and a secondary diagnosis of diabetes, with estimated costs of \$165.8 million.

The target populations for the CDSMP are adults, in Virginia, living with a chronic disease. The program also targets persons caring for or living with an adult who has a chronic disease. Special emphasis will be placed on conducting CDSMP in areas of the Commonwealth where there are limited health care resources and access to care.

Special emphasis will be placed on conducting the CDSMP in areas of the Commonwealth where there are limited resources and access to care. Currently, the Lenowisco Health District is conducting the program in the Southwest part of the state, and staff will work to expand the program's implementation in this area. The CDSMP coordinator will target implementation of the program in areas of the Commonwealth which have a higher prevalence of heart disease, stroke, high blood pressure, diabetes and other chronic conditions, e.g. Crater, Cumberland Plateau, Eastern Shore, Mount Rogers, Norfolk, Piedmont, Richmond City and Southside Virginia. These health districts were chosen based on a review of the 2006 Chronic Disease Burden Report. That data indicates these areas to have a higher prevalence of many chronic conditions.

Target Population:

Number: 200

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Disparate Population:

Number: 100

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: Yes

Location: Specific Counties

Target and Disparate Data Sources: Chronic Disease Burden Report, 2006

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: The CDSMP was developed by researchers at Stanford University and is recognized as an evidence-based program. A complete report on the measures used and their psychometric properties can be found in Outcome Measures for Health Education and Other Health Care Interventions, by Lorig, Stewart, Ritter, González, Laurent and Lynch, 1996.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$70,000

Total Prior Year Funds Allocated to Health Objective: \$0

Funds Allocated to Disparate Populations: \$15,000

Funds to Local Entities: \$0

Role of Block Grant Dollars: No other existing federal or state funds

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

100% - Total source of funding

ESSENTIAL SERVICES –OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Essential Service 3 – Inform and Educate**Objective 1:****Increase knowledge and skills in self-management and self-efficacy**

Between 10/2008 and 09/2009, the Division of Chronic Disease Prevention and Control staff will conduct 8 CDSMP trainings and 16 workshops to trained personnel in health districts, community agencies, and

health partner agencies to assure that at least eighty percent of participants completing the training demonstrate a ten percent increase in knowledge and skills in self-management and self-efficacy.

Annual Activities:

1. Market and target CDSMP training

Between 10/2008 and 09/2009, contract with part-time CDSMP coordinator. Maintain license from Stanford University's licensing office. Market and target CDSMP training to staff in Crater, Cumberland Plateau, Eastern Shore, Mount Rogers, Norfolk, Piedmont, Richmond City, and Southside Health Districts due to their high rates of chronic disease (Chronic Disease in Virginia: A Comprehensive Data Report, 2006 Edition).

2. Conduct CDSMP classes

Between 10/2008 and 09/2009, request paperwork for course material distribution. Purchase required program materials. Conduct CDSMP classes and complete evaluation. Plan and conduct the leader's training. Analyze and report CDSMP evaluation results.

State Program Title: Community Water Fluoridation

State Program Strategy:

Program Goal: Because Virginia has met the 2010 objective, the goal of the Community Water Fluoridation (CWF) program is to maintain the number of Virginia's citizens served by optimal community water fluoridation.

Program Health Priority: The program priority is to link people to services. Approximately 5.7 million citizens are served by community water systems out of 6.9 million Virginians. The first system to fluoridate in Virginia was the Town of Fries, which initiated water fluoridation in June 1952. However, the majority of initiations of community water fluoridation occurred from 1970 to 1980. As such, the majority of the infrastructure of Virginia's fluoridated water systems is 20 to 30 years old. The next five years are projected to reflect increased requests for funding, as systems need to be upgraded to maintain their fluoridation status. Fluoridated water remains the most equitable and cost-effective method of delivering fluoride to members of a community, regardless of an individual's age, educational attainment or income level.

Primary Strategic Partners: Primary strategic partnerships for the CWF Program include the Virginia Department of Health Office of Drinking Water (ODW) and associated field offices, the Virginia Rural Water Association and local governments.

Evaluation Methodology: Evaluation methodology for the CWF program includes monitoring of fluoridated water systems through reviewing monthly fluoridation operational reports and inspection surveys of water treatment plants; collecting, interpreting, and compiling monthly fluoride operational reports of all fluoridated water systems; exporting data to the Centers for Disease Control and Prevention (CDC) Water Fluoridation Monitoring System (WRFS); and site visits to funded localities.

State Program Setting:

Local health department

FTE's (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0

Total FTE's Funded: 0.00

National Health Objective: HO 21-9 Community water fluoridation

State Health Objective(s):

Between 10/2008 and 09/2009, maintain the population served by community water systems with optimally fluoridated water in Virginia at 93.8%.

Baseline:

93.8% Virginia population receiving service from public water systems.

Data Source:

Virginia Water Fluoridation Reporting System

State Health Problem:

Health Burden:

Over the last half century, children's dental health has improved remarkably under the tandem of influences of fluoride and modern dental care. However, because of lack of access to preventive services, many children still suffer needlessly from dental diseases and conditions. Dental caries (tooth decay) remains the most common chronic disease among children. Only the common cold, the flu and ear infections occur more often among toddlers and young children. Tooth decay in children is four to five times more common than asthma, the second most common chronic disease. Chronically poor oral health is associated with failure to thrive in toddlers, compromised nutrition in children, and cardiac dysfunction or life threatening infections in adulthood. Poor oral health has also been related to decreased school performance and poor self-esteem.

Dental disease is now a chronic problem that disproportionately affects low-income populations. Eighty percent of tooth decay is now found in only 25% of school-age children. Dental surveys conducted in Virginia have consistently shown that children that participate in the free lunch program have higher decay levels than those children that do not participate in the program. This trend was confirmed in a statewide comprehensive dental survey recently conducted to determine the disease status of the teeth of school children in Virginia. In 1999, a total of 5,300 children from 204 schools were randomly selected to participate in the survey. All indicators of dental disease were higher in children who participated in the free lunch program. Surveys have been conducted in Virginia since the 1950's to ascertain the prevalence of dental disease. The results of these surveys are shown below.

Dental caries (i.e., tooth decay) is an infectious, multifactorial disease afflicting most persons in industrialized countries. Dental caries is not self-limiting. Today, all residents are exposed to fluoride to some degree, and widespread use of fluoride has been a major factor in the decline in the prevalence and severity of dental caries in the United States and other economically developed countries. Although this decline is a major public health achievement, the burden of disease is still considerable in all age groups. Many older adults have health conditions or take medications that reduce their salivary flow and increase their risk for dental caries. Some have difficulties with self-care and often face challenges related to access to professional dental care. Many studies indicate community water fluoridation reduces root caries in older adults (Grembowski, et al JADA 1992; Eldridge and Beck 1987, Brustmann 1986, Burt et al 1986 and Stamm, J D Res, 59 (A) 408: 1980). The CDC states adults also benefit from fluoride, rather than only children, as was previously assumed.

Target Population:

Number: 5,800,000

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Disparate Population:

Number: 5,800,000

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 -

64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Specific Counties
Target and Disparate Data Sources: U.S. Census Bureau

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Community Preventive Services (Task Force on Community Preventive Services)
MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

Other: Association of State and Territorial Dental Directors Best Practices

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$25,000
Total Prior Year Funds Allocated to Health Objective: \$0
Funds Allocated to Disparate Populations: \$25,000
Funds to Local Entities: \$25,000
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
10-49% - Partial source of funding

ESSENTIAL SERVICES –OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Essential Service 7 – Link people to services

Objective 1:

Maintain optimal fluoridation

Between 10/2008 and 09/2009, the Division of Dental Health will maintain 5.8 million residents on optimal community water fluoridation.

Annual Activities:

1. Upgrade water fluoridation testing equipment

Between 10/2008 and 09/2009, contract with communities to upgrade fluoridation testing equipment in six areas to maintain optimum fluoride levels (Hillsville, Covington, Clifton Forge, Buchanan, Brookneal and Nokesville).

State Program Title: Dental Disease Reduction Program

State Program Strategy:

Program Goal: The Dental Disease Reduction Program (DDRP) is designed to prevent dental caries (tooth decay) and reduce the burden and cost of this chronic disease. Priorities for the DDRP include preventing disease through population-based topical fluoride programs, assuring for the provision of dental care in underserved areas for high risk populations, and determining the statewide oral disease status of Virginia's children.

Program Health Priority: Priorities for the DDRP include preventing disease through population-based topical fluoride programs, assuring for the provision of dental care in underserved areas for high risk populations, determining the status of the oral diseases in Virginia's children, and providing quality assurance for local health department dental clinics.

Primary Strategic Partners: The Division of Dental Health (DDH) and the DDRP have partnerships within the Virginia Department of Health (VDH) including the Division of WIC and Community Nutrition Services, the Policy and Assessment Unit in the Office of Family Health Services, the Office of Community Health Services including local health departments, and the Office of Health Policy and Planning. Valuable external partnerships exist with the Virginia Dental Association, Virginia Dental Hygiene Association, Virginia Department of Education, Virginia Department of Medical Assistance Services, Virginia Commonwealth University (VCU) School of Dentistry, Boy's and Girl's Club of Virginia, Virginia Head Start Collaborative Project at the Department of Social Services, and other members of the Virginians for Improved Access to Dental Care Coalition.

Evaluation Methodology: In performing the public health core function of assessment and evaluation, the Division of Dental Health (DDH) has conducted oral health surveys, needs assessments and surveillance. Surveys have been utilized to assess samples of a defined population through clinical open mouth screenings, in addition to the use of questionnaires. DDH has also conducted needs assessments, including a statewide assessment in 1999.

A surveillance system provides the functional capacity for data collection and analysis, and the timely dissemination of information derived from these data to persons who can undertake effective prevention and control activities. Currently, DDH participates in the Virginia Behavioral Risk Factor Surveillance System and the National Oral Health Surveillance System, which monitors the burden of oral disease, utilization of the oral health care delivery system, and the status of community water fluoridation. Surveys and screenings are instruments for conducting oral health surveillance for evaluating program effectiveness. DDRP will utilize screenings and questionnaires to evaluate the effectiveness of the collection of oral health indices in programs. Screening will also be utilized to evaluate the ongoing effectiveness of the fluoride varnish program. Baseline data are being collected prior to the application of varnish to determine the prevalence of early childhood caries and changes in disease status based on applications of varnish. A three year evaluation is underway of the fluoride rinse program. This year's projects include a statewide assessment of third grade school children to determine oral health status.

State Program Setting:

Medical or clinical site, Schools or school district

FTE's (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Title: Dental Hygienist
State-Level: 30% Local: 70% Other: 0% Total: 100%
Position Title: Dental Hygienist
State-Level: 30% Local: 70% Other: 0% Total: 100%
Position Title: Dental Hygienist
State-Level: 15% Local: 35% Other: 0% Total: 50%

Total Number of Positions Funded: 3
Total FTE's Funded: 2.50

National Health Objective: HO 21-1 Dental caries experience

State Health Objective(s):

Between 10/2008 and 09/2009, the Division of Dental Health will increase the number of children provided with dental services (prevention and treatment) and increase the number of children screened for oral disease. Target: Increase to 50,500 the number of children participating in the fluoride rinse program; increase to 4,500 the children provided with fluoride varnish; increase to 80 the number of children receiving treatment services and increase to 12,000 the number of children screened for oral disease.

Baseline:

49,500 children participate in the fluoride rinse program; 1,500 children have been provided with fluoride varnish; 60 children have received treatment services and 5,044 children were screened for oral disease.

Data Source:

Division of Dental Health

State Health Problem:

Health Burden:

Children's dental health has improved remarkably under the influences of fluoride and modern dental care over the last century. However, because of lack of access to preventive services, many children still suffer from dental diseases and conditions, which are preventable. Dental caries (tooth decay) remains the most common chronic disease among children. Only the common cold, the flu and ear infections occur more often among toddlers and young children. Tooth decay in children is four to five times more common than asthma, the second most common chronic disease. Chronically poor oral health is associated with failure to thrive in toddlers, compromised nutrition in children, and cardiac dysfunction or life threatening infections in adulthood. Poor oral health has also been related to decreased school performance and poor self-esteem. Dental disease is now a chronic problem among low-income populations who bear a disproportionate level of dental disease. According to the National Health and Nutrition Examination Survey (NHANES), oral disease is primarily concentrated in a small segment of the population with 80% of tooth decay found in only 25% of school-age children. Virginia dental studies have consistently shown that children enrolled in the free lunch program have higher decay levels than those children that do not participate in the program. This finding was confirmed in a 1999 statewide comprehensive dental survey, which documented the oral health status of school children in Virginia. All indicators of dental disease were higher among children enrolled in the free lunch program relative to non-enrolled children.

Demographics such as race and ethnicity are more likely to put a child at risk for oral disease and reduce the probability that they will receive treatment. Previous Virginia studies have consistently demonstrated that Hispanic children have the highest prevalence of untreated decay followed by black children as show below. Culturally appropriate health promotion and disease prevention initiatives are needed to help these populations understand the importance of good oral health and place a high priority in obtaining dental care.

Children who suffer the most dental disease are least likely to have access to oral health care services. In 1996, the Office of the Inspector General of the U.S. Department of Health and Human Services (DHHS) reported that only one in five Medicaid eligible children received routine preventive dental services. According to a 2002 NHANES survey, lower-income children were much more likely to have unmet dental treatment needs relative to their more affluent counterparts.

A 1994 Robert Wood Johnson Foundation (RWJF) survey indicated that dental care was the most commonly reported unmet health care need in the U.S. Moreover, unmet dental care was twice as likely to be reported compared to medical care.

State oral health programs can contribute significantly to improving oral health access and quality for low income children through professional development for dental staff and training for non-dental health providers (e.g., physicians and nurses) to make the necessary referrals for early dental treatment.

Preschool and elementary school children (birth to 13 years) are the primary targets for dental disease prevention activities. The target population includes male and female students of all races. The disparate population includes low-income preschool and elementary school children (birth to 13 years) for dental disease prevention activities.

Target Population:

Number: 500,000

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: Yes

Disparate Population:

Number: 50,000

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: Yes

Location: Entire state

Target and Disparate Data Sources: U.S. Census Bureau

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)

Guide to Community Preventive Services (Task Force on Community Preventive Services)

MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

Other: Association of State and Territorial Dental Directors Best Practices

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$245,000

Total Prior Year Funds Allocated to Health Objective: \$0
Funds Allocated to Disparate Populations: \$245,000
Funds to Local Entities: \$245,000
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
75-99% - Primary source of funding

ESSENTIAL SERVICES –OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Essential Service 7 – Link people to services

Objective 1:

Increase dental health services to preschool children

Between 10/2008 and 09/2009, the Division of Dental Health will increase the number of preschool children with preventive fluoride varnish application, assessment, and oral health education from 1,200 to 5,400 preschool children.

Annual Activities:

1. Provide education, assessment, and dental varnish to migrant children

Between 10/2008 and 09/2009, contract with a dentist, dental hygienist or nurse to provide education, assessment and dental varnish for 150 migrant children enrolled in the Early Head Start and Head Start Programs on the Eastern Shore.

2. Provide education, assessment, and dental varnish to low-income children

Between 10/2008 and 09/2009, contract with a dentist, dental hygienist or nurse to provide education, assessment and dental varnish for 4,000 low-income children enrolled in the Early Head Start and Head Start Programs and WIC programs in targeted programs in Virginia.

3. Fluoride varnish program assessment

Between 10/2008 and 09/2009, screen all children during the assessment portion of the fluoride varnish program for decayed, missing and filled primary teeth. Evaluate all children and parents using the parental questionnaire.

Objective 2:

Collect data and refer for treatment

Between 10/2008 and 09/2009, the Division of Dental Health will increase the number of school children participating in a dental survey and referred for treatment from 2,000 to 7,000 school children.

Annual Activities:

1. Develop survey design

Between 10/2008 and 09/2009, develop final survey design working with the Association of State and Territorial Dental Directors.

2. Obtain approval on final design

Between 10/2008 and 09/2009, work with Research and Evaluation Team to approve final survey design. Prepare institutional review board (IRB) submission regarding counties targeted for survey.

3. Obtain school administration approval

Between 10/2008 and 09/2009, obtain approval from school administration at the state and local levels. Print and distribute forms to schools. Work with local health directors and school principals in targeted area.

4. Conduct screenings

Between 10/2008 and 09/2009, coordinate dental screening schedule for staff who will be conducting screenings. Calibrate staff on BSS technique. Collect data through open mouth survey of 7,000 third grade children.

5. Analyze data

Between 10/2008 and 09/2009, enter and analyze data and produce report.

Objective 3:

Increase access to preventive and treatment services

Between 10/2008 and 09/2009, the Division of Dental Health will increase the number of high risk children who have access to preventive and treatment services from 52 to 82 high risk children.

Annual Activities:

1. Hold a project

Between 10/2008 and 09/2009, hold a Give Kids a Smile Project to determine children who can cooperate for care.

2. Provide treatment

Between 10/2008 and 09/2009, provide comprehensive treatment to targeted children to complete care. Receive detailed reports of services provided.

Objective 4:

Provide access to fluoride

Between 10/2008 and 09/2009, the Division of Dental Health will provide access to preventive fluoride rinse to 50,500 at risk school children.

Annual Activities:

1. Purchase fluoride rinse

Between 10/2008 and 09/2009, purchase fluoride rinse and train school staff and children to utilize the rinse once weekly during the school year.

State Program Title: Dental Sealant Project

State Program Strategy:

Program Goal: The Dental Sealant Project (DSP) is designed to prevent dental caries (tooth decay) through the application of dental sealants on the teeth of high risk children, an evidence-based preventive measure. The goal of the program is to reduce the burden and cost of this chronic disease and increase the number of children with preventive dental sealants.

Program Health Priority: The main priorities for the DSP are to provide access to preventive dental sealants to children at high risk in targeted schools in the state.

Primary Strategic Partners: The partnerships that are critical for the DSP are between the Division of Dental Health (DDH) and the Piedmont and Crater Health Districts, as well as other targeted school systems (Virginia Department of Education) in that area who will participate in the program. Final sites will be determined by utilizing sealant prevalence rates from screenings of children in these schools as well as acceptance of the program by the school systems.

Evaluation Methodology: Activity sheets on the numbers of children receiving dental sealants in the school sites will be submitted to DDH. VDH quality assurance standards will be followed including clinical inspection during and after the project, as well as through following the Best Practices Criteria established by the Association of State and Territorial Dental Directors outlined below. The Seal America program utilizes a database program in Epi Info, "SEALS," that will be utilized to enter and evaluate the dental sealant project. Children who have received sealants will also be evaluated clinically for retention of sealants placed last year.

State Program Setting:

Schools or school district

FTE's (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Title: Dentist

State-Level: 0% Local: 50% Other: 0% Total: 50%

Position Title: Dental Assistant

State-Level: 0% Local: 70% Other: 0% Total: 70%

Position Title: Dental Hygienist

State-Level: 0% Local: 50% Other: 0% Total: 50%

Total Number of Positions Funded: 3

Total FTE's Funded: 1.70

National Health Objective: HO 21-8 Dental sealants

State Health Objective(s):

Between 10/2008 and 09/2009, increase the proportion of children who have received dental sealants on permanent molars.

Baseline:

In FY08, 175 children received 580 dental sealants.

Data Source:

Piedmont Dental Sealant program provided the baseline data.

State Health Problem:**Health Burden:**

Children's dental health has improved remarkably under the influences of fluoride and modern dental care over the last century. However, because of lack of access to preventive services, many children still suffer from dental diseases and conditions, which are preventable. Dental caries (tooth decay) remains the most common chronic disease among children. Only the common cold, influenza and ear infections occur more often among toddlers and young children. Tooth decay in children is four to five times more common than asthma, the second most common chronic disease. Chronically poor oral health is associated with failure to thrive in toddlers, compromised nutrition in children, and cardiac dysfunction or life threatening infections in adulthood. Poor oral health has also been related to decreased school performance and poor self-esteem.

Dental disease is now a chronic problem among low-income populations who bear a disproportionate level of dental disease. According to the National Health and Nutrition Examination Survey (NHANES) oral disease is primarily concentrated a small segment of the population with 80% of tooth decay found in only 25% of school-age children. Virginia dental studies have consistently shown that children that are enrolled in the free lunch program have higher decay levels than those children that do not participate in the program. This finding was confirmed in a 1999 statewide comprehensive dental survey, which documented the oral health status of school children in Virginia. All indicators of dental disease were higher among children enrolled in the free lunch program relative to non-enrolled children.

Children who suffer the most dental disease are least likely to have access to oral health care services. In 1996, the Office of the Inspector General of the U.S. Department of Health and Human Services (DHHS) reported that only one in five children eligible for Medicaid received routine preventive dental services. According to a 2002 NHANES survey, lower-income children were much more likely to have unmet dental treatment needs relative to their more affluent counterparts. Additionally, minority children are more likely to have untreated tooth decay regardless of family income.

A 1994 Robert Wood Johnson Foundation survey indicated that dental care was the most commonly reported unmet health care need in the U.S. Moreover, unmet dental care was twice as likely to be reported compared to medical care.

Elementary school age children are the primary targets for dental disease prevention activities such as dental sealants. The target population includes male and female students of all races. The disparate population consists of male and female school children of all races without access to dental services in rural areas of Virginia and is estimated at 250,000.

Target Population:

Number: 500,000

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: 4 - 11 years

Gender: Female and Male

Geography: Rural
Primarily Low Income: Yes

Disparate Population:

Number: 250,000
Ethnicity: Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 4 - 11 years
Gender: Female and Male
Geography: Rural
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: U.S. Census Bureau

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)
MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

Other: Association of State and Territorial Dental Directors Best Practices

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$50,000
Total Prior Year Funds Allocated to Health Objective: \$0
Funds Allocated to Disparate Populations: \$50,000
Funds to Local Entities: \$50,000
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

ESSENTIAL SERVICES –OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Essential Service 7 – Link people to services

Objective 1:

Provide dental sealants

Between 10/2008 and 09/2009, the Division of Dental Health will increase the number of low-income children receiving dental sealants from 198 children to 400 children.

Annual Activities:

1. Utilize mobile dental van to provide sealants

Between 10/2008 and 09/2009, the Division of Dental Health will run a targeted dental sealant project in the Piedmont Health District (200 children) and the Crater Health District (200 children) utilizing mobile dental vans to provide dental sealants to low income children.

2. Finalize targeted schools

Between 10/2008 and 09/2009, Dental Sealant Project staff will finalize targeted schools for the program based on dental sealant prevalence from recent dental screenings.

3. Receive superintendent approvals

Between 10/2008 and 09/2009, staff will receive superintendent approvals and meet with school principals for approval/ finalize project with health director.

4. Review and revise Seal America Manual materials

Between 10/2008 and 09/2009, staff will review and revise materials for use in the project from the Seal America Manual including permission forms, data forms, etc..

5. Contract with local health department staff

Between 10/2008 and 09/2009, staff will contract with local health department staff, establish wage positions or School of Dentistry for dentist and dental hygienist to complete the project.

6. Purchase supplies

Between 10/2008 and 09/2009, staff will purchase sealant supplies.

7. Provide quality assurance and oversight

Between 10/2008 and 09/2009, staff will set up quality assurance review schedule and project oversight from DDH Quality Assurance Program Manager.

8. Place sealants on children

Between 10/2008 and 09/2009, staff will send out permission forms; complete treatment plans; and place dental sealants on 800 children.

State Program Title: Injury Prevention

State Program Strategy:

Program Goal: The goal of the VDH Injury Prevention Program is to reduce the burden of injury deaths and hospitalizations among Virginians by 2% by 2010.

Program Health Priority: In Virginia, injury is the leading cause of death for persons between the ages of 1 and 34. The Injury Prevention Program will support the start-up of community based injury prevention projects, resources, and training to reduce injuries related to burns, falls, poisoning, traumatic brain and spinal cord injury, fractures, and asphyxiation (from suffocation and drowning) among at risk populations.

Program Primary Strategic Partners: In addition to collaborating with relevant programs in the VDH Offices of Family Health Services, Emergency Medical Services, and the Chief Medical Examiner, the VDH Division of Injury and Violence Prevention partners with a variety of organizations and agencies at the local level (including Safe Kids coalitions, Red Cross chapters, schools, child care centers, fire and police departments) and at the state level (including but not limited to the Departments of Social Services, Criminal Justice Services, Education, Aging, Rehabilitative Services, Fire Programs, Motor Vehicles and Transportation, Perinatal Councils, the VA Poison Network, BIKE Walk Virginia, AAA divisions, VA Fire and Life Safety Coalition, Brain Injury Association of VA, Drive Smart Virginia).

Program Evaluation Methodology: Outcomes of awareness and training activities will be assessed through tracking of activities; monitoring of audience exposures to information provided; and behavior change that results from activities. Changes in injury will be assessed through annual analysis of Virginia injury hospitalization and death data.

State Program Setting:

Child care center, Community based organization, Faith based organization, Home, Schools or school district, Senior residence or center, University or college, Other: Fire or police department

FTE's (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Title: Community Injury Prevention Coordinator

State-Level: 0% Local: 10% Other: 0% Total: 10%

Position Title: Research and Data Coordinator

State-Level: 10% Local: 5% Other: 0% Total: 15%

Position Title: Executive Secretary

State-Level: 25% Local: 0% Other: 0% Total: 25%

Total Number of Positions Funded: 3

Total FTE's Funded: 0.50

National Health Objective: HO 15-13 Unintentional injury deaths

State Health Objective(s):

Between 10/2008 and 09/2010, reduce deaths caused by unintentional injury prevention by 2%.

Baseline:

The unintentional injury death rate in Virginia during 2006 was 34.87 per 100,000 population.

Data Source:

Virginia Center for Health Statistics

State Health Problem:**Health Burden:**

In Virginia, injury is the leading cause of death for persons between the ages of 1 and 34. Sixty-seven percent of these deaths were the result of unintentional injuries. In 2006, 2,665 Virginians died as a result of unintentional injury. Furthermore, in 2006, Virginia hospitals reported 38,635 hospital discharges for injury. The vast majority (82 percent) of injury hospitalizations in Virginia resulted from unintentional causes. Because of its toll on youth (19 years of age and younger), injury accounts for more years of productive life lost than all other causes of death. In 2006, 313 youth died as a result of injury before reaching their twentieth birthday. Again, the majority (68%) of these deaths were due to unintentional injuries. In 2006, Virginia hospitals reported 4,375 injury-related discharges for children and adolescents 19 years of age and younger, with 75% being unintentional in nature. Unintentional injury death rates were highest for the elderly. The three leading external causes of unintentional injury hospitalization for Virginians were: falls, motor vehicle traffic injuries, and poisoning.

In 2006, hospital injury discharge alone resulted in over \$891 million in billed charges to public and private payers. The average median charge was \$14,955 per episode of care. A little over half of the discharges listed a government source, mainly Medicare (81%) and Medicaid (16%) as the expected payer. The average length of stay for an episode of care due to an injury was 5 days. Patients aged 75 and older had the longest total and average length of stay and incurred the highest charges.

Target Population:

Number: 1,244,000

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Disparate Population:

Number: 55,000

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: Yes

Location: Entire state

Target and Disparate Data Sources: U.S. Census Bureau

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: CDC Research and Guidelines on Fall Prevention
Virginia Data on Leading Causes of Falls
Best or Promising Practices (Safe Kids Worldwide, Home Safety Council, STIPGA, Children's Safety Network, Harborview Injury Prevention and Research Center)

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$350,000
Total Prior Year Funds Allocated to Health Objective: \$0
Funds Allocated to Disparate Populations: \$290,000
Funds to Local Entities: \$290,000
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
50-74% - Significant source of funding

ESSENTIAL SERVICES –OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Essential Service 3 – Inform and Educate

Objective 1:

Implement injury prevention programs

Between 01/2009 and 08/2009, the Division of Injury and Violence Prevention (DIVP) staff will implement 11 injury prevention programs that reflect the leading injury areas and recommendations identified in the Virginia Unintentional Injury Prevention Strategic Plan through contract with organizations in 11 local communities throughout the Commonwealth.

Annual Activities:

1. Implement 11 community injury prevention programs

Between 01/2009 and 08/2009, eleven communities will implement injury prevention programs that reflect the leading injury areas and recommendations identified in the Virginia Unintentional Injury Prevention Strategic Plan. An estimated 6,000 children will receive and be fitted for an appropriately sized bicycle helmet that will reduce their risk of brain or head injury sustained from a fall off of a bicycle or other wheeled motor mode of transportation.

Objective 2:

Reduce fall-related traumatic brain injury and fractures

Between 12/2008 and 08/2009, DIVP staff will develop 3 projects through contract with local Area Agencies on Aging to reduce fall-related traumatic brain injury and fractures among high risk older adults.

Annual Activities:

1. Implement evidence-based fall prevention intervention projects

Between 12/2008 and 08/2009, three local Area Agencies on Aging will implement projects to reduce fall-related traumatic brain injury and fractures among high risk older adults. An estimated 300 fragile older adults will engage in a CDC evidenced-based fall prevention intervention that reduces their risk of fall-related injury.

Objective 3:

Implement helmet use promotion project

Between 01/2009 and 08/2009, DIVP staff will develop 60 helmet use promotion and distribution projects targeting low-income children through contact with organizations in sixty local communities in Virginia.

Annual Activities:

1. Disseminate helmets

Between 01/2009 and 08/2009, sixty communities will disseminate helmets to low-income children by implementing helmet use and distribution projects. An estimated 6,000 children will receive and be fitted for an appropriately sized bicycle helmet that will reduce their risk of brain or head injury sustained from a fall off of a bicycle or other wheeled motor mode of transportation.

Objective 4:

Develop and distribute resources

Between 10/2008 and 09/2009, DIVP staff will develop 510,000 (estimated) publications and educational resources and/or distribute them throughout the Commonwealth to professionals, child care providers, schools, health professionals, and other injury prevention advocates to strengthen state and community level infrastructure and partnerships for injury prevention.

Annual Activities:

1. Provide resources, home safety information, and devices

Between 10/2008 and 09/2009, approximately 2,800 family day home providers will receive childhood and home safety information and safety devices; three Virginia Injury Updates will be provided on a quarterly basis to professionals; and Injury and violence prevention bi-lingual tip cards, videos, and posters will be distributed to assist with local injury prevention efforts.

State Program Title: OFHS Research and Analysis - Surveillance Program

State Program Strategy:

Program Goal: Increase the availability of public health data for analysis and decision making. Information is an essential tool for the Office of Family Health Services to carry out the core functions and the essential public health services for the Commonwealth. Having reliable data readily available is critical at all levels from the identification of needs, to program planning and evaluation. The Office of Family Health Services (OFHS) Policy and Assessment Unit works to develop the capacity to meet customers' needs for reliable, accurate, timely, and relevant public health information and to assure its use in decision-making. The unit performs periodic needs assessments and develops and updates an ongoing surveillance plan that includes timely data from sources such as Behavioral Risk Factor Surveillance System (BRFSS), vital records, and hospital discharges (VHI).

Program Health Priority: The program priority is to monitor health status, provide data for program evaluation, and increase the OFHS internal capacity to analyze data and conduct needed health services research. This unit carries out many functions including the following: working with local health districts to improve access to morbidity and mortality data and reports; developing and implementing surveys; developing and linking information systems; and analyzing and displaying routine surveillance data as well as responding to emerging data issues.

Through surveillance, VDH is able to identify high-risk populations for premature death and disability. Disparate population groups that receive substandard medical care or have less accessibility to a health care system are also identified. Responsibilities toward disparate populations encompass preventing epidemics and the spread of disease; protecting against environmental hazards; preventing injuries; encouraging healthy behavior; helping communities recover from disasters; and ensuring the quality and accessibility of health services. The PHHS Block Grant supports a portion of the projects of the Policy and Assessment Unit within the Office of Family Health Services.

Primary Strategic Partners:

OFHS Internal Partners

Child and Adolescent Health Division
Women's and Infants' Health Division
WIC and Community Nutrition Services Division
Dental Health Division
Injury and Violence Prevention Division
Chronic Disease Prevention Division

OFHS External Partners:

VDH Division of Vital Statistics
35 District Health Departments
Virginia Commonwealth University
Virginia Health Information
Department of Medical Assistance Services

Program Evaluation Methodology: The evaluation criteria will be the timely completion of the objectives and activities listed.

State Program Setting:

State health department

FTE's (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0

Total FTE's Funded: 0.00

National Health Objective: HO 23-5 Data and Information systems**State Health Objective(s):**

Between 10/2008 and 09/2010, the Office of Family Health Services (OFHS) will increase the availability of national survey data for leading health indicators, health status indicators, and priority data needs which includes information on disparities at the state and local levels.

Baseline:

Two CDC SLAITS surveys have been loaded and cleaned, zero have been fully documented and put in the OFHS Data Mart. The current BRFSS sample size is 5,000.

Data Source:

OFHS Data Mart; BRFSS

State Health Problem:**Health Burden:**

It is important for PHHS-funded programs in Virginia to measure progress toward achieving the targeted health status objectives. There are problems with the specificity of available databases and the ability to link different data sets that would indicate mortality, morbidity and preventable risk exposure for chronic diseases

Population-based data for behavioral risk factors that are specific to racial and ethnic groups have not been readily available. This data would be useful in setting priorities for public health programs. The Virginia hospital discharge data set has significant potential that has not been fully utilized

The Behavioral Risk Factor Surveillance System (BRFSS) sample size increased to 5,000 starting from the calendar year 2003. In addition, each year OFHS adds a number of questions to the BRFSS standard telephone survey questions. This increase in both the number of questions and the sample size has provided enough data to pool in order to provide health district level estimates of risk behaviors. The representative sample of the Commonwealth's population will allow effective analysis of health behaviors at both the state and health district levels. Local health districts, managed care organizations, and hospitals have expressed an interest in having access to population-based data on health risk behaviors so that they can better plan, deliver, and evaluate health promotion and disease prevention programs.

OFHS remains committed to creating easier access to data systems such as the BRFSS and Health Statistics. An office-level memorandum of agreement with the Division of Health Statistics has been established that eliminates the need for individual programs to negotiate data requests. Virginia BRFSS data are now available on the internet. Using Instant Atlas software, the BRFSS data can be geographically displayed by health districts. In the future, additional data can be geographically displayed by health districts. There is a continued need to expand public access to other health related data sources including social indicators that impact health disparities.

Target Population:

Number: 5,471,916

Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers, Community Based Organizations, Research and Educational Institutions

Disparate Population:

Number: 5,471,916

Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers, Community Based Organizations, Research and Educational Institutions

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

No Evidence Based Guideline/Best Practice Available

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$103,141

Total Prior Year Funds Allocated to Health Objective: \$0

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$0

Role of Block Grant Dollars: Supplemental Funding

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

Less than 10% - Minimal source of funding

ESSENTIAL SERVICES –OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Essential Service 1 – Monitor health status

Objective 1:

Increase the availability of data

Between 10/2008 and 09/2009, the Policy and Assessment Unit will increase the number of health-related national survey datasets available in the OFHS Data Mart from 2 CDC SLAITS surveys that have been loaded and cleaned to 4 data sets loaded, cleaned, fully documented, and put in the OFHS Data Mart.

Annual Activities:

1. Load, clean, fully document, and release national survey data in the OFHS Data Mart

Between 10/2008 and 09/2009, data from national surveys including the 2003 NSCH, 2007 NSCH when available, 2003 NAS, and 2005-06 CSHCN will be released in the OFHS Data Mart so that staff will have ready access to cleaned and documented data. Each dataset and its documentation will be downloaded from the CDC SLAITS website. If available, a Virginia specific subset will be extracted from the national file. Key demographic variables including age groups and race/ethnicity will be recoded to be consistent with other datasets in the OFHS Data Mart. Data dictionaries for existing and newly created variables will be prepared and the data will be placed in the OFHS Data Mart. After each dataset is released, a brief introduction and training will be provided to the OFHS Epidemiology Workgroup.

Objective 2:

Maintain the BRFSS sample size at 5,000.

Between 10/2008 and 09/2009, the Policy and Assessment Unit will obtain 5,000 complete respondent surveys to maintain the current BRFSS sample size of 5,000.

Annual Activities:

1. Completion of 5,000 BRFSS surveys.

Between 07/2009 and 09/2009, The BRFSS sample size will be maintained at 5,000 completed surveys. In 2003, the BRFSS sample size increased to 5,000. The increase in the sample size has provided enough

data to pool in order to provide health district level estimates of risk behaviors. This representative sample allows effective analysis of health behaviors at both the state and the health district level. The 35 health districts, as well as health care organizations, depend on this data in order to target at risk populations and to plan, deliver, and evaluate their health promotion and disease prevention programs. Increasing contractual costs to conduct the BRFSS and the lack of sufficient federal funding has jeopardized the ability to maintain a sufficient sample size. Maintaining the sample size of 5,000 completed surveys is essential for district level data analysis.

State Program Title: Sexual Assault Intervention and Education Program

State Program Strategy:

Program Goals: The goal of the Sexual Assault Intervention and Education program is to reduce the number of sexual assault victimizations.

Rape and sexual assault are a public health problem in Virginia. In 2006, there were 5,156 forcible sex offenses reported to the Virginia police. (Source: Crime in Virginia, Virginia State Police, 2006). In cases of sexual assault, however, the victim is often hesitant to report the crime to law enforcement officials. It has been estimated that the actual incidence of sexual assault is at least three times higher than police reports (U.S. Department of Justice, Bureau of Justice Statistics, 1998).

Primary Strategic Partners: The Virginia Department of Health will continue to contract with the Department of Criminal Justice Services (DCJS) to provide statewide coordination, technical assistance, training and other support to the state coalition, Virginia Sexual and Domestic Violence Action Alliance (VSDVAA), and local sexual assault crisis centers.

The PHHSBG set-aside enables DCJS to fund VSDVAA, and to provide advocacy and support to victims and survivors of sexual assault and their families and friends, crisis centers, and professionals offering services to survivors. VSDVAA provides technical assistance, information, training, coordination and other resources to centers that provide direct victims services. Direct victims services include:

- hotlines for support and information;
- crisis intervention in courtrooms, hospitals and other community settings; and
- counseling, support and accompaniment.

VSDVAA and the sexual assault crisis centers also provide professional and public education programs to raise awareness about sexual assault and existing prevention and intervention efforts.

Evaluation Methodology: The program will complete outcome and process evaluations.

State Program Setting:

Community based organization, Rape crisis center, University or college

FTE's (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Title: Co-Director

State-Level: 19% Local: 0% Other: 0% Total: 19%

Position Title: Training Manager

State-Level: 13% Local: 0% Other: 0% Total: 13%

Position Title: Hotline Worker

State-Level: 22% Local: 0% Other: 0% Total: 22%

Position Title: Advocacy Manager

State-Level: 15% Local: 0% Other: 0% Total: 15%

Position Title: Resources Manager

State-Level: 13% Local: 0% Other: 0% Total: 13%

Position Title: Hotline Worker

State-Level: 22% Local: 0% Other: 0% Total: 22%

Position Title: Hotline Worker
State-Level: 11% Local: 0% Other: 0% Total: 11%
Position Title: Public Awareness Manager
State-Level: 17% Local: 0% Other: 0% Total: 17%
Position Title: Co-Director
State-Level: 11% Local: 0% Other: 0% Total: 11%
Position Title: Events Coordinator
State-Level: 9% Local: 0% Other: 0% Total: 9%
Position Title: Training Coordinator
State-Level: 19% Local: 0% Other: 0% Total: 19%
Position Title: Hotline Manager
State-Level: 9% Local: 0% Other: 0% Total: 9%
Position Title: Services Coordinator
State-Level: 30% Local: 0% Other: 0% Total: 30%
Position Title: Hotline Worker
State-Level: 22% Local: 0% Other: 0% Total: 22%
Position Title: SV Contract Manager
State-Level: 34% Local: 0% Other: 0% Total: 34%

Total Number of Positions Funded: 15
Total FTE's Funded: 2.66

National Health Objective: HO 15-35 Rape or attempted rape

State Health Objective(s):

Between 10/2008 and 09/2014, reduce the number of forced sexual assaults reported to police in Virginia by 2%.

Baseline:

5,009 forcible sex offenses

Data Source:

Crime in Virginia, Virginia State Police, 2007

State Health Problem:

Health Burden:

In 2006, there were 5,156 forcible sex offenses reported to the Virginia police. (Source: Crime in Virginia, Virginia State Police, 2006). In cases of sexual assault, however, the victim is often hesitant to report the crime to law enforcement officials. It has been estimated that the actual incidence of sexual assault is at least three times higher than police reports (U.S. Department of Justice, Bureau of Justice Statistics, 1998).

Virginia's sexual assault crisis centers annually provide services to approximately 10,000 victims of sexual assault. In FY2005, Virginia sexual assault crisis centers provided services to 9,795 new victims of sexual assault.

The annual cost of sexual violence is a staggering \$127 billion. (Miller, Ted, Cohen, Mark and Wiersema, Brian. 1996. Victim Costs & Consequences: A New Look. Washington, D.C. National Institute of Justice Report, U.S. Department of Justice)

Researchers estimate that the 1.1 million rape victims suffer 1.45 million rape victimizations annually. That means annual rape victimizations average 1.27 per victim. Multiplying 1.27 by the \$81,400 quality of life loss per rape victimization yields estimated quality of life losses of \$103,400 per rape victim. (Victim Costs and Consequences: A New Look, Series: NIJ Research Report, January 1996)

Victim-related revenue by mental health care providers in 1991 was estimated to be between \$5.8 billion and \$6.8 billion, with about one-half of that amount caused by crimes committed that year and the remainder by child abuse years earlier.

Target Population:

Number: 10,000

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Disparate Population:

Number: 10,000

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Location: Entire state

Target and Disparate Data Sources: Crisis center service delivery figures.

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

No Evidence Based Guideline/Best Practice Available

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$156,006

Total Prior Year Funds Allocated to Health Objective: \$0

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$0

Role of Block Grant Dollars: No other existing federal or state funds

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

100% - Total source of funding

ESSENTIAL SERVICES –OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Essential Service 4 – Mobilize Partnerships

Objective 1:

Increase level of partnerships

Between 10/2008 and 09/2009, sexual assault crisis centers will increase the number of identified partnerships in the Hispanic community and with college and university communities from 8 to 10 identified partnerships.

Annual Activities:

1. Develop and support outreach services

Between 10/2008 and 09/2009, Virginia Sexual and Domestic Violence Action Alliance will develop and support Hispanic outreach services in at least four communities through intensive technical assistance, including on-site visits and meetings with organized task forces.

2. Develop partnerships

Between 10/2008 and 09/2009, Virginia Sexual and Domestic Violence Action Alliance will work with sexual assault crisis centers to partner with colleges and universities, community arts organizations, and community spiritual and therapeutic counseling agencies to host "The Art of Surviving" in their communities.

Essential Service 8 – Assure competent workforce

Objective 1:

Provide comprehensive services to victims of sexual assault

Between 10/2008 and 09/2009, sexual assault crisis center staff will increase the percent of crisis centers receiving fully accredited status from the Action Alliance from 100% provisional status to 50% fully accredited status.

Annual Activities:

1. Complete first round of accreditation

Between 10/2008 and 09/2009, complete the first full round of accreditation of sexual assault crisis centers, including the review of applications, determination of an accreditation status, and scheduling site visits for fall 2009.

2. Produce report

Between 10/2008 and 09/2009, produce a report on the 2008 data from the enhanced VAdata system, describing the services provided by sexual assault crisis centers to victims of sexual assault.

3. Hold regional meetings and provide training

Between 10/2008 and 09/2009, partner with the Virginia Department of Health and the Virginia Department of Criminal Justice Services to hold at least three statewide meetings in different regions of the state to provide training and information that support comprehensive services for victims of sexual assault.

4. Visit all new directors of sexual assault crisis centers

Between 10/2008 and 09/2009, visit all new directors of sexual assault crisis centers within six months of hire to provide information about the Action Alliance, statewide training and technical assistance, VAdata, and the Accreditation process.

5. Produce newsletter

Between 10/2008 and 09/2009, produce four editions of a quarterly service provider newsletter to provide at least 75 SACC staff with resources, information, policy, and protocol to enhance services to victims of sexual violence over twelve months.

6. Provide training

Between 10/2008 and 09/2009, provide 36 hours of training to 50 SACC staff designed to increase their knowledge of sexual assault issues and improve practice in the field over twelve months.

State Program Title: Virginia Suicide Prevention Program

State Program Strategy:

Program Goal: To address the Virginia PHHS priority 3, mental health, and reduce the burden of suicide on Virginia's population.

Program Health Priority: The Division of Injury and Violence Prevention (DIVP) proposes to continue the statewide suicide prevention program. DIVP proposes to maintain the suicide prevention infrastructure developed over the past seven years and to continue to implement recommendations of the Youth Suicide Prevention Plan and the Commonwealth Suicide Prevention Across The Lifespan Plan.

Specific goals of the program are to: (1) provide state leadership to secure broad based support for suicide prevention in Virginia; (2) raise awareness about risk factors for suicide and encourage help seeking; and (3) improve comprehensive community-based prevention/early intervention in the Commonwealth through evidence based skills training, program and policy development.

Primary Strategic Partners: Strategic partnerships have been developed with the Virginia Department of Education and school districts, Department of Juvenile Justice Services, the State Council on Higher Education (SCHEV), local crisis centers, community service boards, local suicide prevention coalitions, and the Virginia Network of Suicide Prevention Coalitions. The plan is to continue to work with these existing partners and include others as warranted.

Evaluation Methodology: In 2006, the University of Virginia completed an evaluation of the QPR and ASIST gatekeeper training being done under the VDH Suicide Prevention Program. That evaluation concluded that "the results provide support for the benefit of gatekeeper training for school personnel to identify potentially suicidal students". DIVP's staff epidemiologist will continue to coordinate on-going program evaluation and data collection. Trainings will be evaluated through participant surveys, contract performance will be monitored, and data will be collected on the exposures to public awareness campaigns and materials disseminated.

State Program Setting:

Child care center, Community based organization, Faith based organization, Local health department, Rape crisis center, Schools or school district, State health department, University or college

FTE's (Full Time Equivalent):

Full Time Equivalent positions that are funded with PHHS Block Grant funds.

Position Title: Suicide Prevention Manager

State-Level: 2% Local: 4% Other: 0% Total: 6%

Total Number of Positions Funded: 1

Total FTE's Funded: 0.06

National Health Objective: HO 18-1 Suicide

State Health Objective(s):

Between 10/2008 and 09/2009, reduce deaths caused by suicide by 5%.

Baseline:

The suicide death rate in Virginia in 2006 was 11.37 per 100,000 population.

The suicide death rate in Virginia among 10-24 year olds in 2006 was 6.84 per 100,000 population.

The suicide death rate in Virginia among elderly 65 and older in 2006 was 16.22 per 100,000 population.

Data Source:

VDH Hospital Discharge Data

State Health Problem:**Health Burden:**

Between 1996 and 2005, 1,066 suicides occurred in Virginia among youth between the ages of 10 and 24. This represents a ten year suicide rate of 7.2 per 100,000 of population. Suicide was the third leading cause of death (following unintentional injury and homicide) for youth during this time period. Suicide among the elderly is also a significant concern. The elderly make up 12% of the state's population and 17% of all suicides. Over half of Virginia's gun deaths resulted from suicide.

Suicide costs a tremendous amount in years of potential life lost, an annual toll of 25,207 years and the associated lost contribution of these individuals to society. Suicide also leaves deep and long lasting anguish among surviving family and friends and greatly increases their risk for subsequent suicide and mental health problems. The injury hospitalization data further illustrate the tremendous financial impact of suicide on Virginians. In 2004 alone, self inflicted hospitalizations exceeded \$50 million in billed charges to public and private payers. The median charge per self inflicted hospitalization was \$7,018.

The target population will consist of all racial and ethnic groups between the ages of 14-85. This will include males and females in a geographic area that comprises the entire state. The disparate population includes those (age 14-85) who are at selected or indicated risk for suicide and those who have lost friends or relatives to suicide.

Target Population:

Number: 501,500

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Disparate Population:

Number: 300

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Location: Entire state

Target and Disparate Data Sources: U.S. Census Bureau; Virginia Health Statistics and Death Data

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: As mentioned above, Virginia's Suicide Prevention Program utilizes SAMHSA approved evidence-based suicide prevention programs.

(1) Applied Suicide Intervention Skills Training (ASIST) is a two-day training program that teaches risk recognition skills and is designed for individuals who would potentially receive a referral for suicidal ideation. Participant materials for this internationally used program include a workbook, ASIST handbook, and a quick reference wallet card.

(2) Question, Persuade, Refer (QPR) and (3) safeTALK are general suicide prevention awareness training models that can be used with a variety of audiences, even students.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$90,000

Total Prior Year Funds Allocated to Health Objective: \$0

Funds Allocated to Disparate Populations: \$85,587

Funds to Local Entities: \$85,587

Role of Block Grant Dollars: Supplemental Funding

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

Less than 10% - Minimal source of funding

ESSENTIAL SERVICES –OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Essential Service 3 – Inform and Educate

Objective 1:

Maintain current suicide rate

Between 10/2008 and 09/2009, Suicide Prevention Program staff will maintain 11.4 per 100,000 (current suicide rate) over all ages.

Annual Activities:

1. Provide statewide education

Between 10/2008 and 09/2009, improve suicide prevention awareness skills training through statewide education and training.

2. Provide training

Between 10/2008 and 09/2009, provide training to local communities that are not being served by SAMHSA funding.