2014 Annual Report of the State Board of Health

Section 32.1-14 of the Code of Virginia requires that the State Board of Health shall submit an annual report to the Governor and General Assembly. According to statutory mandate, such report shall contain information on the Commonwealth's vital records and health statistics and an analysis and summary of health care issues affecting the citizens of Virginia, including but not limited to, health status indicators, the effectiveness of delivery of health care, progress toward meeting standards and goals, the financial and geographic accessibility of health care, and the distribution of health care resources, with particular attention to health care access for those Virginia citizens in rural areas, inner cities, and with greatest economic need. Such report shall also contain statistics and analysis regarding the health status and conditions of minority populations in the Commonwealth by age, gender, and locality.

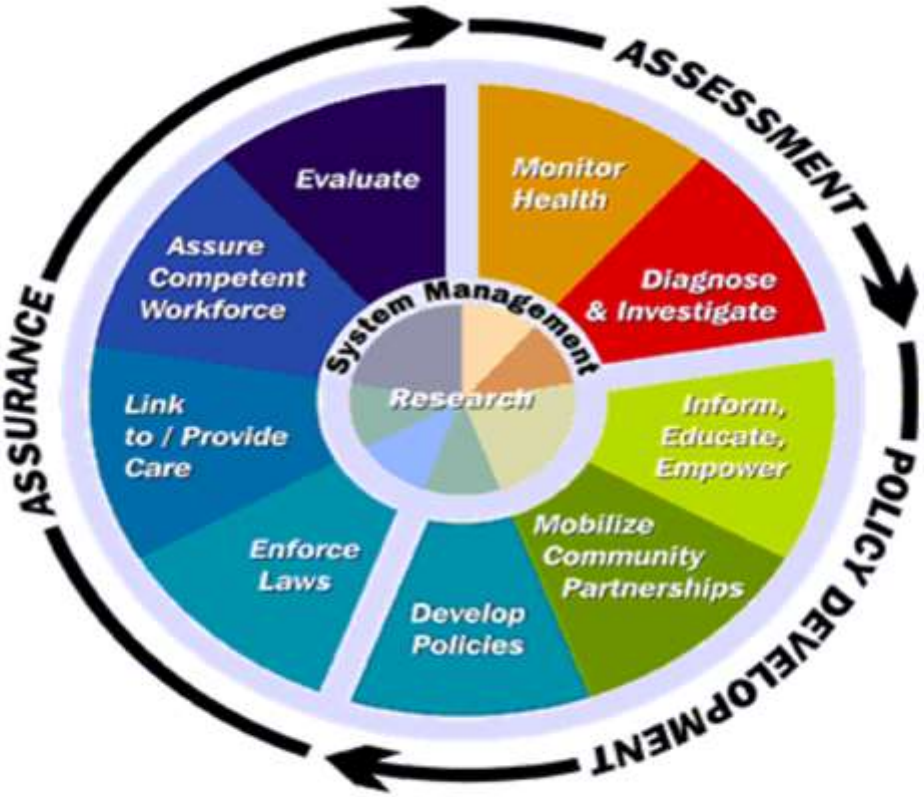
The Virginia Department of Health (VDH) serves as the leader and coordinator of Virginia's public health system. Public health can be defined as what society does collectively to create those conditions in which people can be healthy – which is supportive of the Governor's goal of creating a healthy workforce and New Virginia Economy. In conjunction with local, private sector, and state/federal government partners, VDH plays a fundamental role in promoting and protecting the health of all Virginians – focused on the ten essential public health services (Figure 1). VDH's public health role is distinguished from health care and private medicine in general by focus on the health of populations, emphasis on prevention, orientation towards the community, and efforts directed at system management.

As VDH pursues its mission of promoting and protecting the health of all Virginians, it must evolve to meet changing needs across the spectrum of public health issues, such as:

Aging Population: As aging Virginians encompass an increasing percentage of the Commonwealth's total population, there will likely be growing demand for chronic disease management services, long term care services, various types of acute care and rehabilitation services, and emergency medical services. VDH will need to respond across a number of dimensions, including direct service delivery, regulatory and enforcement, health and medical facilities planning, and emergency preparedness response and recovery.

Immunization: Vaccines continue to provide effective primary prevention against infectious diseases that can cause significant health and economic burdens. In addition, vaccines such as the human papillomavirus vaccine are primary prevention against some types of cancers. However, increased activities of groups opposed to the use of vaccines, and widespread distribution of anti vaccine material, could result in decreased demand for vaccination services and increase the number of susceptible children and. VDH will need to ensure that public and private healthcare providers have the resources to effectively respond to the concerns of resistant parents with information on the value of appropriate immunizations.

Figure 1



Health Disparities: Numerous Virginia localities are classified as medically underserved. To improve access to health and healthcare for residents of those communities, new incentives are being identified to attract and retain the needed providers and to impact the social determinants of health to create conditions for health promotion.

Diverse Populations: Many diseases that cause morbidity and mortality have been essentially controlled (e.g. many infectious diseases) or can be controlled if identified early (e.g. hypertension). However, demographic change in many parts of the state could potentially begin reversing the trend. Healthcare providers in many areas in the state now have to learn how to communicate effectively with patients with cultural differences. Growing numbers of foreign-born Virginia residents create more culturally diverse populations which may impede traditional methods of health care delivery and disease prevention and control activities. This will likely present challenges and require adaptation to communicate across language and cultural barriers.

Environmental Health: The demand for environmental health services has increased due to growth in and geographic expansion of the population. There are more restaurants, an increase in food festivals and other alternative venues for food service, growth in shellfish aquaculture and continued real estate development. Several emerging issues with onsite sewage programs

include: operation and maintenance requirements, wastewater reuse, rainwater harvesting, protecting the Chesapeake Bay for nutrient pollution, health equity initiatives for water and sewer, seeking ways to assist owners financially in upgrading/repairing onsite sewage systems, and increasing VDH's collaboration with the private sector. Additional complex environmental issues such as the impact of fracking, aquifer impacts and climate change resulting in rising water levels in Tidewater will require VDH to be an active participant and collaborator with many other state agencies, especially those in the Natural Resources Secretariat.

Emergency Preparedness, Response and Recovery (EPRR): Being prepared to prevent, respond, and rapidly recover from public health threats is critical. Public Health Emergency Preparedness initiatives upgrade and integrate state, regional territorial and local public health jurisdictions' preparedness to respond to terrorism and other public health emergencies. These efforts also require coordination with Federal, State, local and tribal governments, and government agencies, the private sector, and non-governmental organizations. Hospital Preparedness Program initiatives support the ability of hospitals and health care systems to prepare for and respond to terrorism and other public health and healthcare emergencies. These efforts are intended to support the National Response Plan and the National Incident Management System. The implementation of newly defined public health capabilities and announced future grant alignment include additional requirements, but funding has decreased. VDH's preparedness needs continue to incorporate planning for and response to emerging infections, such as a pandemic strain of influenza and infections (e.g. Ebola Virus Disease) that may originate in foreign countries.

Assurance of Care and System Management: Each city and county is required to have a local health department. VDH also has statutory responsibilities pertaining to the assurance of health care services and management of the state's public health system. This includes:

Statewide Emergency Medical Services (EMS) system

> The Virginia EMS system is very large and complex. It involves a wide variety of EMS agencies and personnel, including volunteer and career providers functioning in volunteer rescue squads, municipal fire departments, commercial ambulance services, hospitals, Regional EMS Councils and, a number of other settings. This coordinated system enables the EMS community to provide the highest quality emergency medical care possible to those in need. Every person living in or traveling through the state is a potential recipient of emergency medical care.

Statewide Medical Examiner System

> The VDH Office of the Chief Medical Examiner (OCME) currently supports more than 178 local medical examiners. Local medical examiners attend death scenes, examine the body, and sign the certificate of death on medical examiner cases or, in accordance with OCME professionally established guidelines, refer certain classes of cases for more intensive death investigation and medicolegal autopsy at an OCME district office.

Communicable Disease Investigation and Control

VDH works to detect, assess, and control the spread of various communicable diseases. Particular focus is placed on approximately 50 different diseases of public health importance, including diarrheal diseases, hepatitis, meningitis, rabies, and vector-borne diseases (such as Lyme disease and West Nile Virus infection).

Immunization

Local health departments have statutory responsibility to maintain and operate effective immunization programs which provide vaccines to the public with an emphasis on the vaccine-preventable diseases of childhood such as chicken pox, diphtheria, pertussis, tetanus, haemophilus influenza, hepatitis A and B, measles, mumps, rubella, polio, pneumonia, influenza and rotavirus. Additional targeted groups for the provision of influenza vaccine are the very young, those with certain environmental or medically high risk conditions, and the elderly who are also targeted for bacterial pneumonia vaccination. Local health departments also maintain an inventory or assure access to rabies vaccine and biologicals for administration to those individuals exposed to wild or domestic animals when rabies disease is suspected or proven in the animal.

Regulation, Oversight and Inspection of Health Care Facilities

VDH licenses and inspects medical facilities in Virginia in order to assure quality of care and to protect the public. Eight categories of medical care facilities or services are licensed: hospitals, abortion facilities, outpatient surgical hospitals, nursing facilities, home care organizations, hospice programs, and managed care health insurance plans and private review agents. VDH is responsible for investigating consumer complaints regarding the quality of health care services received in facilities, and for enforcing licensure laws and regulation. The VDH Office of Licensure and Certification is also the designated state survey agency to conduct federal certification surveys for the Centers for Medicare and Medicaid Services.

Children's Health Care Services

VDH is responsible for administering numerous programs to screen children for various types of diseases and health conditions, and for assuring necessary care based on screening results. These programs include Newborn Screening Services, Early Hearing Detection and Intervention Services, and the Virginia Congenital Anomalies Reporting and Education System (VaCARES, the birth defects registry.)

Vital Records and Health Statistics

VDH is responsible for the registration, collection, preservation, amendment and certification of vital records. The vital records system consists of births, deaths, spontaneous fetal deaths, induced termination of pregnancy, marriages, divorces or annulments, adoptions and amendments (alteration to a vital record). The statistical data

collected on these vital records are used by VDH's Division of Heath Statistics to generate annual reports and special reports that address health-related issues. http://www.vdh.virginia.gov/HealthStats/stats.htm.

Health Care Issues Affecting Virginians

The VDH agency vision statement is that "Virginia shall become the healthiest state in the nation." There are two different national assessments that rank all 50 states from most healthy (No. 1) to least healthy (No. 50). According to the 2014 America's Health Rankings compiled by the United Health Foundation, Virginia is ranked 21st among the states. According to the 2014 Commonwealth Fund Scorecard, Virginia is ranked 24th among the states. If Virginia were to become the healthiest state in the United States, what would Virginia need to look like? Applying Virginia data to the Commonwealth Fund's methodology, VDH has estimated (Table 1) that Virginia's number one ranking would be evidenced by the demonstrable improvements across numerous indicators.

Table 1

640,927 total adults and 59,502 children would be covered by health insurance and therefore be more likely to receive healthcare.

365,818 fewer adults would go without needed health care because of cost.

2,133 fewer premature deaths would occur from causes that are potentially treatable or preventable with timely appropriate healthcare.

263 more infants might live to see their first birthday.

548,728 fewer adults would smoke, reducing their risks of lung and heart disease.

302,075 fewer adults would be obese, with body weights that increase their risk for disease and long-term complications.

352,421 fewer adults would have poor health-related quality of life.

383 fewer individuals might take their own lives.

308 fewer breast cancer deaths would occur.

271 fewer colorectal cancer deaths would occur.

68,838 fewer children would be overweight or obese, thus reducing the potential for poor health as they transition to adulthood.

157,829 more adults (age 50 and older) would receive recommended preventive care, such as colon cancer screenings, mammograms, pap smears and flu shots.

Table 1 - continued

225,484 more children (ages 0-17) from low-income families would have a primary care medical home to help ensure that care is coordinated and accessible when needed.

40,410 fewer emergency department visits for non-emergent or primary care-treatable conditions would occur among Medicare beneficiaries.

4,965 fewer hospital readmissions would occur among Medicare beneficiaries (age 65 and older).

$1,548,763,105 Medicare dollars would be saved.

Source: VDH staff analysis.

Additional information concerning the 2014 America's Health Rankings and the 2014 Commonwealth Fund Scorecard, is contained in Appendix A.

Accessibility of Health Care

Figure 2 analyzes Virginians' access to health care services, relative to residents of other states, as measured by six different indicators. The degree of Virginian's access to care improved, relative to other states, from 2009 to 2014. In 2009, Virginia was ranked 18th among the states in terms of access to care but by 2014 Virginia's ranking had improved to 14th. Rankings for 2014 were calculated from indicators of health care access, quality, costs, and outcomes from data ranging from 2007–2012. Among the six dimensions of access that were analyzed, Virginia ranked highest in terms of the percentage of individuals under age 65 with high-out-of-pocket costs relative to their annual household income. By contrast, Virginia ranked lowest in terms of the percentage of adults who went without care because of cost in the past year. These indicators should be closely monitored to determine Virginia's ongoing performance relative to other states.

Figure 2

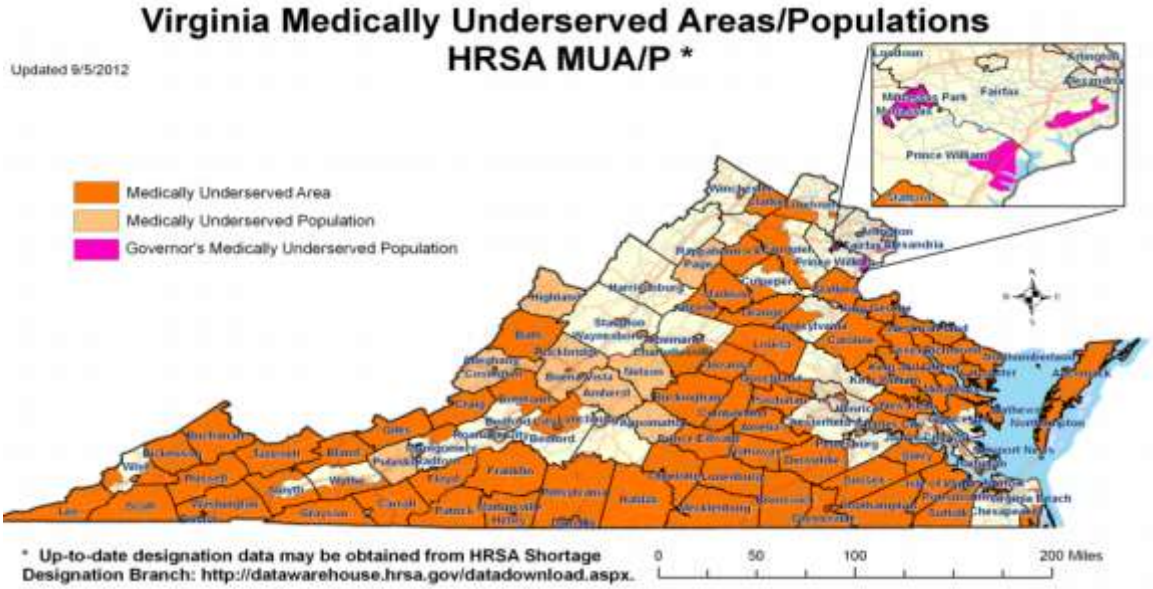
Dimension and Indicator	Data Year	State Rate	All-State Median	Best State Rate	Rank	Revised Data Year	State Rate	All-State Median	Rank	Actual Change in State Rate
▼ Access	2014 Scorecard				14	Revised 2009 Scorecard			18	Change in Rate
Adults ages 19–64 uninsured	2011 - 12	18%	19%	5%	19	2007 - 08	17%	17%	26	1.0
Children ages 0–18 uninsured	2011 - 12	6%	8%	3%	9	2007 - 08	9%	9%	25	-3.0
Adults who went without care because of cost in past year	2012	15%	15%	9%	21	2007	11%	12%	16	4.0
Individuals under age 65 with high out-of-pocket medical costs relative to their annual household income	2011 - 12	13%	16%	10%	7	N/A	N/A	N/A	N/A	N/A
At-risk adults without a routine doctor visit in past two years	2012	12%	14%	6%	15	2007	14%	14%	22	-2.0
Adults without a dental visit in past year	2012	12%	15%	10%	7	2006	13%	14%	16	-1.0

Source: 2014 Commonwealth Fund Scorecard.

Distribution of Healthcare Resources

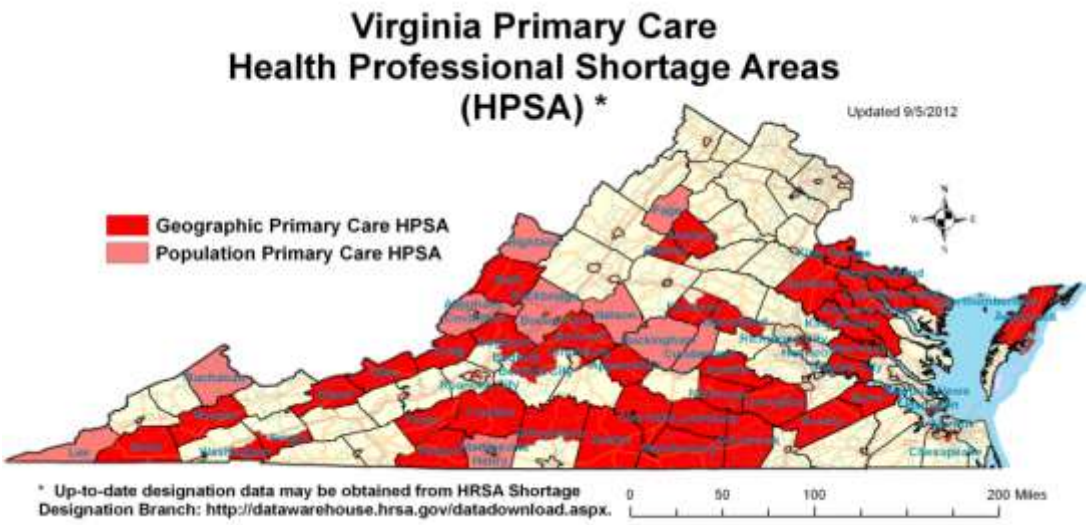
VDH utilizes state and federal criteria to designate a variety of types of medically underserved areas and populations, and several different types of health professional shortage areas. Figures 3 and 4 illustrate that substantial areas of Virginia are either medically underserved or health professional shortage areas.

Figure 3



Source: Virginia Department of Health, Office of Minority Health and Health Equity.

Figure 4

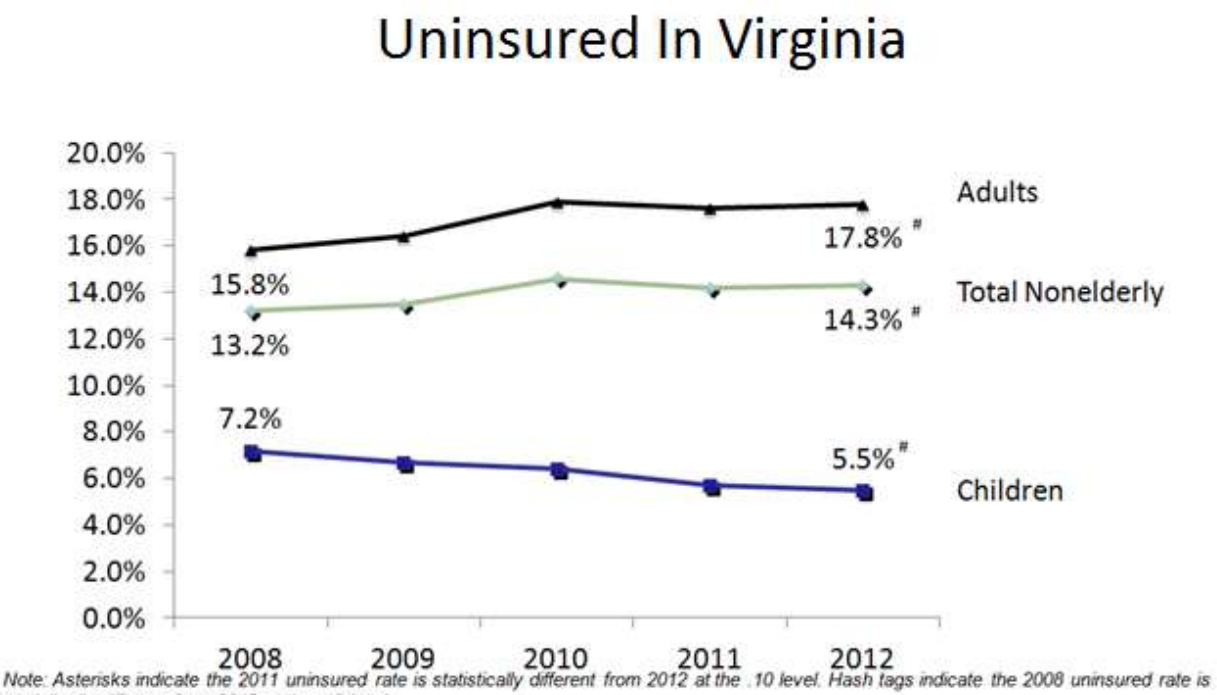


Source: Virginia Department of Health, Office of Minority Health and Health Equity.

Health Insurance Coverage

Health insurance coverage is a key determinant of access to health care services. Figure 5 illustrates that the change in the percentage of uninsured Virginians between 2008 and 2012. The percentage of uninsured adults increased, and the percentage of uninsured children decreased between 2008 and 2012. As shown in Figure 6, uninsured adults in Virginia are more likely than insured adults to have unmet needs and less likely to receive preventive care.

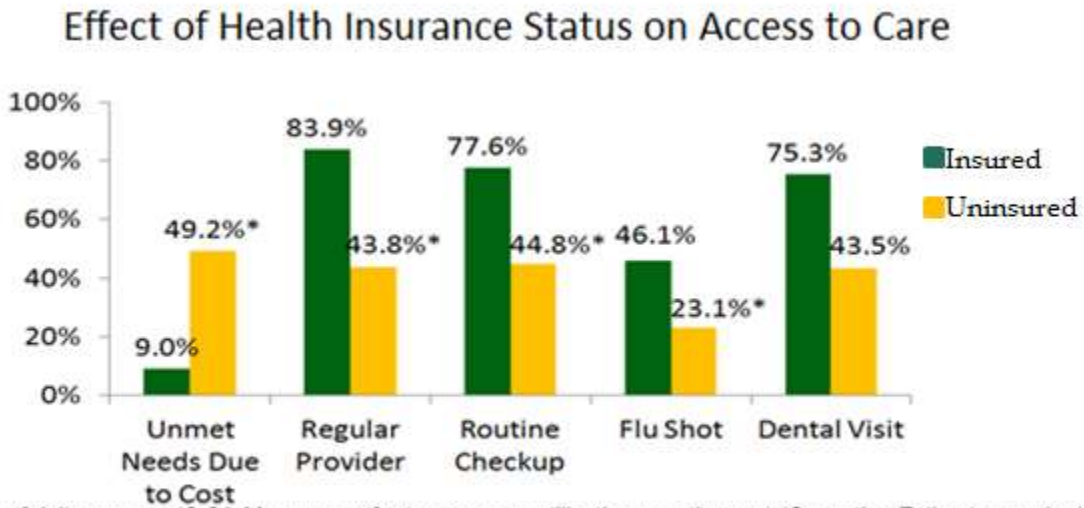
Figure 5



Note: Asterisks indicate the 2011 uninsured rate is statistically different from 2012 at the .10 level. Hash tags indicate the 2008 uninsured rate is statistically different from 2012 at the .10 level.

Source: Urban Institute, April 2014. Based on the 2008, 2009, 2010, 2011 and 2012 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS). The estimates reflect Urban Institute adjustments for potential misreporting of coverage, based on a simulation model developed by Victoria Lynch under a grant from the Robert Wood Johnson Foundation.

Figure 6



*Note: Adults are age 19-64. Measures refer to access or utilization over the past 12 months. Estimates marked with * indicate the difference between the insured and uninsured estimates is significant at the .01 percent level.*

Source: Urban Institute, April 2014. Based on the 2012 Behavioral Risk Factor Surveillance System.

Certificate of Public Need Charity Care Conditions. Under the authority of § 32.1 – 102.2(C) of the Code, the State Health Commissioner may condition the issuance of a Certificate of Public Need (COPN) for the:

- Provision of an acceptable level of care at a reduced rate to indigents;
- Provision of care to persons with special needs; or
- Facilitate the development and operation of primary medical care services in designated medically underserved areas of the applicant's service area.

These COPN conditions (Table 2) play an important role in Virginia's health care safety net. Due to a host of reasons, not the least of which is the geographic location of a facility, some COPN holders have been unable to comply with conditions requiring the provision of indigent care, which were accepted as part of receiving COPN authorization for a project. The inclusion of language in indigent care conditions providing for the development and operation of primary care services for underserved populations, in an amount to be aggregated with the amount of indigent care, is an effort to afford those COPN holders an alternative way to satisfy their obligations while still meeting the intention of the process.

Table 2 – Amount of COPN Charity Care Conditions

Report	Rec'd	Reported Compliant	Compliant By Providing Care	Compliant By Making Donation	Reported Non-Compliant	$Value of Care From Conditions	$ In-Kind & Cash Donations
2013 Interim	163	159	81	78	4	1,287,152,440	33,468,806
2012 Final	217	217	120	97	0	1,203,966,290	32,259,775
2011 Final	244	244	157	87	0	856,950,546	15,528,163

Note: 2013 Interim Report dated 12/3/14.

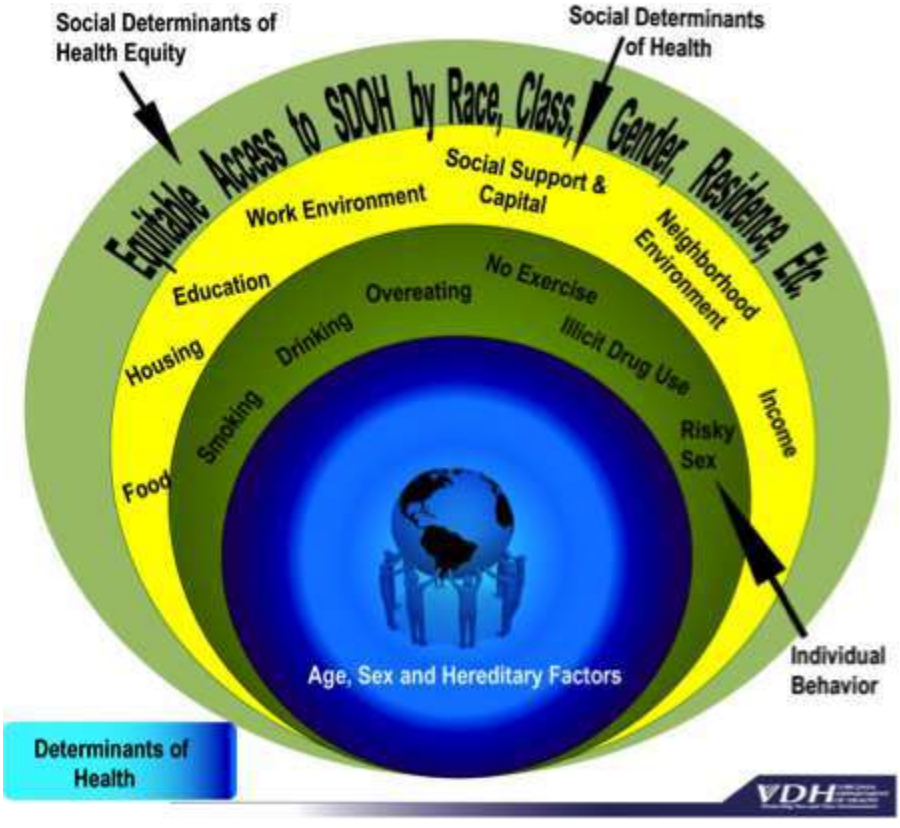
Source: Virginia Department of Health, Office of Licensure and Certification.

Disproportionate Disease Burden in Virginia: Opportunities for Health Improvement

All Virginians deserve equal opportunities to be healthy. However, our public health system continues to be challenged by disparities in access to quality health care, access to opportunities that promote health and overall health status. These disparities can be related to income, education, race, ethnicity, or place of residence. Health status disparities lead to preventable health care, social, and economic costs, as well as reductions to lifespan and quality of life. The continued presence of health disparities also poses a significant obstacle to VDH's vision of having Virginia become the healthiest state in the nation. Ultimately, success in achieving more equitable opportunities to be healthy and reducing health inequities requires strong, action-oriented partnerships within the Commonwealth to create the conditions in which it is easier for people to make daily decisions that are more healthful.

According to the World Health Organization, social determinants of health factors are responsible for the majority of diseases and injuries. In the U.S., such factors are estimated to account for 70 percent of avoidable mortality. Consequently, recognition and understanding of the social determinants of health (Figure 7) is important and useful to developing strategies to provide greater opportunities for health improvement in Virginia. Issues pertaining to reducing health disparities, and promoting health equity, are addressed in VDH's 2012 Health Equity Report http://www.vdh.virginia.gov/OMHHE/2012report.htm

Figure 7



Health Disparities Related to Place of Residence

The Robert Wood Johnson Foundation annually prepares County Health Rankings for each state. Each county and city in Virginia is ranked from most healthy to least healthy. The rankings take into account both health factors (Figure 8) and health outcomes (Figure 9). The results of the

Figure 8

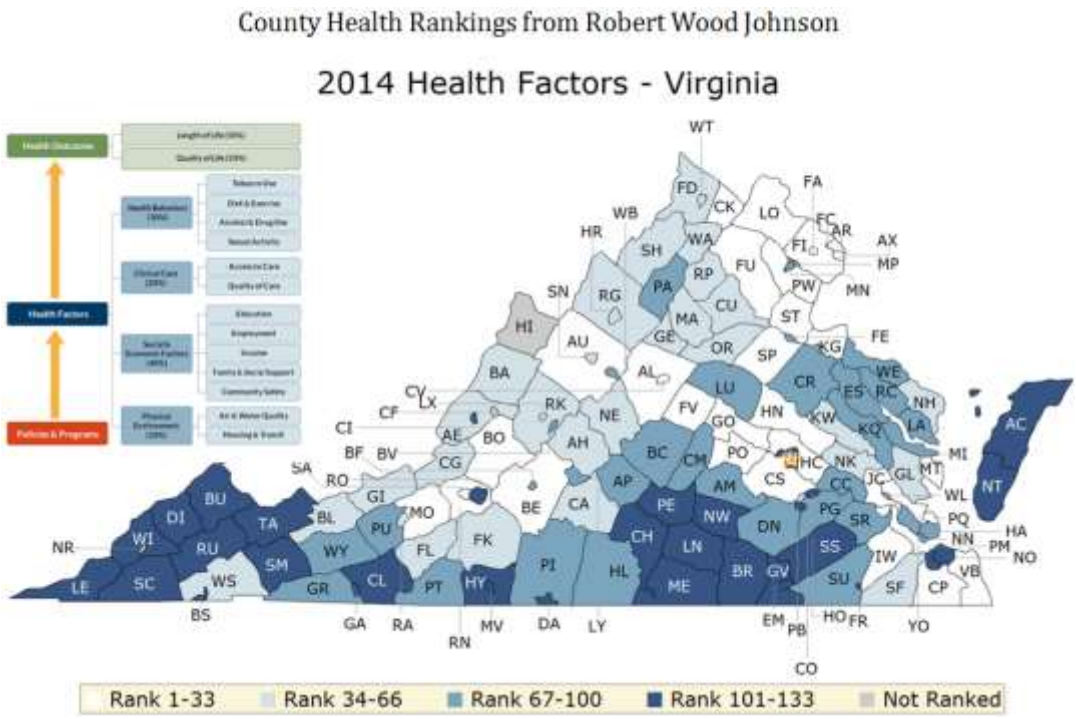
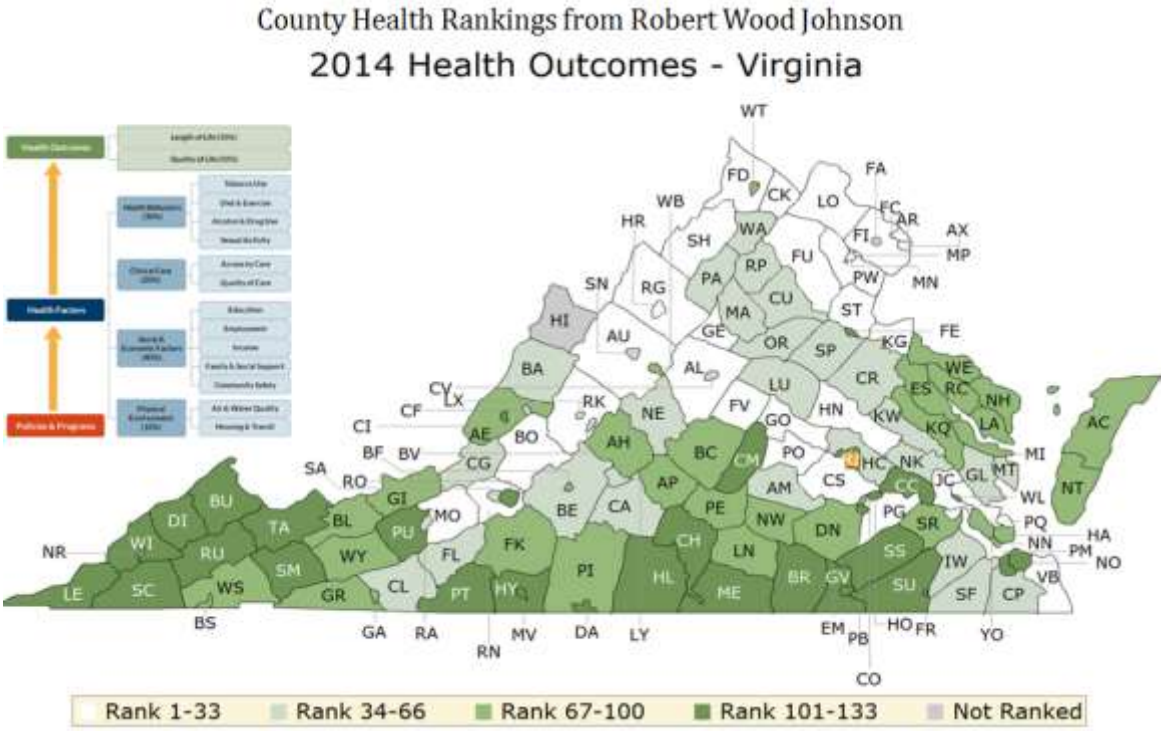


Figure 9



county health rankings for Virginia illustrate, in many respects, "two Virginias" in terms of health status. Generally speaking, localities in the northern part of the state rank higher in health factors and outcomes than localities in the southern part of the state.

Disparate Chronic Disease Burdens

Disparities Based on Place of Residence. Another approach to examining health disparities in Virginia is to review the mortality rate associated with specific chronic disease states (i.e., stroke, cancer and heart disease). The trend in mortality rates for these diseases resembles the trend from the county health rankings. Generally speaking, as illustrated by Figures 10, 11 and 12, localities in the northern region of the state have mortality rates that are lower than localities in the southern part of Virginia

Figure 10 – Stroke, Cancer and Heart Disease Mortality Rates

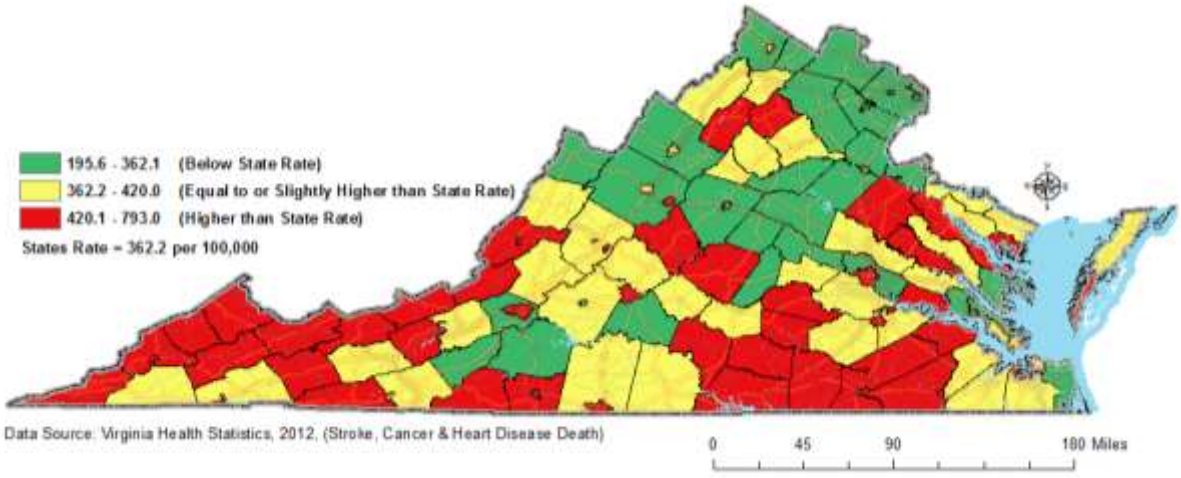


Figure 11 – Cancer Mortality Rates

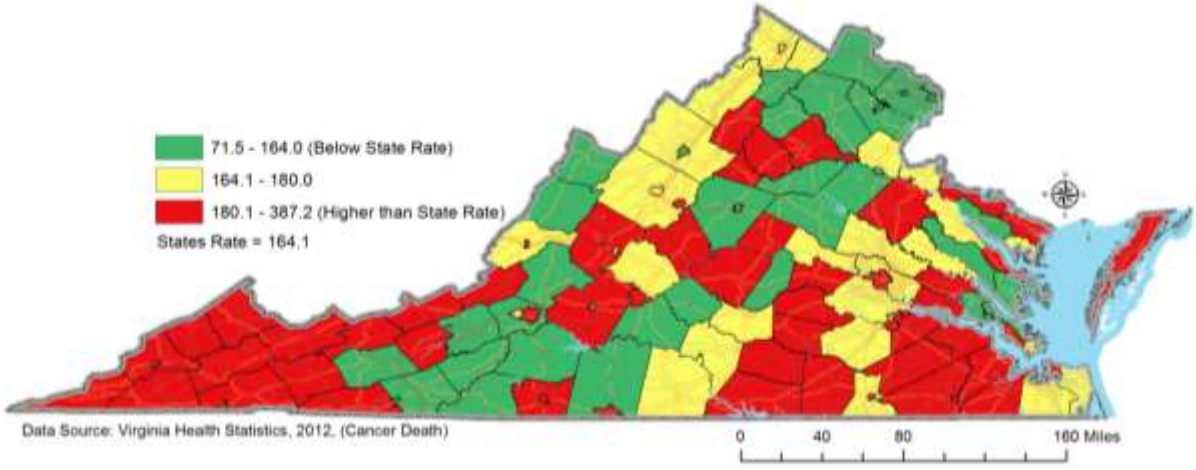
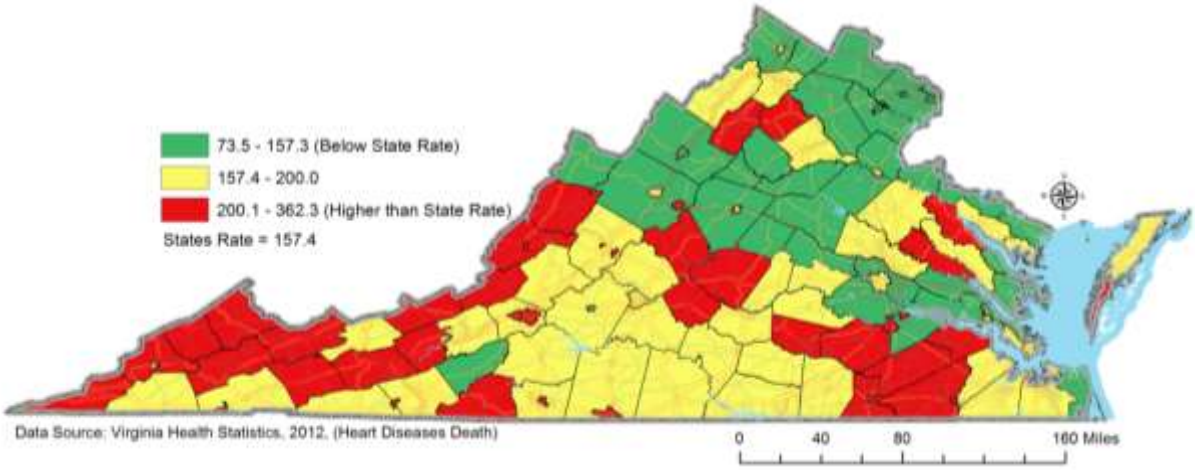


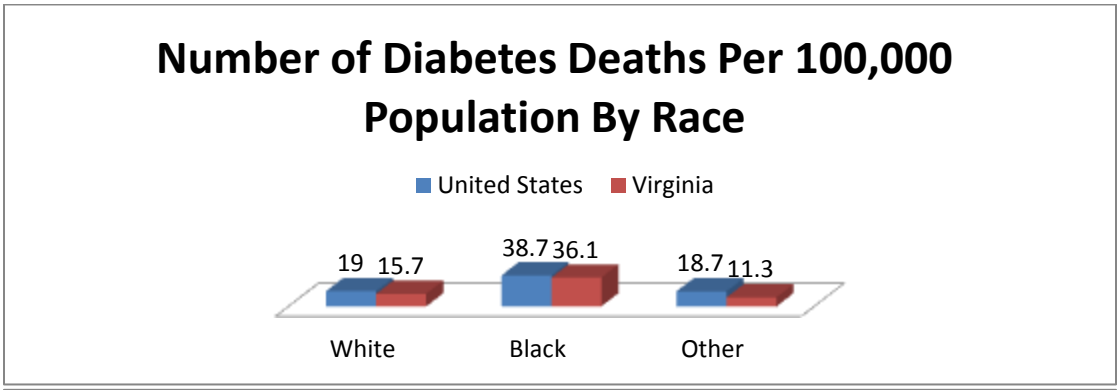
Figure 12 – Heart Disease Mortality Rates

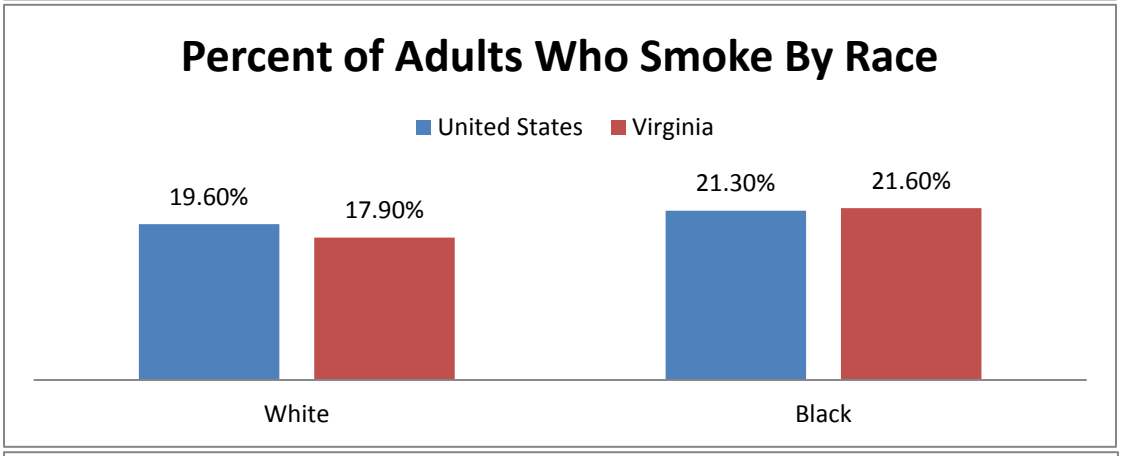


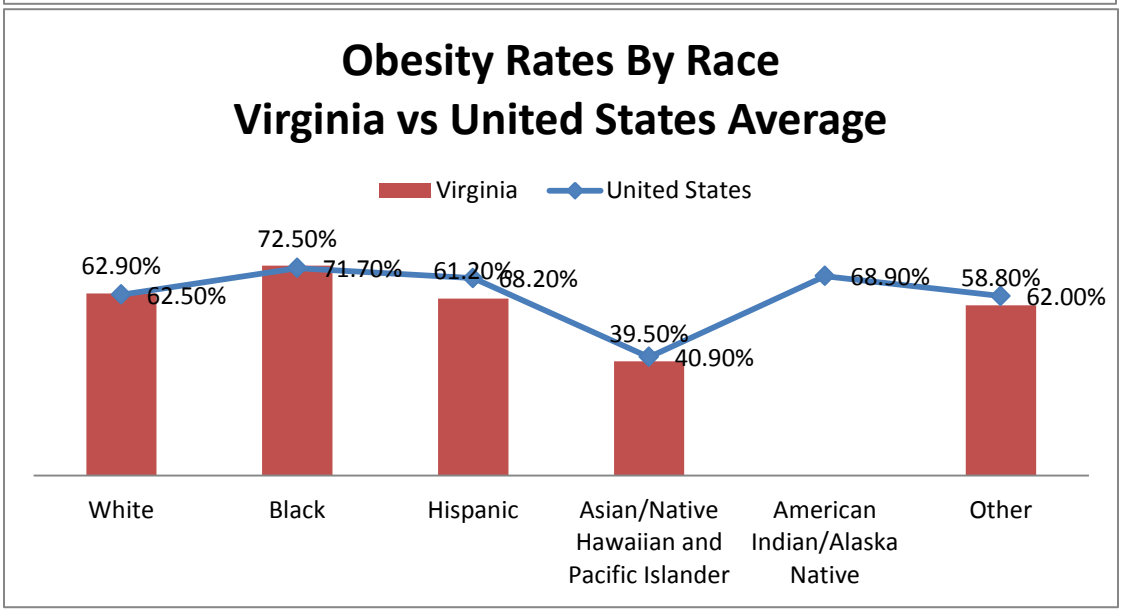
Racial Disparities

Within Virginia, there are significant disparities, based on race, pertaining to health risk factors and health status. For example, as illustrated in Figures 13 and 14, compared to the White population, the Black population has substantially higher mortality rates resulting from diabetes, higher smoking rates, higher obesity rates, as well as greater rates of infant mortality.

Figure 13

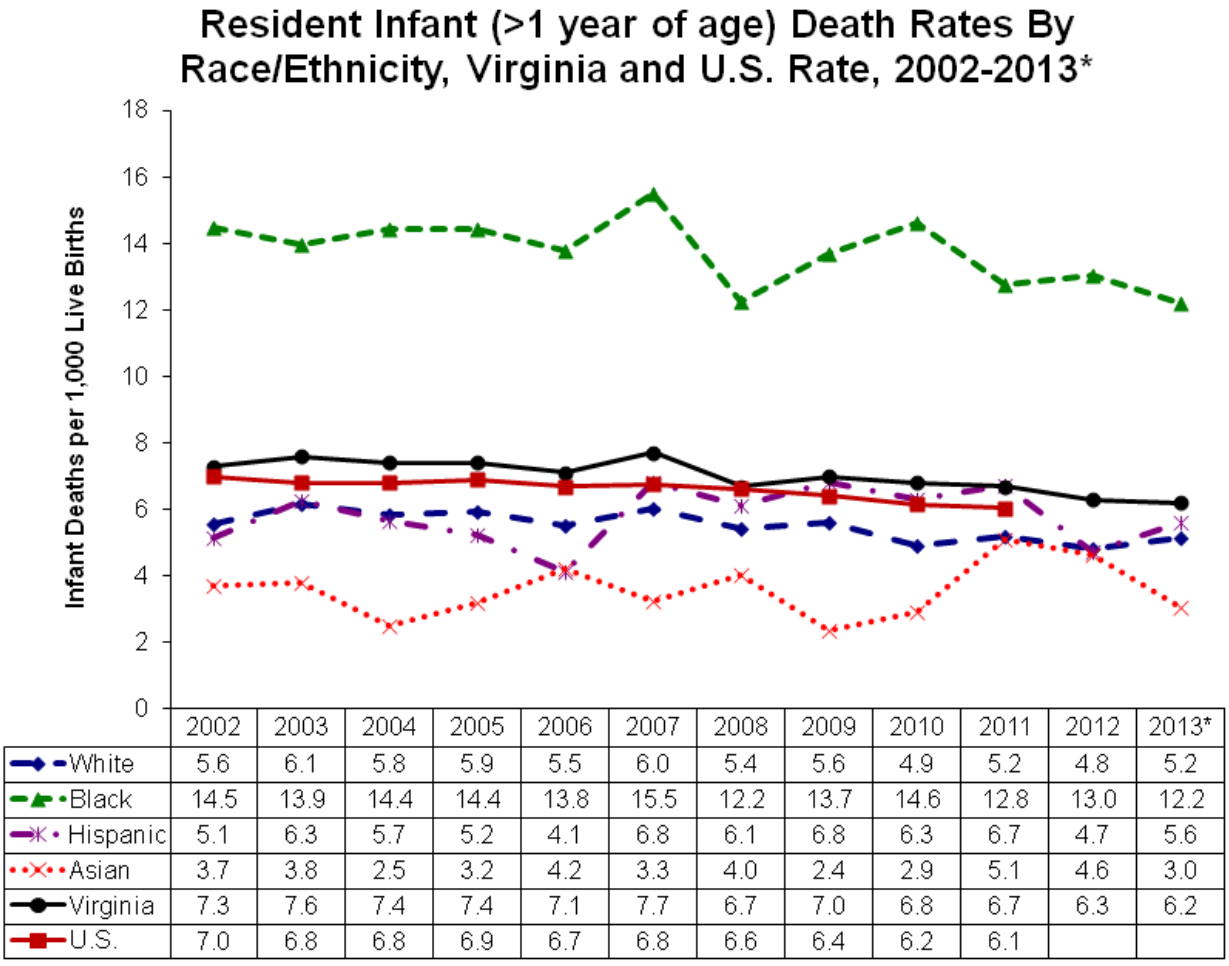






Source: Kaiser Family Foundation**.** Data for 2010

Figure 14



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

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

Next Steps

Population health has been defined as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group." It is an approach to health that aims to improve the health of an entire human population Population health improvement seeks to complement the traditional efforts of public health agencies by addressing a broader range of factors shown to impact the health of different populations. The concept of population health, and population health improvement, is receiving increased attention at the state level.

Joint Commission on Health Care – Population Health Measures

In August 2014, VDH was requested by the Joint Commission on Health Care (JCHC) of the General Assembly to work with a wide range of external stakeholder organizations to identify statewide core regional population health measures, as well as opportunities for their collection and dissemination. This request followed a JCHC study of factors that increase health care costs. According to that study, five percent of the U.S. population accounts for 50% of health care

spending. The study also found that health care costs are impacted by rising rates of chronic disease and co-morbidities. JCHC identified measuring and improving population health as cost containment strategies, but recognized that each region will have different infrastructure, needs and opportunities.

In making the request, the JCHC asked VDH to build on existing efforts, including Virginia Atlas for Community Health, and Community Health Needs Assessments. JCHC also asked that VDH work collaboratively with the following organizations: Virginia Health Care Foundation, Virginia Hospital and Healthcare Association, Virginia Community Healthcare Association, Medical Society of Virginia, Department of Medical Assistance Services, Virginia Association of Free and Charitable Clinics, Virginia Center for Health Innovation, Virginia Chamber of Commerce, Virginia Health Information, and the Virginia Rural Health Association. VDH will work with the stakeholders as requested in order to complete this study request and report back to the JCHC by October 2015

Statewide Plan for Improving Population Health

In December 2014, Virginia received a $2.6 million State Innovation Model grant from the U.S. Centers for Medicare and Medicaid Services. As part of this grant, VDH will be working with the Virginia Center for Health Innovation (VCHI), under the direction of a Governor's Office Leadership Team, to produce a statewide, data-driven, Plan for Improving Population Health. The plan will have an initial focus on adult and child populations that have or are at risk for chronic or complex conditions (such as diabetes, heart disease, asthma, chronic obstructive pulmonary disease, hypertension, mental illness, and substance abuse). To address these conditions, statewide population health objectives will include reductions in tobacco use and obesity, and improvements in prevention and management of cardiovascular disease, diabetes, respiratory disease, high-risk pregnancy, and selected mental health and oral health conditions. Population-based measures of health status, access, quality, utilization, and consumer experience will be generated from multiple Virginia-specific sources including vital records and Virginia's all-payer claims database.

VDH Strategic Objectives

VDH's focus on population health improvement is consistent with the agency's strategic objectives, particularly those pertaining to maternal and child health and chronic diseases. VDH actively monitors its performance relative to those objectives through a series of agency metrics (Table 3.)

Operations

Continue to support and improve the health of all Virginian's through efficient and effective execution of operations and delivery of services

Communicable Disease

Stabilize the incidence of reported cases of chlamydia, syphilis and gonorrhea

Increase the percentage of active tuberculosis cases completing a standard treatment regimen within 12 months

Increase the percentage of children receiving 4 doses of DTaP by age 2

Increase the percentage of adolescent women (age 13-17) receiving 3 doses of HPV vaccine

Increase the percentage of cases in which control measures were initiated within Public Health Emergency Preparedness (PHEP) required timeframes for specified reported diseases

Maternal & Child Health

Increase the number of infants who survive their first year of life

Increase the number of African American infants who survive their first year of life

Reduce the pregnancy rate of women age 15-19 years

Chronic Disease

Increase the percentage of Virginians reporting physical activity or exercise outside of work in the last 30 days

Increase the number of children and pregnant women with access to healthy and nutritional food

Increase the percentage of mothers reporting not to have smoked during pregnancy

Maintain the number of low income children and adolescents receiving dental services

Environmental Health, Health Hazards & Healthcare Facilities

Complete scheduled facility inspections within required time frames

Increase the percentage of violations corrected at the time of inspection

Emergency Preparedness

Maintain the percentage of local health districts that are certified by Project Public Health Ready

Increase the percentage of VDH employees responding to Health Alert Network messages within one hour

Increase the number of licensed EMS agencies that are submitting pre-hospital data with a minimum quality score of 98 to the Virginia Pre-hospital Information Bridge and version 3 National EMS Information System

Chief Medical Examiner

Complete death investigations within 90 days

Table 3 - VDH Agency Metrics

Category	Metric	Metric Type	Baseline	2016 Mid-Term Target	2018 Mid-Term Target	Objective
Chief Medical Examiner	Number of suitable cadavers provided to Virginia medical Schools & research Centers	Other	258	350	400	Continue to support and improve the health of all Virginian's through efficient and effective execution of operations and delivery of services
	Percentage of Death Investigations completed within 90 days	Other	90%	90%	90%	Complete death investigations within 90 days
Chronic Disease	Percentage of Virginians who participated in any physical activities in the last 30 days	Other	78%	85.3%	93.7%	Increase the percentage of Virginians reporting physical activity or exercise outside of work in the last 30 days
	Percentage of women reporting smoking during pregnancy	Other	7.4%	6.60%	5.94%	Increase the percentage of mothers reporting not to have smoked during pregnancy
Communicable Disease	Percentage of children receiving 4 doses of DTaP by age 2	Key	83%	88%	90%	Increase the percentage of children receiving 4 doses of Dtap by age 2
	Percentage of adolescents (age 13-17) receiving 3 doses of HPV vaccine	Other	27.9%	45%	60%	Increase the percentage of adolescent women (age 13-17) receiving 3 doses of HPV vaccine
	Percentage of active Tuberculosis Cases Completing a Standard Treatment Regime within 12 months	Other	84%	90%	93%	Increase the percentage of active Tuberculosis Cases Completing a Standard Treatment Regime within 12 months
	Primary and secondary syphilis incidence rate	Other	3.9	3.9	3.9	Stabilize the incidence rate of reported cases of Chlamydia, Syphilis and Gonorrhea
	Percentage of reported disease cases in which control measures were initiated within PHEP required timeframes	Other	68%	90%	90%	Increase the percentage of reported disease cases in which control measures were initiated within PHEP required timeframes
	Percentage of people linked to HIV care after a positive HIV test	Other	75%	78%	80%	Continue to support and improve the health of all Virginian's through efficient and effective execution of operations and delivery of services
Drinking Water	Percentage of waterworks inspections completed within established time frames	Other	93%	100%	100%	Completed scheduled facility inspections within required time frames
	Percentage of program expenditures for drinking water construction financing spent in expected time frames	Other	TBD	TBD	TBD	Continue to support and improve the health of all Virginian's through efficient and effective execution of operations and delivery of services

Category	Metric	Metric Type	Baseline	2016 Mid-Term Target	2018 Mid-Term Target	Objective
Emergency Preparedness	Number of licensed EMS agencies that are submitting pre-hospital data with minimum quality score of 98 to the Virginia Prehospital Information Bridge and version 3 National EMS Information system.	Other	72%	85%	88%	Increase by 13% (current baseline 72%) the number of licensed EMS agencies that are submitting prehospital data with a minimum quality score of 98 to the Virginia Prehospital Information Bridge and version 3 National EMS Information System (NEMSIS) by December 31, 2016
	Number of local health districts maintaining NACCHO Project Public Health designation	Key	35	35	35	Ensure that all districts are certified by Project Public Health Ready
	Percentage of staff that response to the health alerting messages within 60 minutes of receiving alerts	Other	59%	70%	80%	Increase the percentage of VDH employees responding to HAN Messages
Environmental Health & Health Hazards	Percentage of Requests for Public Health Consultation or Assessment for Chemical Exposure Responded To Within 48 Hours of Receipt	Other	TBD	95%	95%	Continue to support and improve the health of all Virginian's through efficient and effective execution of operations and delivery of services
	Percentage of Failing Onsite Sewage Systems Corrected Within 60 Days of Local Health Departments becoming Aware of the Issue	Key	37%	40%	43%	Continue to support and improve the health of all Virginian's through efficient and effective execution of operations and delivery of services
	Percentage of food service establishment inspections completed within required time frames	Other	49%	54%	60%	Completed scheduled facility inspections within required time frames
	Percentage of risk factor violations corrected at time of inspection	Other	60%	66%	73%	Increase the percentage of violations corrected at the time of inspection
	Percentage of Shellfish and Crustacea Plant Establishment Inspections Completed Within Required Timeframes	Other	93%	95%	95%	Completed scheduled facility inspections within required time frames
	Percentage of violations corrected within 30 days notification for radioactive material licenses	Other	100%	100%	100%	Increase the percentage of violations corrected at the time of inspection
	Percentage of serious violations corrected within 45 days notification for X-ray registrants	Other	100%	100%	100%	Increase the percentage of violations corrected at the time of inspection

Category	Metric	Metric Type	Baseline	2016 Mid-Term Target	2018 Mid-Term Target	Objective
Maternal Child & Health	Number of Children with Special Health Care Needs (CSHCN) receiving care coordination services.	Other	6779	8050	8855	Continue to support and improve the health of all Virginian's through efficient and effective execution of operations and delivery of services
	Newborn Survival Rate/Infant Mortality rate	Key	993.68	995.44	997.56	Increase the number of infants who survive their first year of life. (Reduce the infant mortality rate
	Injury hospitalization for youth 0-19 years of age	Other	135.6	127.7	123.9	Continue to support and improve the health of all Virginian's through efficient and effective execution of operations and delivery of services
	Number of children and pregnant women with access to healthy and nutritional food	Key	299,703	314,688	330,422	Number of children and pregnant women with access to healthy and nutritional food
	Number of low income children and adolescents receiving dental services	Other	9270	4550	4550	Maintain the Number Of Low Income Children And Adolescents Receiving Dental Services
	Pregnancy rate of women age 15-19 years (per Thousand)	Other	12.3	10	10	Reduce the pregnancy rate of women age 15-19 years
Operations	Number of scholarships or loan repayment recipients receiving awards	Other	14	14	14	Continue to support and improve the health of all Virginian's through efficient and effective execution of operations and delivery of services
	Number of months from the close of data to production of the DHS statistical annual report	Other	13 Months	11 Months	9 Months	Continue to support and improve the health of all Virginian's through efficient and effective execution of operations and delivery of services
	Number of data reports automated and available on the data warehouse	Other	0	4	10	Continue to support and improve the health of all Virginian's through efficient and effective execution of operations and delivery of services
	Number of J-1 waiver recommendations	Other	30	30	30	Continue to support and improve the health of all Virginian's through efficient and effective execution of operations and delivery of services
	Number of small rural hospitals receiving technical assistance and funding	Other	23	24	24	Continue to support and improve the health of all Virginian's through efficient and effective execution of operations and delivery of services
	Percentage of health care facilities inspected within the required time frames	Other	84%	95%	99%	Completed scheduled facility inspections within required time frames
	Number of Community-based Nursing Home Pre-admission screens performed	Other	12300	12500	12600	Continue to support and improve the health of all Virginian's through efficient and effective execution of operations and delivery of services

Conclusion

A wide range of public health and health care issues affect Virginians from all walks of life. Guided by its strategic objectives, VDH is taking a data driven, population health-based approach to making Virginia the healthiest state in the nation. An effective approach to population health improvement must include a significant component focused on recognizing, and reducing, various types of health disparities that currently exist. Creative and novel strategies, in close and extensive collaboration with public and private sector partners, will be critical to VDH's ultimate success.

Appendix A

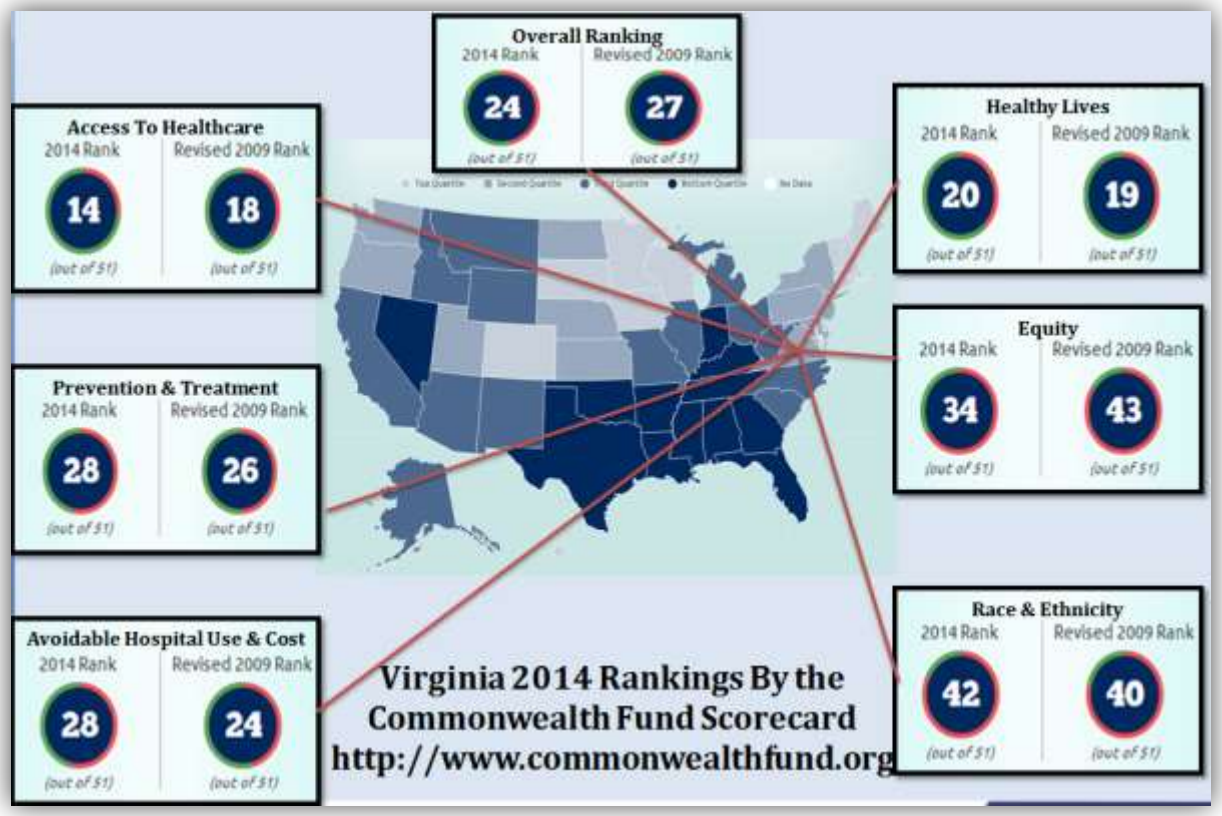
Understanding The Baseline Summary of Health Care Issues Affecting Citizens of Virginia

(Using National & Local Data Sources)

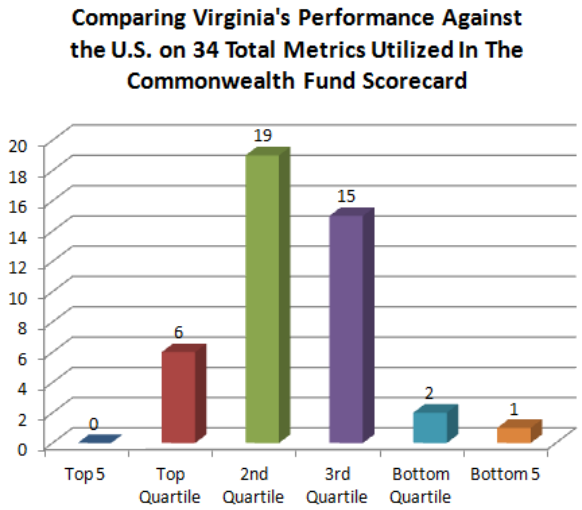
Commonwealth Fund

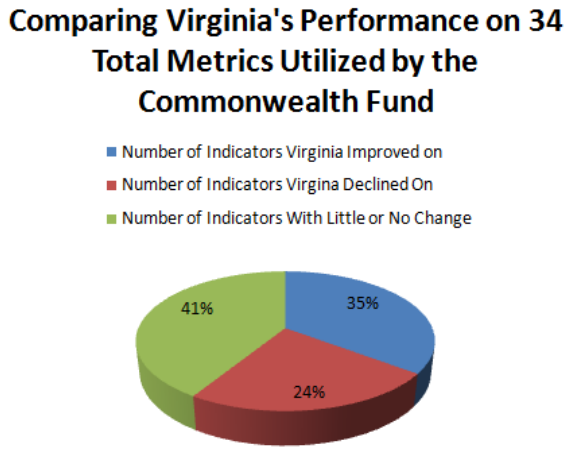
America's Health Rankings

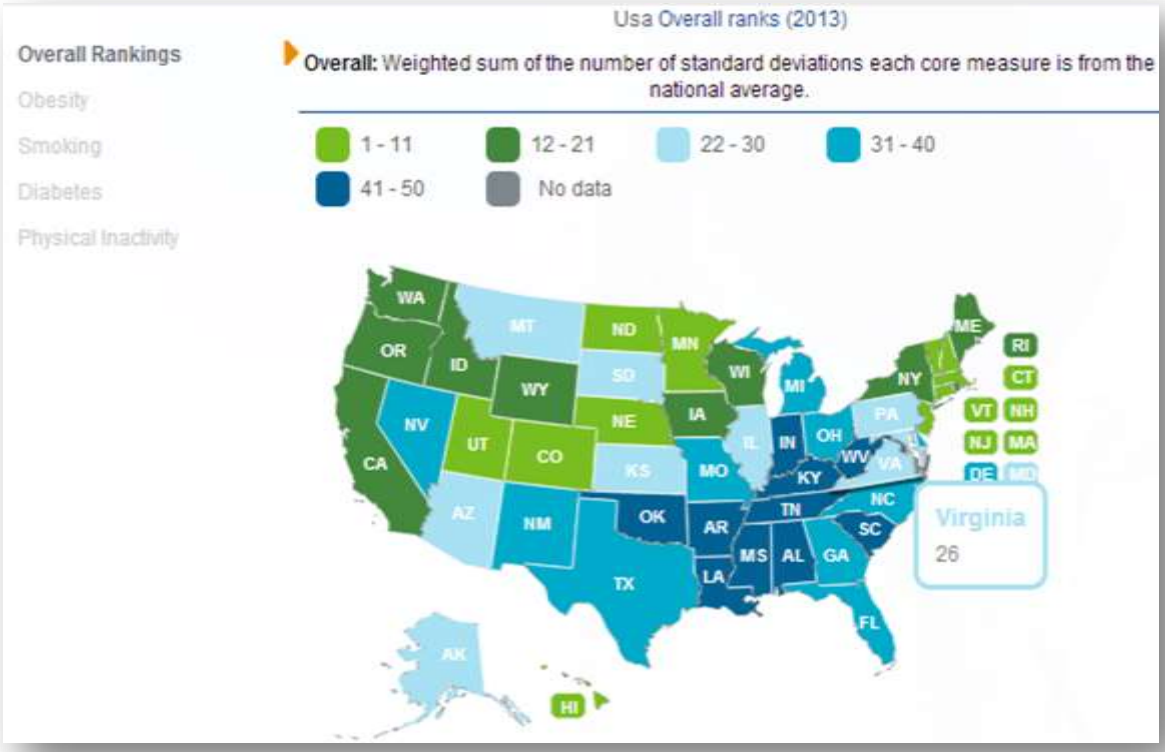
County Health Rankings

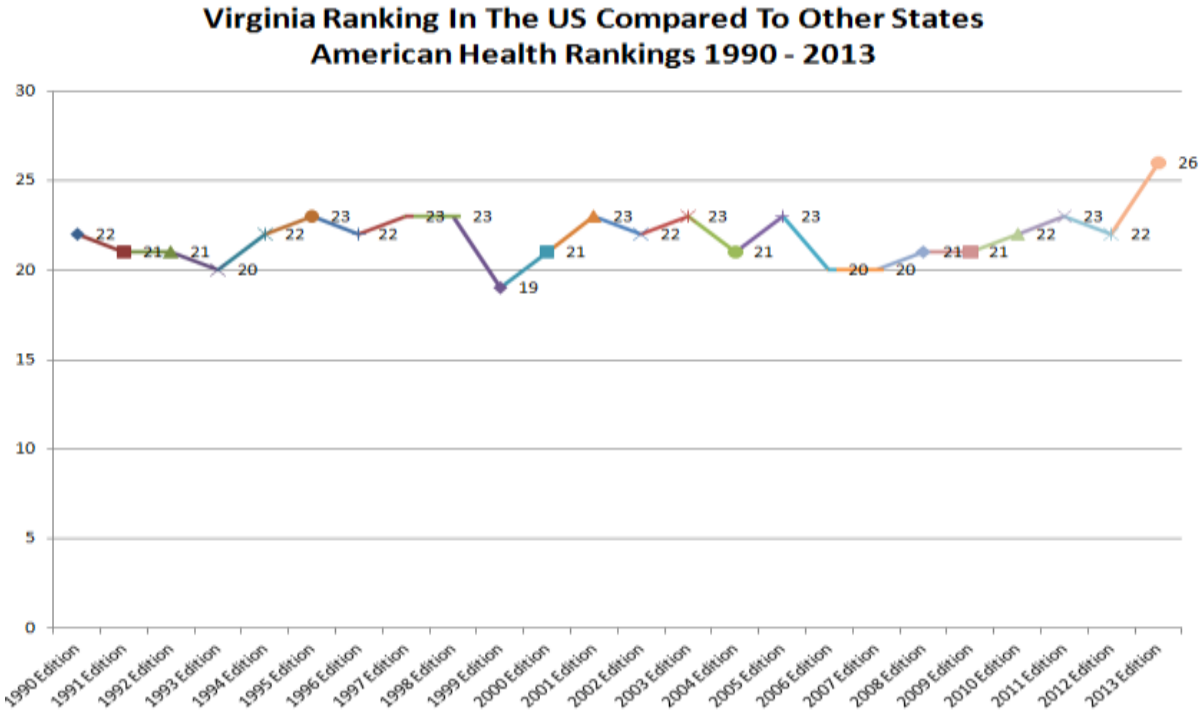


Summarizing Virginia 2014 Rankings By the Commonwealth Fund Scorecard http://www.commonwealthfund.org






Usa Overall ranks (2013)
Overall Rankings
Obesity
Smoking
Diabetes
Physical Inactivity
Overall: Weighted sum of the number of standard deviations each core measure is from the national average.
1 - 11
12 - 21
22 - 30
31 - 40
41 - 50
No data
Virginia
26


Virginia Ranking In The US Compared To Other States
American Health Rankings 1990 - 2013
30
25
20
15
10
5
0
1990 Edition
1991 Edition
1992 Edition
1993 Edition
1994 Edition
1995 Edition
1996 Edition
1997 Edition
1998 Edition
1999 Edition
2000 Edition
2001 Edition
2002 Edition
2003 Edition
2004 Edition
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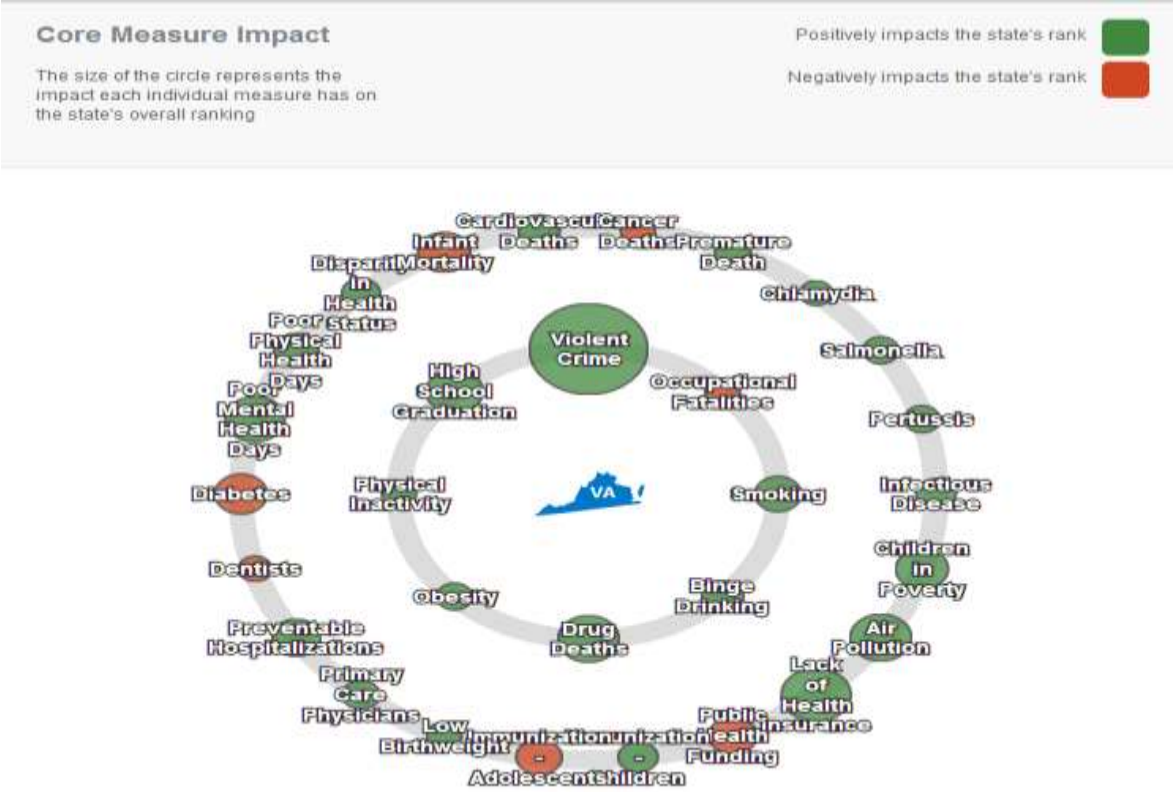
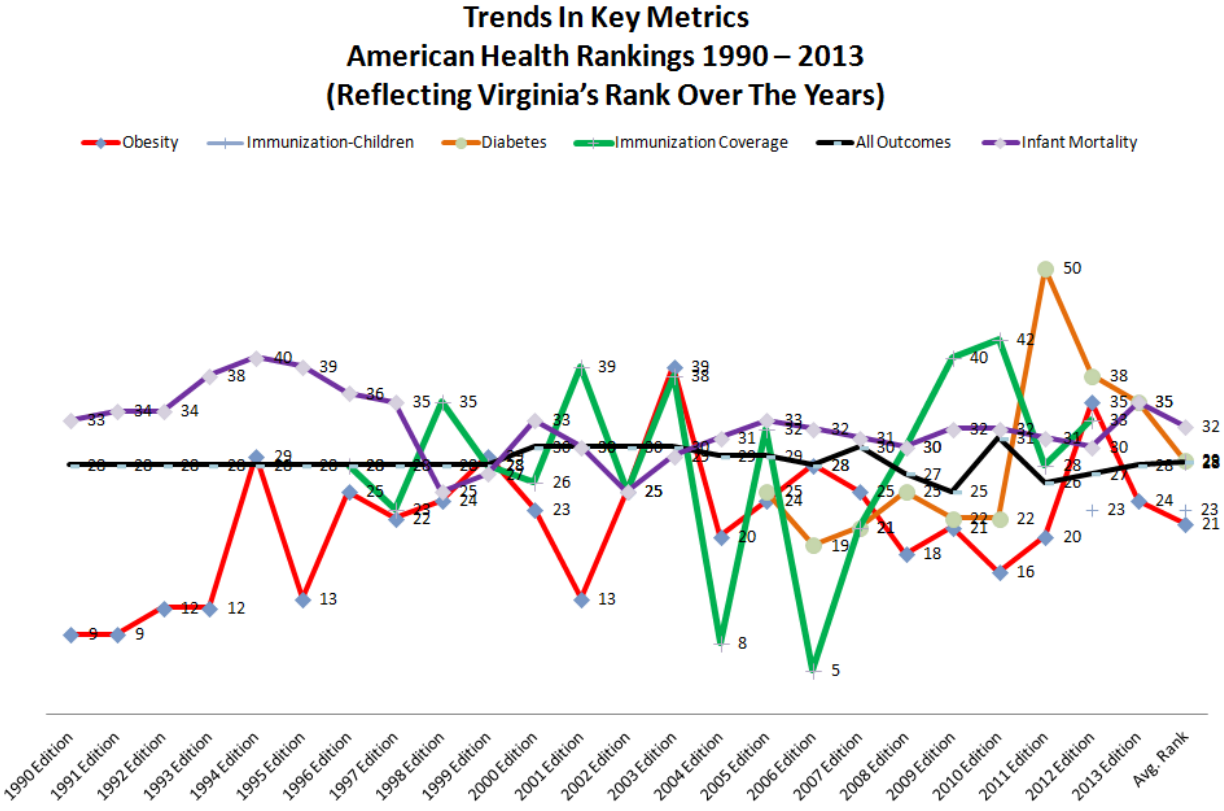
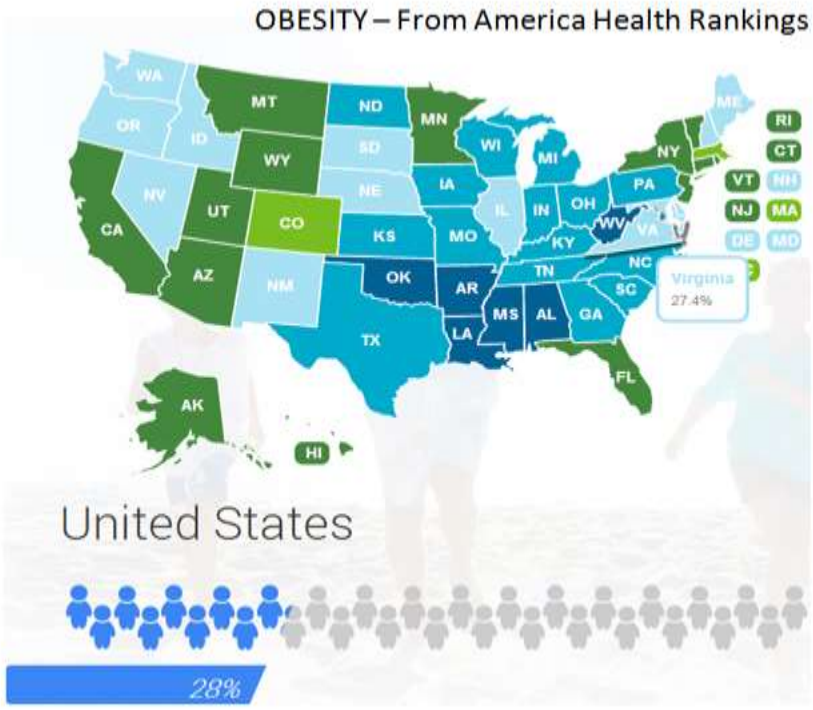
2008 Edition
2009 Edition
2010 Edition
2011 Edition
2012 Edition
2013 Edition

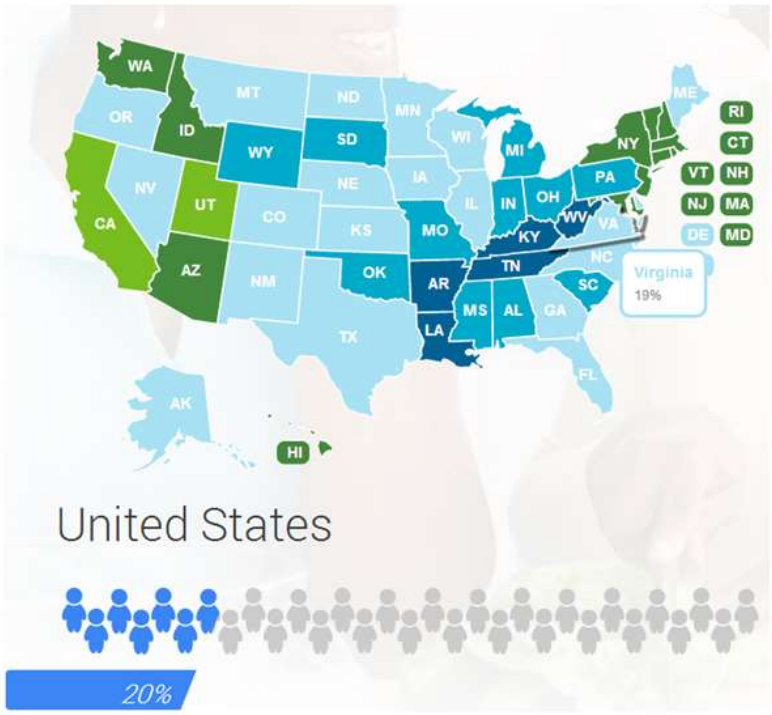

Core Measure Impact
The size of the circle represents the impact each individual measure has on the state's overall ranking
Positively impacts the state's rank
Negatively impacts the state's rank
Violent Crime
Occupational Fatalities
High School Graduation
Physical Inactivity
Obesity
Smoking
Binge Drinking
Drug Deaths
Lack of Health Insurance
Public Health Funding
Low Birthweight
Immunization-Children
Immunization Coverage
Adolescents
Primary Care Physicians
Preventable Hospitalizations
Dentists
Diabetes
Poor Mental Health Days
Physical Health Days
Poor Status
Disparity in Health
Infant Mortality
Cardiovascular Deaths
Cancer Deaths
Premature Death
Chlamydia
Salmonella
Pertussis
Infectious Disease
Children in Poverty
Air Pollution


Trends In Key Metrics
American Health Rankings 1990 – 2013
(Reflecting Virginia's Rank Over The Years)
Obesity
Immunization-Children
Diabetes
Immunization Coverage
All Outcomes
Infant Mortality
1990 Edition
1991 Edition
1992 Edition
1993 Edition
1994 Edition
1995 Edition
1996 Edition
1997 Edition
1998 Edition
1999 Edition
2000 Edition
2001 Edition
2002 Edition
2003 Edition
2004 Edition
2005 Edition
2006 Edition
2007 Edition
2008 Edition
2009 Edition
2010 Edition
2011 Edition
2012 Edition
2013 Edition
Avg. Rank



In Virginia, 27% of the Population is Considered Obese, with a body mass index (BMI) of 30.0 or higher

Smoking – From America Health Rankings

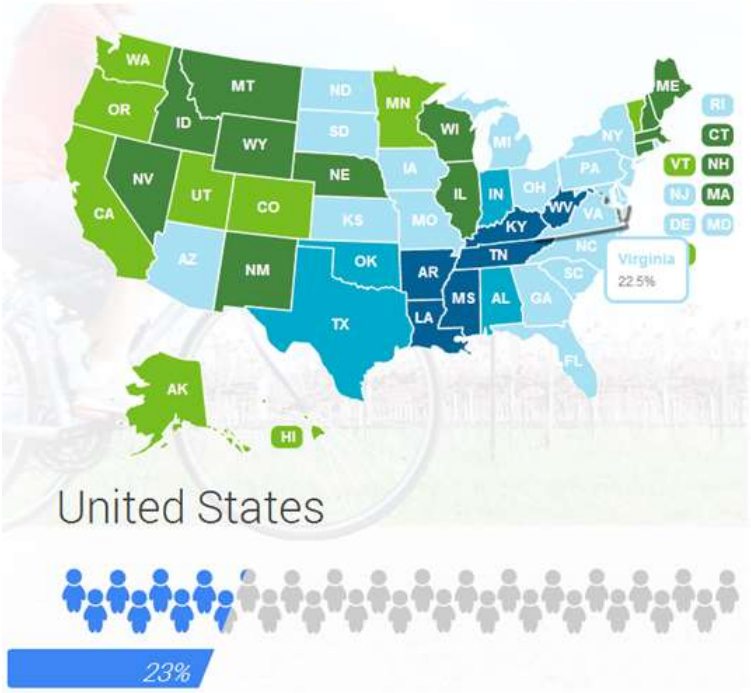


In Virginia 19% of adults are current smokers (who self-report smoking at least 100 cigarettes in their lifetime and currently smoke)

DIABETES

In Virginia, 10.6% of Adults responded yes to the question "Have you ever been told by a doctor that you have diabetes?"

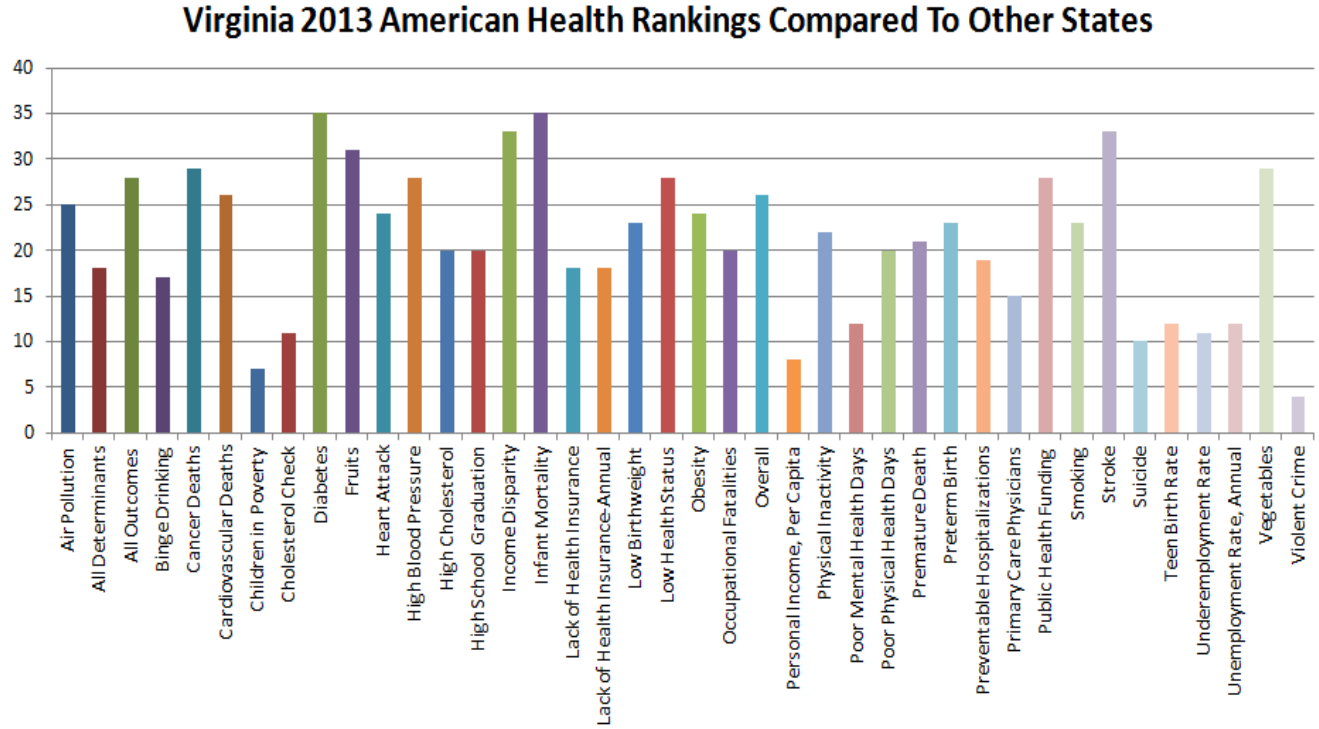
PHYSICAL INACTIVITY – From America Health Rankings



In Virginia, 22.5% of adults reported doing no physical activity or exercise (such as running, calisthenics, golf, gardening or walking) other than their regular job in the last 30 days.

Challenges Ahead

There are no shortages of issues or challenges. Virginia has room for improvement on every front.



Appendix B

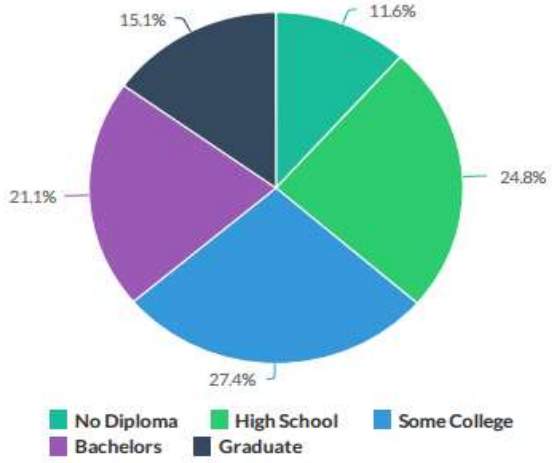
Virginia Demographic Indicators

2013 POPULATION
8,260,405

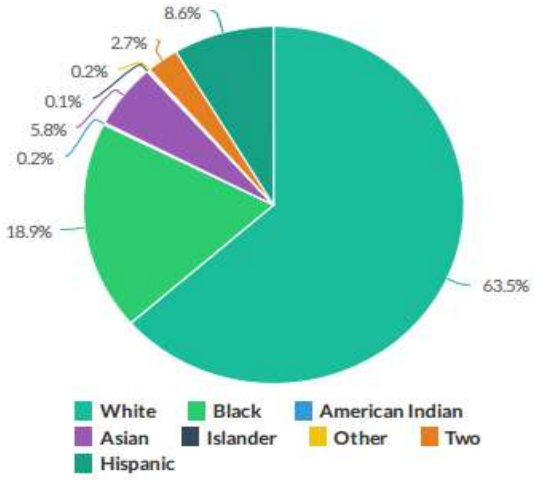
MEDIAN HOUSEHOLD INCOME
$62,666

SEX BY AGE

EDUCATIONAL ATTAINMENT



RACE & ORIGIN



POVERTY
8.4%
for all families whose income in the past 12 months is below the poverty level

UNEMPLOYMENT
4.3%
for the population 16 years & over in the labor force

HOUSING UNITS
3,412,577
houses, apartments, mobile homes, group of rooms or single rooms that serve as separate living quarters

HOUSEHOLDS
3,055,863
all the people who occupy a housing unit

Source: US Census Bureau's 2013 Population Estimates Program