

**Maternal and Child
Health Services Title V
Block Grant**

Wyoming

**FY 2017 Application/
FY 2015 Annual Report**

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I. General Requirements

I.A. Letter of Transmittal



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Thomas O. Forslund, Director

Governor Matthew H. Mead

June 13, 2016

Ref: LPM-2016-086

Dorothy Kelley
Grants Management Officer
5600 Fishers Lane
Rockville, Maryland 20852-1750

Dear Ms. Kelley:

Letter of Transmittal

The DUNS number for Wyoming Maternal and Child Health (MCH) Block Grant is 809915796, as requested in the Terms and Conditions issued on November 16, 2004. The core grant number for Wyoming's Title V Block Grant is B04MC26706.

If you need additional information, please contact me by phone at 307-777-6326, or by e-mail at linda.mcelwain@wyo.gov.

Sincerely,

A handwritten signature in blue ink that reads "Linda P. McElwain".

Linda P. McElwain, BSN, Unit Manager
Maternal and Child Health
Public Health Division

LPM/lm

- c: Wendy Braund, MD, MPH, MEd, FACPM, State Health Officer and Senior Administrator, Public Health Division
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I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix C of the 2015 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

I.E. Application/Annual Report Executive Summary

Wyoming began planning for the five-year needs assessment in October 2013. The Maternal and Child Health (MCH) program and epidemiology staff formed the planning group to study project management and the six-step Peterson and Alexander Needs Assessment Process. The process was designed, a steering committee selected, and the work began.

Hundreds of MCH indicators were given a quick assessment to weed out indicators that were the focus of other programs or had no political will, or were outside the budget. The epidemiologists identified counties, based on population density, geographic location, and health status that would represent the state's MCH population for the community meetings. Surveys were developed and sent to state level stakeholders.

Even with quickly identifying indicators to remove from the group, the result was a lot of data. Ashley Busacker, Senior Epidemiology Adviser, led the group through the process.

Concept mapping, capacity analysis, and identification of clusters for Wyoming's population programs--Women and Infants, Children, and Adolescents--were the next steps. This process came to be known as the "Funnel" as we moved from many indicators to a final product of the following seven priorities.

- Prevent infant mortality
- Improve breastfeeding duration
- Improve access to and promote use of effective family planning
- Reduce and prevent childhood obesity
- Promote preventive and quality care for children and adolescents
- Promote healthy and safe relationships in adolescents
- Prevent injury in children

Accomplishments and Priority Needs by Domain

A summary of MCH accomplishments and the 2016-2020 priorities is listed below. This section is presented by domain. Strategic planning, led by a contractor, began in FY16 with the identification of leadership skills within the MCH team, followed by revision of the MCH Unit's vision and mission. The contractor assisted the team in selecting strategies to focus on during the first year and creating measures to be reviewed on a quarterly basis to determine ongoing progress of each strategy.

Women/Maternal Health Domain:

The 2016-2020 priorities for this domain are to:

- Prevent infant mortality through a focus on decreasing cesarean deliveries among low-risk first births
- Improve access to and promote use of effective family planning by increasing the number of hospitals equipped to provide immediate post-partum long acting reversible contraception (LARC).

While researching strategies to address these priorities in preparation for strategic planning, the Adolescent Health Program (AHP) continued to provide contraceptives to counties with little to no access to Title X clinics. Discussions

with the Title X grantee, Wyoming Health Council, were held several times during FY16.

Perinatal/Infant Health Domain:

The 2016-2020 priorities for this domain are to:

- Prevent infant mortality by ensuring very low birth weight (VLBW) infants are born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU).
- Improve breastfeeding duration with a goal of exclusive breastfeeding of the infant until six months of age.

MCH has continued encouragement of breastfeeding. MCH assisted public health nurses (PHN) attend Certified Lactation Consultant (CLC) trainings. An environmental scan of the state for breastfeeding resources began during FY16. The information will help to identify areas with few resources which can provide a focus for where peer counselors would be useful.

The Women and Infant Health Program (WIHP) and Senior MCH Epidemiologist were able to elicit responses from all Wyoming hospitals to the Centers for Disease Control (CDC) Level of Care Assessment Tool (LOCATe) survey. The CDC is currently analyzing the survey results. The results will help identify what level of care Wyoming hospitals can provide. Surrounding states have agreed to complete the survey. This will allow providers and hospitals to know which hospitals can handle a high risk delivery.

Child Health Domain:

The 2016-2020 priorities for this domain are to:

- Promote preventive and quality care with a focus on developmental screening.
- Prevent injury in children by assisting entities, such as Safe Kids Wyoming (SKW), to find and utilize evidence based strategies for prevention of motor vehicle crashes, falls and poisonings.
- Reduce and prevent obesity in children with a focus on physical activity.

Adolescent Health Domain:

The 2016-2020 priorities for this domain are to:

- Promote healthy and safe relationships in adolescents through implementation of Communities that Care.
- Promote preventive and quality care in adolescents by increasing adolescent well visits and increasing the number of providers addressing transition.

The AHP was initiated in FY14. Considering the rate of teen birth, suicide, and obesity among this age group in Wyoming, the program focused on positive youth development and adolescent development training for health professionals. The goal is to provide the infrastructure for youth friendly clinics and an understanding of risk and protective factors.

MCH, in conjunction with the Personal Responsibility and Education Program (PREP) provides training on Making Proud Choices, Reducing the Risk, and Understanding Adolescence: Seeing Youth through a Developmental Lens curriculum. PREP in Wyoming began with a few Boys and Girls Clubs and is now being requested by schools and PHN offices.

Children with Special Health Care Needs (CSHCN) Domain:

The 2016-2020 priority for this domain is to:

- Promote preventive and quality care for children and adolescents with focus on medical home and transition

The Newborn Screening (NBS) program began working with the Colorado NBS program to improve the timeliness of screens arriving at the Lab from the hospital by courier. Projects include the hospital report cards, outreach to midwives and development of an online NBS toolkit to assist providers and hospitals to improve the timeliness of newborn screening.

Transition has been an MCH priority for the last five years. Direction improved with the addition of the adolescent health program and recognition of the need to educate families, youth, and providers on the need for preparation to transition between childhood and adulthood. Additionally, adult providers need to understand adolescents and be ready to welcome them into their practices.

Although growth of the Parent Leadership Training Institute (PLTI) has been slow, communities are recognizing the benefit of parents who can identify a problem, suggest a solution, and work to make it happen. PLTI national and the

Kellogg Foundation are working to create a program more suitable for rural areas.

Cross-Cutting/Life Course Domain:

The 2016-2020 priorities for this domain are to:

- Prevent infant mortality through tobacco cessation resources.

Tobacco is a preventable cause of death. Tobacco use is a risk factor for cardiovascular disease, cancer, lung disease, and diabetes. Maternal smoking is associated with preterm delivery, low birth weight, and sudden infant death syndrome.

MCH requires PHNs providing home visits to assess tobacco use at every visit. The state Infant Mortality (IM) Collaborative Improvement and Innovative Network (ColIN) team has chosen tobacco cessation as an important issue to address in relation to infant mortality. The Public Health Division (PHD) Tobacco Cessation Program (TCP) is a critical member of the ColIN. The TCP is responsible for the Quitline and has a contract with National Jewish Hospital. The contract has created a prenatal tobacco cessation program which continues to provide support for one year after delivery. The numbers of pregnant women referred to the Quitline have been low. A goal of the ColIN is to increase prenatal use of the Quitline fax referral.

II. Components of the Application/Annual Report

II.A. Overview of the State

Geographically, Wyoming is the tenth largest state in the United States (U.S.) spanning 97,813 square miles. There are 23 counties ranging from the Great Plains to the Rocky Mountains. The Wind River Indian Reservation (WRIR), located towards the center of the state, is home to two federally recognized tribes, the Eastern Shoshone and the Northern Arapaho.

Wyoming is the least populous state in the U.S. with an estimated population of 586,107 (2015 estimate). The population is predominantly White alone (92.7%), Black or African American alone (1.6%), American Indian and Alaska Native alone (2.7%), Asian alone (1.0%), Native Hawaiian and Other Pacific Islander alone (0.1%), and Hispanic or Latino (9.8%) (2014, U.S. Census Bureau). Almost one quarter of the population is under 18 years of age. More than 90% of persons over 24 years of age have a high school education or higher. A quarter of this group have a Bachelor's degree or higher. The median household income is \$58,252 in 2014 dollars. Persons in poverty are estimated to be 11.2% of the population. (www.census.gov, Quick Facts for Wyoming)

Wyoming is a rural/frontier state. Two counties, Laramie and Natrona, each have a town with over 60,000 people and are considered urban ([Economic Analysis Division, WY](#)). Seventeen, of the remaining 21 counties, are considered frontier with less than 6 persons per square mile (U.S. Census Bureau 2010). These 17 counties are home to 47% of the population.

The economy in the state has suffered from the weak demand for oil, warmer weather, and increases in domestic supply for natural gas. The most recent jobless rate (April 2016) is 5.5%. Oil and gas jobs have decreased by over 4,000 compared to one year ago. The current state of the state has required major budget cuts for FY17 and 18. ([Economic Analysis Division, WY](#))

According to America's Health Rankings (2015), Wyoming's strengths include a low prevalence of diabetes, low percentage of children in poverty, and low levels of pollution. Per the same Health Rankings report, Wyoming's challenges include low immunization coverage among children and adolescents and limited availability of primary care physicians.

The leading cause of death for children between the ages of one and 24 years in Wyoming is unintentional injury (Children's Safety Network, 2015 Wyoming State Fact Sheet). According to that same report, the second leading cause of death for 15 to 24 year old residents of Wyoming is suicide.

Of the total population, 200,000 residents live in shortage areas with inadequate access to primary care. Two-fifths of the population (205,000) lives in areas with inadequate access to dental care. The entire state is designated a shortage area for mental health care. (<http://www.health.wyo.gov/rfhd/index.html>) Additionally, there are no tertiary facilities within the state. This requires families to travel long distances for healthcare, miss work, and coordinate care for children left at home.

How MCH fits within the Wyoming Department of Health

The Maternal and Child Health (MCH) Title V Block Grant is managed by the MCH Unit within the Public Health Division (PHD) of the Wyoming Department of Health (WDH). The mission of the WDH is to Promote, Protect, and Enhance the Health of all Wyoming Residents. The 2014-2018 WDH priorities include:

- Medicaid reform:
 - improve health outcomes while containing costs
 - redesign waivers to increase access within the budget
- Redesign of the mental health and substance abuse system to improve outcomes,
- Focus on Wyoming's significant public health problems to improve overall health (tobacco, alcohol, and suicide),

- Maintain Wyoming's emergency response capability,
- Strengthen Wyoming's rural health care infrastructure to ensure access to appropriate, cost-effective, quality care,
- Enhance the continuum of long-term care options for the elderly to support healthy aging in the most appropriate setting, and
- Support the health of Wyoming children

The PHD is working toward public health accreditation and has set several strategic priorities to address the division's mission to Promote, Protect and Improve Health and Prevent Disease and Injury in Wyoming:

- Promote understanding of the relevance and value of public health
- Foster programmatic excellence
- Support the integration of public health and health care
- Foster a competent, flexible workforce
- Build a sustainable, cohesive organization

Several work groups continue to address each of these PHD strategic priorities. One example is the work addressing the priority to foster a competent, flexible workforce. Every two years the Division staff is surveyed regarding individual perception of the public health competencies, as well as other areas of training. This is a valuable tool for assessing the types of training most beneficial for professional development of PHD staff.

The Performance Management Initiative (PMI), begun several years ago, continues to assist with employee development. Employees set individual goals in addition to the required competencies of communication, customer service, judgement and decision making, team work, and personal effectiveness. Individual goals allow focus on areas specific to a particular position.

As MCH began their facilitated strategic planning, leadership skills were assessed using StrengthsFinder 2.0, an online assessment to assist individuals to identify, understand, and maximize their unique combination of strengths. StrengthsFinder assess four domains of leadership strength (executing, influencing, relationship building, and strategic thinking) and 34 themes which are all critical to the overall effective functioning of a leadership group.

In addition to leadership training provided at the beginning of strategic planning, the vision and mission for the Wyoming MCH Unit were revised and core principles were added:

Vision: Wyoming MCH envisions a Wyoming where all families and communities are healthy and thriving.

Mission: The mission of Wyoming MCH is to improve the health and well-being of Wyoming families and communities by supporting public health activities that will benefit the health of mothers, infants, children, youth, and young adults.

Core Principles:

- **Data Driven:** MCH strives to utilize data, best evidence and continuous quality improvement to identify areas of MCH health inequity and guide MCH interventions for Wyoming.
- **Engagement:** MCH strives to address health priorities by empowering, leading, investing in and advocating for community-engaged systems with diverse partnerships.
- **Population Health Focus:** MCH strives to achieve optimal health with targeted interventions and policies that link health outcomes with social determinants of health (SDOH).
- **Healthy Equity:** MCH strives to eliminate health disparities in order to achieve health equity.
- **Life Course Perspective:** MCH strives to improve MCH services, policy and practice utilizing a life course perspective.
- **Sustainability:** MCH strives for sustainability by investing limited resources strategically.

The Needs Assessment, to identify the 2016-2020 Wyoming MCH priorities, began in the fall of 2013. To determine the health needs of women, children, and families in Wyoming, the MCH program and epidemiology staff formed a planning committee to create the process for the needs assessment. The process for identifying the priorities was

nicknamed the “funnel” as it began with hundreds of indicators, community meetings, and stakeholder input. Eleven communities were selected as sites representative of the state population. A meeting was held within each community and two questions were posed to the attendees:

- What are the challenges to being healthy within your community?
- What are the successes to being healthy within your community?

The data collected was narrowed to final priorities through the use of concept mapping, cluster analysis, and capacity analysis. Some methods were new and challenging, but the results proved to be user-friendly as the planning committee, advisory group, and steering committee determined Wyoming's MCH priorities:

- Prevent infant mortality
- Improve breastfeeding duration
- Improve access to and promote use of effective family planning
- Reduce and prevent childhood obesity
- Prevent injury in children
- Promote preventive and quality care for children and adolescents
- Promote healthy and safe relationships in adolescents

There will be more in-depth discussion about process and selection in following sections, including information regarding strategic planning for these priorities.

Medicaid expansion in Wyoming has not been approved by the state legislature. Wyoming had two health plans in the Federal Health Insurance Marketplace, Blue Cross Blue Shield (BCBS) of Wyoming and WINhealth. In January 2016, WINhealth, the second largest Wyoming health insurance company closed leaving BCBS the sole carrier offering individual and small group plans in the Wyoming exchange for 2016.

Title V offers the Children's Special Health (CSH) program as a payer of last resort. Applicants to the program must first apply to Medicaid, Kid Care Children's Health Insurance Program (CHIP) and the Federal Marketplace. The program provides reimbursement for certain services based on financial and medical eligibility. CSH staff and PHNs in the counties encourage families to attend their specialty and well-child appointments. All enrolled children are sent reminders for well-child visits based on the Bright Futures periodicity chart.

State statutes relating to MCH

Three state statutes impact the work of MCH. The Newborn Screening (NBS) statute, Wyo. Stat. § 35-4-801 and 802, mandates newborn screening be available to all newborns and the necessary education be provided to hospitals, providers, and families. WDH bills the hospitals/providers per initial screen. These funds are then used to contract with the Colorado Department of Public Health and Environment (CDPHE) Laboratory Services Division for testing and relaying of results to the provider and Wyoming MCH. Additionally, funds are used for contracts with a courier to transport the blood spots to CDPHE and contracts with specialists to provide follow-up for abnormal screens. The Wyoming NBS staff manages the contracts and participates with the Colorado Newborn Screening Advisory Committee. Currently, Wyoming and Colorado newborn screening programs are participating in a CoIN for Timeliness in Newborn Screening. Although NBS will not prevent a condition from happening; early intervention can often prevent the condition from becoming a disability or death.

The second statute, Wyo. Stat. § 35-27-101, 102, 103, 104, Public Health Nurses Infant Home Visitation Services, was passed in FY2000 as legislators became interested in home visitation. The statute directs public health nurses to contact eligible women regarding home visiting services. The initial goal was to expand Nurse Family Partnership (NFP), an evidence-based home visiting model, to all 23 counties using Temporary Assistance to Needy Families (TANF) funds. Due to fidelity requirements and a small birth cohort in some communities, NFP is only provided in 11 counties. Wyoming developed other MCH services to address the needs of families not eligible for NFP services or living in counties where NFP is not available. Those services and opportunities for additional family support have

developed into a home-grown home visiting model called Best Beginnings (BB) using research-informed “Partners for a Healthy Baby” home visiting curriculum developed at Florida State. TANF dollars are combined with MCH state general funds to provide MCH services (which include home visiting) in each County. A funding formula determines the amount provided to each County and a Memorandum of Understanding (MOU) outlines deliverables required to receive funding.

The Wyo. Stat. § 42-5-101, Family Planning and Birth Control, grants WDH with the ability to provide gap-filling contraceptives. The geography of the state, combined with the small population, poses challenges for assuring reproductive health services are available in all counties. MCH collaborates with the state Title X program and public health nurses to improve the availability of services.

II.B. Five Year Needs Assessment Summary

2016 Five-Year Needs Assessment Summary

Following the identification of Wyoming MCH Priorities, each population group (Women and Infants, Child, and Adolescent) met with their specific stakeholders to present the final priorities. Programs began researching evidence-based strategies to address the Wyoming priorities. This research would later be used to determine evidence-based strategy measures (ESM).

Wyoming, like our sister Region VIII states, struggled with what evidence-based strategy measures should look like. A Region VIII conference call was devoted to this topic as states shared their progress and their frustrations. The Maternal and Child Health Bureau (MCHB) offered a Technical Assistance (TA) meeting in April. This provided much needed assistance from the experts. It also offered an opportunity for states to share.

A Request for Proposals (RFP) was created and disseminated in search of a consultant to guide MCH through the strategic planning process and into implementation. Lolina, Inc. was awarded the contract and designed the strategic planning process into the following steps:

- • Baseline Leadership Team Assessment
- • Vision and Mission Work
- • Strategic Planning Retreat
- • Initial Population Team Meetings
- • Community Stakeholder Meeting

Baseline Leadership Team Assessment

StrengthsFinder 2.0 is a leadership development and team building tool. It is an online assessment to help individuals identify, understand, and maximize their unique combination of strengths. Rather than focusing on weaknesses, the tool helps one to understand, apply, and integrate their individual strengths leading to better performance, increased work engagement, and improved team identity. StrengthsFinder 2.0 identifies four domains of leadership strength (executing, influencing, relationship building, and strategic thinking) and 34 themes which are all critical to the overall effective functioning of a leadership group.

Lolina, Inc. developed an “MCH Baseline Leadership Survey”. The purpose of this survey was to provide Lolina, Inc. with broader understanding in the following areas:

- • Makeup of the MCH leadership team
- • Assess the current MCH mission and vision
- • Understand to what degree the MCH leadership team believed they have been successful in the 2010-15 Title V Goals and Objectives
- • SWOT analysis
- • Understand to what degree the MCH leadership team believed they have the resources and support to be successful at achieving the selected 2016-2020 Title V Priorities and Goals
- • Assess how individuals on the MCH leadership team felt about how the team worked together, based on the Team Emotional and Social Intelligence inventory (<http://theemotionallyintelligentteam.com/tesi.asp>, 2016)
- • Assess the degree to which individuals on the MCH leadership team felt they possessed individual leadership qualities, based on “The Five Practices of Exemplary Leadership Model” by Kouzes & Posner (<http://www.leadershipchallenge.com/About-section-Our-Approach.aspx>, 2016)

The survey responses provided Lolina, Inc. with a foundational understanding of the MCH leadership team’s assets and challenges in order to combine the leadership teams’ individual and collective perception of leadership strengths and gaps in leadership skills and knowledge.

Lolina, Inc. facilitated an interactive three-hour StrengthsFinder session. An overview of StrengthsFinder theory and structure were presented to the MCH leadership team. In addition, the Team Talent Map was distributed, analyzed, and discussed, followed by interactive activities to develop a greater understanding of how the unique personal strengths profile of each individual translates to team strengths and a high level of performance. Strengths-based development is an approach that helps individual team members identify how they can purposefully aim their unique talents so that the team is better equipped to accomplish its goals and performance objectives and respond to barriers.

Looking at the team as a whole, we learned that MCH is stronger together. Half of the team have strengths in executing (know how to make things happen) and influencing (can sell the team's ideas inside and outside the organization). Almost every team member has some strength in relationship building (the glue that holds the team together) and in strategic thinking, which keeps the team focused. One essential piece of information from this experience demonstrates that every person is essential to accomplishing our goals over the next five years.

In consideration of the "Maternal and Child Health Pyramid of Health Services" and a shifting focus toward more population-based and infrastructure-building services, MCH requested a presentation to refresh the team's knowledge and understanding of the meaning of "population health". Lolina, Inc. prepared and presented "MCH & Population Health" on April 26, 2016, the first day of the strategic planning retreat. Key elements of this presentation included:

- Defining "public health" and the public health system
- Defining "population health"
- Reviewing 10 Essential Public Health Services
- Defining CDC's "Factors that Affect Health"
- Reviewing the "Socio-Ecological Model: A Framework for Prevention"
- Discussing the "Maternal and Child Health Pyramid of Health Services"
- Explaining rationale for a shift in focus toward the pyramid foundation

The purpose of revising the vision and mission statements was to develop a common foundation for the work that will be implemented in the strategic plan. A vision is intended to be an articulated hope for the future. A mission statement is an extension of a vision statement that describes what will be done and how it will be done. In concise terms, a vision inspires a common dream and a mission statement inspires common action and purpose.

Lolina, Inc. facilitated two leadership team discussions to assess the strengths and gaps in what was the current MCH vision and mission. The MCH Baseline Leadership Assessment identified the current vision and mission of the MCH Unit needed to be revised in order to be more reflective of the current and future work of the unit. Lolina, Inc. facilitated a group process to revise the current vision and mission in consideration of the current context of the Wyoming Department of Health and Title V, as well as the future direction of MCH. In addition, MCH identified the primary target audience as MCH partner and stakeholders, MCH staff, and the end users and beneficiaries of MCH services, Wyoming families and communities.

In the MCH vision and mission work session on April 18, 2016 and April 26, 2016, the definition and purpose of a programmatic vision and mission were reviewed. Through this work, the MCH vision and mission were revised and core principles were added:

Vision: Wyoming MCH envisions a Wyoming where all families and communities are healthy and thriving.

Mission: The mission of Wyoming MCH is to improve the health and well-being of Wyoming families and communities by supporting and collaborating on public health activities that will benefit the health of mothers, infants,

children, youth, and young adults.

Core Principles:

Data Driven: MCH strives to utilize data, best evidence and continuous quality improvement to identify areas of MCH health inequity and guide MCH interventions for Wyoming.

Engagement: MCH strives to address health priorities by empowering, leading, investing in and advocating for community-engaged systems with diverse partnerships.

Population Health Focus: MCH strives to achieve optimal health with targeted interventions and policies that link health outcomes with social determinants of health.

Healthy Equity: MCH strives to eliminate health disparities in order to achieve health equity.

Life Course Perspective: MCH strives to improve MCH services, policy & practice utilizing a life course perspective.

Sustainability: MCH strives for sustainability by investing limited resources strategically in public health interventions that are community-engaged & data driven.

The Needs Assessment aligned priorities with either a national or state performance measure. For each performance measure, MCH staff researched evidence-based strategies. Staff attended a special Maternal Child Health Bureau (MCHB) Technical Assistance (TA) training focused on evidence-based/informed strategy measures (ESMs).

Three full days were set aside for the MCH Leadership Team to work together with Lolina, Inc. and begin creating the Plan. Within the three days, each population group (Women and Infant, Child, Adolescent) met separately with Lolina, Inc. to review identified strategies. It was agreed that each priority required a strategy that was evidence-based, had potential for Wyoming, and was achievable within the MCH resources. The result, after assessing Strengths, Weaknesses, Opportunities and Threats, is as follows:

· **Priority:** Prevent Infant Mortality

o **NPM:** % of cesarean deliveries among low-risk first births

§ **Strategy:** Support quality improvement efforts (e.g. patient safety bundles) to identify and address areas of improvement for hospitals to decrease % low risk cesarean deliveries.

· **ESM:** Development of facility-specific prevalence data

· **ESM:** # hospitals implementing data-driven quality improvement efforts

§ **Strategy:** Provide payment disincentives for early elective, non-medically indicated and low-risk cesarean deliveries (e.g. equalize payment for low-risk vaginal and cesarean births)

· **ESM:** # hard stop policies developed and distributed by insurers

o **NPM:** % VLBW infants born in a hospital with a NICU

§ **Strategy:** Use LOCATe results to inform quality of improvement for identified hospitals, focusing on all levels

· **ESM:** # hospitals initiating action steps to improve level of care based on receipt of survey results

§ **Strategy:** Build capacity for development of a perinatal quality collaborative

· **ESM:** To Be Determined

o **NPM:** % women who smoke during pregnancy

§ **Strategy:** Work with Tobacco Program and WY Quitline to inform development of pregnancy and American Indian focused Quitline media materials

· **ESM:** # maternal smoking'-focused workgroup meetings

- **ESM:** # pregnant women enrolled in the WY Quitline
- **Priority:** Improve access to and promote use of effective family planning
 - o **SPM:** # hospitals equipped to provide immediate postpartum long acting reversible contraception (LARC)
 - § **Strategy:** Apply to participate in learning collaborative on LARC
 - **ESM:** Convene stakeholder workgroup
 - **ESM:** Completed application
 - § **Strategy:** Work with Medicaid and private payers to increase education on coverage and reimbursement for immediate postpartum LARCs
 - **ESM:** Bulletin describing coverage and reimbursement created
 - § **Strategy:** Develop LARC toolkit and work with the Wyoming Hospital Association (WHA) for distribution
 - **ESM:** Toolkit created
 - **ESM:** # toolkits distributed
- **Priority:** Improve breastfeeding duration
 - o **NPM:** % of infants who are ever breastfed
 - § **Strategy:** Complete environmental scan of available breastfeeding support resources
 - **ESM:** Scan completed
 - § **Strategy:** Develop and disseminate a resource directory of local lactation support services available to new mothers
 - **ESM:** Breastfeeding support resource map and web page with county level data developed
 - o **NPM:** % of infants breastfed exclusively through six months of age
 - § **Strategy:** Award mini-grants and provide technical assistance to hospitals for participation in Baby Friendly Hospital Initiative, or a scaled back version like Can Do Five or Baby Steps
 - **ESM:** Mini-grant program structure developed
 - **ESM:** Mini-grant application finalized and approved
 - **ESM:** # applications received
 - **ESM:** # mini-grants awarded
 - **ESM:** # TA meetings
 - **ESM:** # hospitals demonstrating improvement in delivery of a maternity-care practice supportive of breastfeeding
 - § **Strategy:** Work with WHA to develop hospital recognition program
 - **ESM:** To be determined
- **Priority:** Promote Preventive and Quality Care for Children and Adolescents
 - o **NPM:** # children (10-71months) receiving developmental screen using a parent-completed tool
 - § **Strategy:** Support Help Me Grow (HMG) activities to make developmental screens available to families
 - **ESM:** Contract with 2-1-1 Inc. for HMG services completed
 - o **NPM:** % children with and without special health care needs having a medical home
 - § **Strategy:** Support practices with TA to develop and implement Family Engagement policies
 - **ESM:** Environmental scan of medical home in Wyoming completed
 - § **Strategy:** Conduct outreach to PLTI families about availability and benefits of the medical

home.

- **ESM:** Medical Home module created and implemented into PLTI curriculum
- o **NPM:** % adolescents (12-17 years) with preventive medical visit in past year
 - § **Strategy:** Promote Adolescent Champion Model through mini-grants to health care providers
 - **ESM:** Partnership with University of Michigan developed
 - **ESM:** Mini-grant process developed
 - **ESM:** Request for Applications developed
- o **NPM:** % adolescents with and without special health care needs who received services necessary to make transitions to adult health care
 - § **Strategy:** Develop state level Adolescent Provider Team
 - **ESM:** # meetings of the state level Adolescent Provider Team in the last year (with Transition sub-committee meeting)
 - **ESM:** # provider champions participating on team
 - **ESM:** # adolescents participating on team
- **Priority:** Prevent Injury in Children
 - o **SPM:** Rate of hospitalization for non-fatal injury per 100,000 children (1-11 years)
 - § **Strategy:** Support Safe Kids with targeted best practice interventions to address the three major causes of injury/hospitalizations in Wyoming
 - **ESM:** # best practice interventions implemented by Safe Kids across the state
- **Priority:** Reduce and Prevent Obesity
 - o **NPM:** % children (6-11 years) physically active at least 60 minutes a day
 - § **Strategy:** Support development of a healthy schools coalition with a focus on improving nutrition, physical activity, and over-all child health
 - **ESM:** # meetings of the Wyoming School Health Coalition
 - § **Strategy:** District level school health profile data analyzed to determine current policies and practices and determine districts for targeted outreach
 - **ESM:** Focus of targeted outreach is identified
- **Priority:** Promote Healthy and Safe Relationships with Adolescents
 - o **SPM:** % of teens reporting 0 occasions of alcohol use in the past 30 days
 - § **Strategy:** Implement Communities That Care Program in select Wyoming Communities
 - **ESM:** Implementation plan developed
 - **ESM:** RFA for Communities That Care developed

The above information was presented to each population advisory group. The expectation of the group was to provide feedback out of their expertise. MCH received support from each group and agreement to participate in next steps. The next step is to further define the actions entailed within each strategy. This step will also incorporate other MCH activities which are not within the priorities. Some are legislated. Some have a long history and need to be re-examined as to their place within MCH.

Five-Year Needs Assessment Summary (Submitted on July 15, 2015)

II.B.1. Process

1. Needs Assessment Process

A. Goals, Framework, Methodology

Goal: The goal of Wyoming (WY)'s Five-Year Needs Assessment is to determine MCH priorities that reflect stakeholder input, are supported by evidence, and for which the program has capacity to address.

Framework: The WY MCH Unit based their needs assessment on the six-step Peterson and Alexander Needs Assessment Process. The stages are: start-up planning, operational planning, data, needs analysis, program and policy development, and resource allocation.

The Start-up Planning Stage began in October 2013 with the establishment of the 'Planning Group' which consists of internal MCH staff (Title V director, program managers, and MCH Epidemiology (MCH Epi) staff). This group decided the goals of the needs assessment, participants, target populations, and a timeline. These initial decisions included the development of a steering committee comprised of leaders within WDH, state government, and the community.

In the Operational Planning Stage the planning group developed a funnel diagram (see attachment one) to represent the process of gathering data, review by several individuals/groups, and techniques to narrow the pool of indicators into the final priorities. The tenants of project management were expanded upon during this stage to identify strategies for achieving the goals set during the Planning stage.

MCH Epi staff worked concurrently on the Data Stage. They developed a survey of state partners, collected qualitative data during community meetings, and compiled data from existing state and national sources.

The Needs Analysis Stage occurred in several iterations; in each the depth of data presented to decision makers increased and the potential priorities decreased through consolidation or deletion.

The process is now in the Program and Policy Development Stage. Advisory groups were reconvened in May 2015 to learn the final priorities and begin the discussion on strategic planning; planned for fall of 2015. The final stage, Resource Allocation, will begin in early 2016.

Methodology: MCH cast a wide net to determine priorities to avoid biases in the selection process. Information on potential priorities was collected in three ways: community meetings across the state, a survey of state partners, and a review of national and state health indicators of the MCH population. Indicators were divided into three population areas: Women and Infants (women 15-44 and infants 0-1), Child (1-11), and Adolescent Health (12-24).

Members of the MCH Needs Assessment planning group conducted an initial assessment of each indicator on their perception of its MCH relatedness, political will, capacity, and potential partnership for each indicator through an online survey. MCH epidemiologists evaluated each indicator for data availability, comparability, its status as a PHD priority, and as a topic of discussion during the community meetings.

Indicators were grouped using a modified version of concept mapping. Using cluster analysis, six clusters were identified for the women and infant group, six for the child group, and seven for the adolescent group. The clusters became potential priorities.

In each in-person population advisory group the data and strategies were presented by the program manager and the epidemiologist on the items below. The participants of the advisory group used a scoring matrix to evaluate topic areas on a scale of 1-3 in the following areas:

- Magnitude/Extent

- Public health strategies available/MCH responsibility
- Health equity
- Life course effect
- Leverage, political will, capacity

For additional details on the scoring process, please refer to the MCH Issues Criteria Definitions (see attached). Priorities with higher scores were those which the advisory group recommended as future MCH priorities.

Following the advisory group meeting, the planning group reviewed the results. The planning group discussed the following about the advisory group meetings: groupings of topics, topic areas' names to more accurately reflect the meaning and discarding of low scoring topic areas. Each member of the population specific planning group scored the updated priorities. The three members of each population group (program manager, epidemiologist, and CSH staff) ranked each topic within each priority with the same methods as the advisory group scoring. Results can be found in attachment.

The planning group agreed to choose the top two priorities in each population area. Family Planning and Infant Mortality Prevention were tied in the second spot; three priorities were chosen for the Women and Infant group. There was concern about not including injury prevention in the child group as this had been a higher scoring topic among the advisory group. It was decided that injury prevention would be presented to the Steering Committee and they would make the final decision on whether to include it.

The steering committee met to review the process for selecting the final priorities. Comments, suggestions, and decisions made by the steering committee were incorporated into the final priorities.

B. Stakeholder Involvement

Community meetings: Community meetings created a space for the MCH program to perspective on pertinent health issues across the state. The program used a stratified random sampling method to chose nine counties across the state based on location, (Northwest, Southwest, Northeast, Southeast, and Central) density (rural, urban, frontier), and health status (county health rankings). Twelve community meetings, including two on the WRIR were held; a total of 146 community members participated in the process.

Partner survey: The partner survey solicited feedback from state level stakeholders on four components: barriers and enabling factors to health in WY, current Title V priorities, proposed Maternal Child Health Bureau (MCHB) straw measures, and interest in participating in the needs assessment process. The survey was sent to 142 WDH, state, and community partners with a 60.0% response rate. Qualitative data analysis was conducted to define themes.

Steering committee: The goal of the steering committee was to involve decision makers to guide the needs assessment development, approve priorities, and hold MCH accountable to the plan. The steering committee is comprised of PHD leadership, leaders from WDH, and stakeholders from other state departments. The steering committee has approved the needs assessment process, discussed the creation of the advisory groups, and finalizes the selected priorities. The steering committee will meet once per year to monitor progress and provide guidance to MCH.

Advisory committee: Each population subgroup developed an advisory committee to participate in the needs assessment process. Invitees were picked for their statewide perspective and broad focus to prevent region or topic specific preferences from biasing the choice of priorities. An advisory committee meeting was held in February 2015. At this meeting, MCH staff presented findings from the community meetings, partner survey, data collection, and a capacity analysis to the group. The members scored topics on a variety of criteria so the priorities could be ranked and used to inform the final priorities. The advisory committees were brought back together in May 2015 to receive an update and ask for their participation in the next steps of the process. Groups will develop strategies to address the selected priorities in preparation for strategic planning. The advisory group will participate in the

strategic planning process and help implement the strategies.

C. Methods

The MCH team used a variety of methods to assess the strengths and needs of each of the six domains. The community meetings, partner survey and advisory group meeting all provided qualitative data on the strengths and needs of the WY MCH community. Qualitative analysis of phrase frequency and themes were conducted on the community meeting and partner survey data. These data were incorporated into further decisions.

Where possible, additional analysis was conducted (see attachment) and presented to the advisory and planning groups for consideration. The two groups each ranked and scored the topics on specific criteria to determine the final priorities.

D. Data sources

Data collection was an integral step in deciding which health topics to consider as potential priorities. The MCH epidemiologists compiled data from a range of sources including Behavioral Risk Factor Surveillance System (BRFSS), Census, Vital Statistics, Medicaid, Pregnancy Risk Assessment Monitoring System (PRAMS), and the Youth Risk Behavior Surveillance System (YRBS). For a full list of sources and indicators please see attachment one.

E. Interface between collection of data, finalization of state's priority needs and development of state's Action Plan

The data collected for the needs assessment were used to inform staff, stakeholders, and decision makers of the needs of the MCH populations in WY. The process of refining the data gathered into final priorities included many iterations of review by various people and methods. The development of the state action plan will be conducted in the fall with the stakeholders that identified the priority needs and will include selection of strategies and methods to address the identified priority areas.

II.B.2. Findings

II.B.2.a. MCH Population Needs

2. Findings

A. MCH Population Needs

Women and maternal health

- 15.7% of new moms reported smoking during the last three months of pregnancy (PRAMS 2011);
- A significantly higher proportion of WY (24.3%) women aged 18-44 smoke compared with the US (18.7%) (BRFSS, 2009); (cross cutting)
- Among WY reproductive age women (18-44 years), less than half (42.2%) had a healthy BMI (BRFSS, 2012); (cross cutting)
- In 2011, only 29.7% of pregnant women gained adequate weight during pregnancy; 46.7% gained excessive and 23.6% gained insufficient weight (PRAMS);
- Lifetime prevalence of rape, physical violence and/or stalking by an intimate partner in WY was reported at 35.8% in WY, similar to the US rate (NISVS 2010);
- Between 2009-2013, the maternal mortality rate was 18.5 deaths per 100,000 live births (VSS).

Perinatal/infant health

- In 2012, WY (9.0%) met the preterm (<37 weeks) Healthy People (HP) 2020 goal of 11.4% (VSS);

- In 2013, 22.4% of WY births were low-risk Cesarean deliveries (VSS);
- PRAMS data from 2011 indicate that 23.5% of WY mothers report always or usually sharing their bed and 82.5% of women primarily put their children to sleep on his or her back;
- WY exceeds the HP 2020 goal for breastfeeding initiation (87.6%);
- In WY, 84.7% of infants are cared for in a medical home, significantly higher than the nation (61.3%) (NSCH, 2011-2012); and (cross cutting)
- Between 2006-2013, the WY infant mortality rate was 5.8 per 1,000 live births compared with 6.1 in the US (VSS)

Child health (1-11 year olds)

- 59.4% received care in a medical home (NSCH, 2011-2012); (cross cutting)
- 73% of WY children had a preventive dental visit in the previous year (NSCH, 2011-2012);
- Current insurance usually or always adequately met the needs of 23.4% of WY children (NSCH, 2011-2012);
- Among kids 10-11 years old in WY, 40.6% were reported to be overweight or obese; 73.8% of kids 6-11 were reported to have exercised at least 4 out of the last 7 days (NSCH, 2011-2012); (cross cutting)
- Of middle school students in WY 56.1% reported being bullied on school property, the highest of any participating state (YRBS -middle school, 2013); and
- Leading causes of death among this population: unintentional injury, malignant neoplasms, congenital anomalies, homicide, and suicide (WISQARS, 2004-2013).

Adolescent health (12-24 year olds)

- Teen birth rate in WY 34.6 per 1,000 teens girls aged 15-19 (VSS, 2012);
- 10.3% of WY high school students reported intimate partner violence compared the same as reported in the US (YRBS, 2013);
- 17.4% of high school students report current tobacco use; WY teens were significantly more likely to smoke consistently and heavily than teens nationally (YRBS, 2013); (cross cutting)
- Parents reported that 67.1% of WY adolescents aged 12-17 had adequate insurance (NSCH, 2011-2012);
- WY adolescents are significantly less likely than the U.S. to self-report being overweight or obese (23.5% v. 30.3%), and more likely to meet the physical activity recommendations of 60 minutes per day, 5 or more days per week (YRBS, 2013); (cross cutting)
- In WY 78.7% of adolescents reported they had a parent or other adult in their lives with whom they could talk about serious problems (YRBS, 2013); and
- Parents reported that 60% of adolescents 12-17 had experienced at least one adverse childhood experience in WY (NSCH, 2011-2012);
- WY's suicide rate among teens is double the national rate (21.1 compared to 8.0 per 100,000 teens) (WISQARS, 2009-2013); and
- WY's death rate due to motor vehicle crashes is double the national rate (32.2 v. 16.4 per 100,000) (WISQARS, 200-2013).

CSHCN

- Only 42.8% of CSHCN received care in a medical home compared with 63.5% of non-CSHCN (NSCH, 2011-2012); (cross cutting)
- CSHCN (11.6%) were more likely to report 0 days of exercise in the last week compared with non-CSHCN (3.8%) in WY (NSCH, 2011-2012);
- CSHCN were less likely to receive a well-child visit in the previous year compared with non-CSHCN (78.9% v. 87.7%) (NSCH, 2011-2012);
- 27.1% of CSHCN have a health condition that consistently and often greatly affect their daily activities (NS-

CSHCN, 2009-2010); and

- Under half (47.4%) of all CSHCN aged 12-17 received the necessary services for transition to adulthood (NS-CSHCN, 2009-2010).

Cross-cutting

- Cross cutting measures are reported within individual populations

Summary of population specific strengths/needs

Pregnant women, mothers, and infants:

Nearly three quarters of pregnant women receive prenatal care in the first trimester. Alcohol, smoking and inadequate weight gain are risk factors for preterm and low birthweight babies.

WY met the HP 2020 goal for preterm birth. Infants born preterm often must go out of state to a tertiary facility for care which creates emotional and financial stress for families. Almost one quarter of mothers co-sleep with their infant. WY has met the HP 2020 goal for breastfeeding initiation. Focus is now on duration, while continuing to encourage initiation.

Children:

Over 80% of infants are reported to have a medical home, which decreases with age. Insurance is often not adequate for the child's needs. Almost half of 10-11 year olds were reported to be overweight or obese. WY has the highest percent of children reporting being bullied at school and the teen suicide rate is double the national rate. Death due to motor vehicle crashes is double the national rate. The teen birth rate is higher than the national rate. Over 10% of teens didn't use a contraceptive method at last sexual intercourse. Access to contraception may become more limited as Title X clinics are decreasing around the state.

CSHCN:

Less than half of WY children were reported to have a medical home and almost a quarter of CSHCN had an unmet need. Just over 25% of CSHCN have a health condition that affects their daily activities. Less than half received one of the necessary services for transition. The AHPM has been working with the WAHP and the WDE and has been invited to participate in groups regarding transition.

Cross-cutting:

Throughout the gathering of data from the community meetings, partner survey, and state/national data sources a common theme of access to services emerged for all MCH populations. This was related to types and quantity of providers, services available in a community, and the distance to travel for specialty services.

State's successes, challenges, gaps and areas of disparity

Women and maternal health - MCH leads a coordinated efforts team to reduce early elective inductions and low risk cesareans in WY. These efforts were selected as a strategy in the MCHB CoIIN to reduce infant mortality. Currently, 22.4% of deliveries to WY women are classified as low-risk cesareans.

Perinatal/infant health - Infant mortality in WY is similar to the infant mortality rate at the national level (5.8 per 1,000 live birth compared with 6.1). However, large disparities exist in the state based on geographic and racial differences. The lowest county infant mortality rate between 2006-2013 was 0.0 and the highest was 12.0 deaths per 1,000 live births. The rate of infant mortality among American Indian (AI) women in WY is significantly higher than the non-Hispanic white rate. Infant mortality was selected as a priority for WY. The MCH program is focusing on maternal smoking, preterm delivery, and risk-appropriate care to address infant mortality. WY is part of the IM CoIIN. MCH supports home visitation with PHN and MIECHV and has worked to provide a data system that can report on

outcomes such as breastfeeding, safe sleep, and tobacco cessation.

Child health (1-11 year olds) - Three of the five leading causes of death in this age group are injury related which is a continued focus area for MCH. The program has many ties to local coalitions and the statewide SK campaign. Additionally, WDH has recently developed an injury prevention program which MCH will work closely with to develop strategies around injury prevention in children. A similar number of children aged 10 months to 5 years have had a developmental screen in the previous year in WY and nationally. A significantly lower proportion of WY Medicaid children received at least one screen in the last year compared with the nation. Working through the Early Childhood Comprehensive System (ECCS) grant, a strong system of referral and screening is being designed using the Help Me Grow (HMG) framework.

Adolescent health (12-24 year olds) - In this population the rates for death due to suicide and motor vehicle crashes (MVC) are double the national rates but disproportionate across counties. The rate of teen births is also higher in WY compared to the U.S. Native American and Hispanic teens are significantly more likely to be teen parents compared with white non-Hispanic teens in WY. The selected priorities of improving healthy and safe relationships and access to family planning are aimed at reducing risk behaviors in adolescent and promoting protective factors that reduce these negative outcomes. Additionally, the priority to promote preventive and quality care for children addresses the need to improve screening and access to services in this population. The need is apparent in the Medicaid population where only 30% received a preventive screen in the previous year.

CSHCN - Disparities in most measures exist when comparing children with and without special needs in WY. CSHCN are less likely to receive care from a medical home, more likely to be overweight/obese, more likely to experience adverse childhood experiences, and less likely to receive the care they need compared to children without a special health care need. A strength of the MCH program in WY is its incorporation of CSHCN into all priorities. CSHCN are disproportionately affected in most of the selected priorities; different strategies may be needed to address the needs of this population when addressing priorities.

Cross-cutting - In WY 15.7% of mothers smoke during the last trimester; no change in recent years. WY is far from the Healthy People 2020 goal of 1.4% during this time frame. Many disparities exist in the maternal smoking rates. Native American women, teens, Medicaid clients, and those without a high school education are at higher risk of smoking during pregnancy. Nearly one in four WY women (24.3%) of reproductive age smoke. Addressing smoking during pregnancy and for women of reproductive age was chosen as a strategy in the MCHB CoIIN to reduce infant mortality and selected as a priority for MCH. MCH has strong working relationships with the WY Quit Tobacco program and Public Health Nursing (PHN) offices who will be allies in the development and implementation of strategies to address this issue.

Analysis of program: where current efforts work well and where new efforts are needed

The MCH program conducted a capacity assessment (SWOT - straw measures; CAST5 - potential priorities) during the needs assessment process. This assessment will be combined with current work on identifying evidence-based strategies to address the priority areas in the strategic planning process. Strategic planning will occur in fall 2015.

II.B.2.b Title V Program Capacity

II.B.2.b.i. Organizational Structure

B. Title V Program Capacity

Organizational Structure

The Wyoming Department of Health (WDH) is one of 47 WY state agencies. MCH frequently works with WDE, DFS, DWS, Transportation, State Parks, and the University of Wyoming. (Organizational charts for WDH and PHD are

attached)

The WDH is located in Cheyenne, WY's capitol, in the southeastern corner of the state. WDH is divided into four divisions, Aging, Behavioral Health (BHD), Healthcare Financing (HCFD), and Public Health (PHD). The MCH Unit sits within the Community Health Section (CHS) of PHD. The other Units within the CHS include PHN, Immunizations, WIC, and Chronic Disease and Substance Abuse Prevention.

State health agency responsible for the administration of programs

The MCH program and MCH Epi staff are funded by federal and state funds which are included in the maintenance of effort (MOE) required by Title V. MCH receives the PRAMS, State Systems Development Initiative (SSDI), Rape Prevention and Education (RPE), PREP and ECCS grants which provide funding for staff and specific programs.

Women/Maternal Health:

Activities supporting Wyoming's Infant Mortality ColIN project are covered by state and federal Title V funds.

Activities are organized by the following Learning Networks: smoking cessation, pre and early term birth and risk appropriate perinatal care. The Coordinated Efforts to Reduce Preterm Birth group has morphed into the Pre and Early Term Birth Learning Network for the Infant Mortality ColIN and its activities are covered by state and federal Title V funds.

The Maternal High Risk (MHR) program promotes access to care for high risk pregnant women who require care at a Level III facility and who meet eligibility criteria. Care coordination with the assistance of PHN and gap-filling resources (e.g. travel assistance) are offered to eligible clients. This program is funded with federal Title V funds.

Perinatal/Infant Health:

The Healthy Baby Home Visitation Program (known in statute as PHN Infant Home Visitation Services) is a primary service included in an MCH Services MOU with 22 of 23 counties and is funded by state general funds and TANF funds. Payment under the contract is made through a fee-for-service reimbursement system for home visits, classes that support home visitation and trainings.

The Newborn Intensive Care (NBIC) Program promotes access to care for high-risk families and infants who require care at a Level III nursery and who meet eligibility criteria. Care coordination with the assistance of PHN and gap-filling resources are offered to eligible clients. This program is funded with federal Title V funds.

The Fremont County Fetal Infant Mortality Review (FIMR) pilot project is funded with state and federal Title V funds. Funds support the development of the community-led project. Planning committee members representing Fremont County Public Health, Indian Health Service (IHS), Eastern Shoshone Tribal Health, Northern Arapaho Tribal Health, Northern Arapaho WIC, SageWest Healthcare, and Parents as Teachers Home Visitation program participate in monthly planning meetings. Title V Director, Women and Infant Health Program Manager (WIHPM) and Senior MCH Epi Advisor facilitate and support planning efforts. Lessons learned are valuable for implementing FIMR projects in other counties.

The WIHPM position, funded 100% by Title V dollars, directly supervises one staff member, a Benefits and Eligibility Specialist (BES) also referred to as the Newborn Screening and Genetics Coordinator. The WIHP BES is funded half by Title V funds and half Newborn Screening Trust and Agency account funds. This position works with the Genetics contractor and the Cleft Palate clinic.

The WIHPM manages the Healthy Baby Home Visitation Program, Newborn Screening, Genetics Clinics, Coordinated Efforts to Reduce Preterm Birth, Breastfeeding promotion activities, and is a state trainer for Ages and Stages Questionnaire (ASQ). She works closely with the other MCH program managers, while also active with the EIC and the MIECHV grantee work on early childhood systems within WY.

MCH partnered with Prevent Child Abuse Wyoming (PCAWY) to purchase sleep sacks. PCAWY distributed the

sleep sacks to PHN offices to support safe sleep promotion activities.

Child Health:

Injury prevention is a priority of Child Health. MCH uses Title V dollars to contract with SafeKids Wyoming (SKW) to provide injury prevention statewide. This group provides car seats, training for car seat technicians, and promotes other safety messages through billboards and fairs, and provides leadership for local level programs. Data is provided to MCH quarterly and the CHPM sits on the SKW board. MCH staff is active with the Emergency Medical Services for Children program and provided assistance to Emergency Medical Services (EMS) by purchasing infant and child restraints for EMS transport. Title V dollars are braided with other WDH funds to support an Injury Prevention Program (IPP) Manager within PHD and a half-time injury epidemiologist.

The Wyoming Vision Collaborative provides leadership and training, facilitates discussion, and implements the WY plan to increase vision screening and improve referral processes for early detection of childhood vision problems.

The CHPM position is funded 75% by Title V and 25% from the ECCS grant managed by this position. The ECCS grant is focused on expanding developmental screening and establishing HMG within WY. This work is closely aligned with Title V and is applicable to the new MCH priorities. Work on developmental screening through ECCS is supported by the WIHPM who is a state ASQ trainer and active in the development of HMG in WY.

The dental sealant program utilizes Title V dollars to provide sealants through dental offices for low income children who are not on Medicaid.

Adolescent Health:

Half of the AHPM position is supported by Title V. The other half is split between the RPE and PREP grants. The AH program developed a WY Adolescent Health Partnership (WAHP). Title V funds support meetings and trainings for this partnership which currently includes an adolescent advisor and will support a youth advisory council soon. The AHPM manages the RPE grant which focuses on primary prevention of interpersonal violence.

Title V dollars purchased contraceptives for counties with little or no access to Title X clinics. Contraceptives are distributed through PHN clinics. Approximately half of the clients accessing contraceptives are adolescents. The AHPM is a registered nurse and works with a state pharmacist for this project.

CSHCN:

Title V dollars fund three BESs who assist with coordination of care in the CSH program. State general funds assist families of children that qualify financially and medically for the program. The three CSH staff assists PHN and families with coordination of care.

MCH contracts, using Title V funds, with the University of Utah to provide 25 regional Genetics Clinics annually and genetics consultation to WY physicians. The university is considering the use of telehealth and how that can be supported for the clinics.

The Cleft Palate Clinics are funded with state general funds to provide a one-stop-shop for infants, children and young adults to receive coordinated care in one place from a variety of specialists. CSH staff assists the Oral Health Program Manager (OHPM) with the planning and implementation of the twice-a-year clinic.

Cross Cutting:

Access to Family Planning is limited; Title X provides services with limited locations and availability. Some PHN clinics offer contraception, but require MCH funds to maintain the service. Beginning in FY14, MCH, in conjunction with PHN, determined basic types of contraception needed. The AHPM, with the help of the Medicaid pharmacist, orders and distributes to seven PHN offices. AH program also supplies 14 counties with pregnancy tests.

Title V dollars support the implementation of PLTI. The goal is to assist parents to become advocates for children and active members in their community. Training includes communication skills, civic advocacy, and assistance with the development and implementation of a community project.

WY is carrying forward its Tobacco Cessation priority. The current focus on pregnant women and infants will change to a life course approach under the new structure. The focus will be on prevention among women of reproductive age requiring work to begin before pregnancy. In FY14, a new MCH policy ensured that women receiving home visitation services were asked about smoking status at every visit. Next steps include promotion of the Quitline fax referral.

The MCH epidemiologists work within all population groups. Title V will fund 80% of the MCH CDC Assignee in FY16. The Epidemiology Program Manager is funded 45% by two federal grants (SSDI and PRAMS) and 55% SGF. A second MCH epidemiologist is funded 100% SGF. The IPP/PRAMS epidemiologist is funded with 25% Title V and 50% PRAMS with the remainder through additional injury prevention sources.

II.B.2.b.ii. Agency Capacity

Agency Capacity

Capacity was assessed prior to February 2015 and focused on three areas: Structural Resources, Organizational Resources and Skills/Competencies. The MCH capacity is presented below by the priorities selected.

Women/Maternal Health

Prevent Infant Mortality:

- **Structural resources:** MCH needs more support from PHD programs around tobacco prevention. More formal processes/protocols should be created in order to assess improvement toward goals. MCH is active on efforts around infant mortality prevention and the reduction of adverse birth outcomes through efforts in ColIN, FIMR (at the local level) and Coordinated Efforts to Reduce Preterm Birth. Formalized processes for this work will be built as the State Infant Mortality Reduction Team follows guidance outlined by ColIN. Legislation for death review is missing, which could help move this work even further. MCH partnership with the new Injury Program, within PHD, will advance work around safe sleep.
- **Organizational relationships:** MCH has established good organizational relationships within PHD but has not expanded to include OB/GYN providers. Many relevant partners are currently engaged through both ColIN and Coordinated Efforts. All are equal contributors to the process and motivation is high. Need to identify ways to engage the provider community.
- **Skills/competencies:** MCH benefits from a generous mixture of subject matter expertise, public health experience, and epidemiological skills. The workforce is also well-trained in evidence-based tools such as SBIRT and has access to a pregnant-specific Quitline curriculum. The MCH team focused on infant mortality include MCH Doctoral level Epidemiologist, MCH Unit Manager with MCH experience, particularly in clinical nursing and home visiting, and WIH Program Manager with public health and social work background.

Improve Access to and Promote Use of Effective Family Planning:

- **Structural resources:** The WIHPM and AHPM are working together to refine/improve the Reproductive Health program which provides contraceptives/multivitamins. AHPM is exploring Long Acting Reversible Contraceptives (LARC) training options for providers across the state. AHPM also manages the PREP grant.
- **Organizational relationships:** MCH will continue to work to improve relationship with the Wyoming Health Council (WHC) and will look to also build relationship with Medicaid to explore LARC coverage.
- **Skills/competencies:** In addition to MCH having a full staff with varying expertise, the AHPM has experience ordering/supplying contraceptives.

Perinatal/Infant Health Domain:

Breastfeeding:

- **Structural resources:** MCH has high capacity to further breastfeeding support activities beyond promotion of breastfeeding during home visits. Engaging providers and hospitals is the next step.
- **Organizational relationships:** MCH must expand relationships beyond PHN, while continuing to ensure PHN workforce is trained to adequately promote/support breastfeeding.
- **Skills/competencies:** MCH is at full staff capacity and benefits from a generous mixture of subject matter expertise, public health experience, and epidemiological skills PHNs are well-trained in professional breastfeeding support strategies.

Child Health Domain:

Promote Preventive and Quality Care for Children and Adolescents

- **Structural resources:** Federal legislation mandates Title V and Title XIX Early Periodic Screening, Diagnosis and Treatment (EPSDT) programs to collaborate. An MOU exists between WY Title V and Title XIX. Funding through the ECCS grant is dedicated to increasing developmental screenings throughout the state. MCH has access to up-to-date information for improving outcomes. MCH has mechanisms for accountability/quality improvement.
- **Organizational relationships:** MCH has strong relationships with PHN, MIECHV, and the Home Visiting Committee of the Wyoming Early Childhood State Advisory Council (WECSAC). A developing relationship exists between MCH and Medicaid, including Oral Health. More partnerships need to be forged in the area of EPSDT with Medicaid/CHIP. Gaps exist in services and coverage for needed services. MCH works with PHN, Medicaid, KidCare, families and healthcare professionals to provide care coordination.
- **Skills/competencies:** MCH is able to provide ASQ training and continued organizational development is occurring at the program, unit and division levels. MCH program has staff with expertise with the CSHCN population. MCH is seeking ways to improve care coordination.

Reduce Childhood Obesity:

- **Structural resources:** MCH has funding to address obesity, as does the PHD Chronic Disease Prevention Unit. Gaps exist in partnership mechanisms with schools, local food source agencies and community organizations.
- **Organizational relationships:** MCH has strong relationships with other state agencies and other programs in WDH. Stronger relationships with WDE and local health care providers to effect change are necessary.
- **Skills/competencies:** MCH has the ability to work effectively with public and private agencies that can effect change within this priority.

Prevent Injury in Children:

- **Structural resources:** MCH has minimal structural resources to address the leading causes of death in the child population. MCH funding is provided to SafeKids Wyoming (SK) and the CHPM is a member of the SK Leadership Team to help inform injury prevention activities in the state. PHD recently added an Injury Prevention Program which MCH assists with funding and is a member of the team.
- **Organizational relationships:** MCH is a member of the WY Child Death Review (CDR), SKW Board, and the PHD Injury Prevention Program.
- **Skills/competencies:** MCH Epi provides analysis of data necessary for determination of program focus. There is growing knowledge amongst Injury Prevention staff through conferences, trainings, and webinars.

Adolescent Health Domain:

Promote Healthy and Safe Relationships in Adolescents:

- **Structural resources:** Numerous partnerships exist within WDH and statewide within the medical community and youth organizations. Infrastructure for communication with youth and their parents is in development. Workforce capacity is strong due to numerous overlapping risk and protective factors. MCH has access to up-to-date research and programmatic information. MCH has the ability to measure program success and make improvements to the program. Funding for substance abuse prevention is housed in another Unit of PHD.
- **Organizational relationships:** Strong organizational relationships exist with state government organizations and other statewide agencies. A potential for stronger relationships with WDE and adolescents exists. MCH has an ongoing relationship with the National RPE Directors Council. There is limited availability of youth friendly and accessible services and potential for stronger relationships with youth-serving organizations. Relationships specifically related to substance use are minimal.
- **Skills/competencies:** AHPM is trained as a trainer in the Making Proud Choices, Reducing the Risk, and Understanding Adolescence: Seeing Youth Through a Developmental Lens curricula. MCH provides focus to other programs and agencies on the intersection of common risk and protective factors with other adolescent issues. MCH has the ability to train providers and community organizations in strengths-based strategies and positive youth development. MCH Epi provides analysis of data, necessary for determination of program focus.

Improve Access to and Promote Use of Effective Family Planning (Focus on Teen Birth Prevention):

- **Structural resources:** Funding is available through MCH and other sources to address teen births. Infrastructure for communication with youth and their parents is in development.
- **Organizational relationships:** MCH has strong relationships with other state government agencies and organizations. There is limited availability of youth friendly and accessible services, but as information and trainings are disseminated there is growing interest. MCH continues to develop the relationship with WHC, the Title X grantee.
- **Skills/competencies:** AHPM is a train the trainer for several reproductive health curricula. MCH provides focus to other programs and agencies on the intersection of common risk and protective factors with other adolescent issues. The AHPM is a nurse and able to work with PHN regarding contraceptives.

CSHCN Domain:

Transition:

- **Structural resources:** MCH has funding and ability to address medical transition. Communication with policy makers and agencies is excellent, but significant gaps exist in communication channels with medical providers and provider organizations.
- **Organizational relationships:** There are strong organizational relationships specifically with statewide non-profit agencies, advocacy organizations, and agencies that link directly to families. There is potential for stronger relationships with medical providers and provider organizations.
- **Skills/competencies:** MCH has excellent communication skills and ability to work effectively with groups that can help to improve these measures. The AHPM has a clinical medical background improving access to and credibility with providers. MCH Epi provides analysis of data, necessary for determination of program focus.

Medical Home:

- **Structural resources:** MCH has minimal authority to address this issue, although Title V agencies are charged with linking CSHCN to needed personal health services and ensuring provision of care when otherwise unavailable. MCH does have access to up-to-date policy and programmatic information.
- **Organizational relationships:** MCH continues to develop relationships with Medicaid, WYHealth, Blue Cross/Blue Shield, and KidCare CHIP. PHNs assist the CSH families in establishing a medical home.

Cross-Cutting/Life Course:

Tobacco:

- **Structural resources:** MCH is working with the Tobacco program within the Prevention Unit in order to expand inclusion of non-pregnant women of reproductive age and their families. WY offers Quitline services to all residents including pharmacotherapy. The Quitline has a specific pregnancy module with additional incentives for participation.
- **Organizational relationships:** While MCH has good partners for this work, there is a need to develop consistent communication. Tobacco cessation is one of the learning networks in the IM CoLIN and the PHD Tobacco Program is involved with the CoLIN.
- **Skills/competencies:** MCH is at full staff capacity and benefits from a generous mixture of subject matter expertise, public health experience and epidemiological skills.

State Program Collaboration with Other State Agencies and Private Organizations

The MCH Unit, to ensure activities occur within a system and strives to include other entities from within WY in its program development. March of Dimes (MOD) approached MCH prior to FY 14 to assist with sharing the MOD 39-week toolkit with WY birthing hospitals. A meeting with MOD, the Wyoming Hospital Association (WHA), and MCH illuminated the fact that several entities were interested in early elective delivery (EED) and preterm birth. In response, the State Health Officer (SHO) established the Coordinated Efforts for Preterm Birth group which began monthly meetings in FY13. Members include PHD leadership, MCH, MOD, MCH CDC Assignee, Medicaid, WHA, WINhealth, Wyoming Medical Society (WMS) and the Wyoming Business Coalition on Health. The Coordinated Efforts group recently began working with the State Infant Mortality Reduction Team.

In 2014, the Collaborative Improvement and Innovation Network (CoLIN) for Infant Mortality expanded to include all states. Following the Infant Mortality CoLIN Summit in July 2014 (attended by a representative of MCH, Medicaid, Epidemiology and WinHealth), a state team was formed to address Infant Mortality and participate in the CoLIN. Additional members include a pediatrician, a neonatologist, MOD, a representative from Eastern Shoshone Tribal Health, and a representative from the Primary Care Association (PCA). WY team priorities are:

- Improve community capacity to protect and improve their own health and reduce disparities
- Empower families to protect and improve their health and wellness and use their voices
- Ensure quality of perinatal care

The three Learning Networks chosen by the state team are:

- Tobacco Cessation
- Pre- and Early-Term Birth
- Perinatal Regionalization

Representatives from MCH, Tobacco Prevention, Chronic Disease, Public Health Nursing, Eastern Shoshone Tribal Health, Medicaid, and Epidemiology, comprise a Tobacco Cessation workgroup. The goal of the workgroup is to encourage the use of the Quitline among women of reproductive age through work with the Title X family planning clinics. This workgroup will become the Infant Mortality CoLIN Smoking Cessation Learning Network.

The Pre- and Early Term Birth Learning Network group is currently the same as the Coordinated Efforts Group. The aim of the group will be split between EED and how best to address the use of progesterone with women who have previously had a preterm delivery.

The Risk Appropriate Perinatal Care Learning Network is also working with the Coordinated Efforts Group as membership of both groups is similar. The group is working toward piloting the Level of Care Assessment Tool (LOCATe) tool to help identify the appropriate hospitals for high risk pregnancies.

The WIHPM assumed the role of the MCH representative on the EIC in early 2014. In April 2015, the WIHPM was nominated to be the Vice Chair of the Council and will assume the Chair role in 2016. This council presents ample opportunities for collaborative efforts and systems work, particularly around the improvement of early referrals for pregnant women and infants to necessary services including but not limited to home visitation, Early Intervention Part C services, etc.

The WIHPM has participated in a handful of systems-building meetings focused on early childhood mental health. The initiative is ongoing and involves stakeholders from WDH and other state agencies such as WDE, DWS, and DFS. MCH involvement focuses on ensuring focus on mental health begins prenatally and considers the role of maternal depression and adverse childhood experiences.

The ECCS grant began a new focus in FY14. The State team, comprised of PHN, child developmental centers, WDE early childhood staff, DWS, WDH and DFS and co-led by the CHPM and a developmental pediatrician, chose to expand developmental screening activities in early care and education settings statewide. The group decided the use of the same screening tool would provide a common language between providers. The Ages and Stages Questionnaire (ASQ), including the social emotional tool, was selected as the common screener. Diane Edwards, MD, FAAP, co-lead of the state team, is assisting with engagement of the WY Chapter of the American Academy of Pediatrics. The WIHPM and Jen Davis, WYCRP, provide ASQ trainings around the state.

Increasing developmental screening means families and providers need to be aware of the service. In searching for a strategy to link families with providers, the state ECCS team identified HMG. WY MCH received technical assistance through Title V, in FY15, to travel to Utah with several stakeholders (211, early intervention and WDE) to view Utah's HMG program, data collection and how it fits within their 211 system. Since that trip, the HMG team has created work groups to consider all aspects of the program including sustainability and provider outreach.

As part of the required MIECHV systems work, MCH, PATNC, and PAT (WY) met with a facilitator to determine how to move HV within the WY Early Childhood System. The consensus was that a common understanding and language around HV is necessary among all HV providers. The second meeting added PHN, Early Head Start, and Tribal MIECHV to the conversation. The goal is to create a unified definition and vision of HV in WY. Future activities will focus on workforce development, training and shared outcome measurement.

State Support for Communities

In FY13, several groups within Fremont county approached WDH about the county's high infant mortality. MCH sponsored an Infant Mortality Summit that summer. Staff shared the Fetal Infant Mortality Review (FIMR) strategy as one way of addressing the issue. Attendees from PHN, IHS, Tribal Health, Fremont County Coroner's office, and Tribal Health participated. The following November, MCH visited those who attended and offered to assist the community with development of a FIMR. Beginning in January 2014, the Fremont FIMR planning committee began meeting monthly to plan implementation. Training for the Case Review Team and the Community Action Team was provided by MCH and the National FIMR Program in June 2015.

MCH has a Memorandum of Understanding (MOU) with 22 of the 23 counties to provide MCH services. The funding for the MOU is a combination of State General Funds (SGF) and Temporary Assistance to Needy Families (TANF). The MOU reimburses for HV of clients/families enrolled in the Healthy Baby HV program. It also assists with CSHCN HV, as well as classes offered by nurses. The WIHPM and PHN MCH Consultant meet weekly and this past year have focused on the roll-out of a revised data system which more accurately captures the services provided by PHNs.

Over the past few years, MCH gradually assumed responsibilities of the Oral Health Section. During FY14, the CHPM oversaw the Community Oral Health Coordinators (COHCs). COHCs provide dental screenings, referral to treatment, fluoride varnish and fluoride rinse programs, and educational programming for preschools, Head Starts, Cleft Palate Clinic and school districts in 13 counties. At the end of FY14, an MCH MPH intern reviewed the COHC

program. In spring of FY15 she was hired as the Oral Health Program Manager (OHPM) and is revising the program to assure standardization of activities.

MCH hired a part-time dentist with an MPH. He resides in Billings, MT and provides oversight of the dental hygienists as per their scope of work. The dentist and OHPM have begun strategically planning an oral health program to meet the public health needs of WY.

II.B.2.b.iii. MCH Workforce Development and Capacity

MCH Workforce Development and Capacity

The PHD of the WDH is comprised of four sections. Dr. Wendy Braund is the State Health Officer and Senior Administrator of PHD. The MCH Unit is within the Community Health Section. The Section Chief and supervisor to the MCH Unit Manager is Stephanie Pyle.

At the beginning of FY14, MCH had two vacant positions--WIHPM and AHPM. In FY14, MCH replaced the CSHCN Director position with an Adolescent Health Program Manager. Adolescent health had only been addressed through specific activities such as with the RPE grant's focus on 12 to 24 year olds. MCH made this change understanding CSHCN are within all MCH populations. To help each population group (Women and Infants, Child and Adolescent) remember CYSHCN in different discussions, a Benefits and Eligibility Specialist (BES) was placed in each program and one is directly supervised by the Unit Manager.

MCH hired the AHPM in September 2013 and the WIHPM in January 2014. The administrative assistant position was vacant for only a short time during the summer of 2014. The administrative assistant position is currently vacant again, but will be refilled soon.

The MCH Unit grew to eleven staff with the addition of the Oral Health program in FY14. Full time staff include Linda McElwain, MCH Unit Manager and Title V/CYSHCN director, Vicky Garcia, BES, and a vacant administrative assistant. The Unit is divided into three population groups and the Oral Health Program. CYSHCN are included within each of the population groups.

The Women and Infant Health Program is managed by Danielle Marks. Danielle works closely with the PHN MCH Consultant on the Healthy Baby Home Visitation Program, a joint effort of MCH and PHN. Carleigh Soule, BES, is the liaison between MCH and the Colorado Lab for NBS and the University of Utah for Genetics Clinics.

Charla Ricciardi is the Child Health Program Manager. Sheli Gonzales, BES, works with the CHPM, provides care coordination for CYSHCN, and assists with PRAMS.

The Adolescent Health Program Manager is Shelly Barth. Paula Ray, BES, works with the AHPM and provides care coordination for CYSHCN.

Cassandra Walkama is the Oral Health Program Manager. She is working with the part-time dentist and four COHCs to standardize the COHC program and refine the gap-filling marginal and severe malocclusion services.

MCH staff extend beyond the MCH Unit. MCH epidemiologists include Amy Spieker, Kerry Olmsted, Pedro Martinez, and, Ashley Busacker, a CDC MCH assignee to WY. All staff, but one, is located in Cheyenne. The part-time state dentist is located in Billings, Montana.

In FY14, as part of the PHD strategic planning priority to "Foster a competent, flexible workforce," PHD employees participated in a survey to determine training needs across the division. The assessment included public health (PH) competencies, knowledge of WDH/state processes (fiscal, HIPAA, human resources, IT, contracts, HealthStat), and interest in training on various computer programs. This information was utilized by the PHD to determine training

offerings.

Provide examples of mechanisms that the state has developed and utilized to promote and provide culturally competent approaches in its services delivery.

Since 2011, MCH Epi has worked with both tribes on Tribal PRAMS when PRAMS began to oversample all AI births. Through the process a Tribal PRAMS logo and an AI specific PRAMS survey cover were developed. During the Tribal PRAMS program response rates have improved among the AI mothers by 20%.

PHNs in a county with a population of undocumented Hispanic women are creating a group prenatal class to complement home visits. These women are not eligible for Medicaid until delivery. To provide support and prenatal education, the PHNs developed a class schedule to support the women and provide information regarding their pregnancy. This class will be piloted and could guide other PHN offices seeking to support pregnant women in similar ways.

MCH and DFS created an eligibility form to assist PHNs in accurately determining client eligibility. Prior to the new form, which is being piloted in several PHN offices, if a woman was undocumented the family would not qualify for services. With DFS assistance, the new form considers all members within the family and their income. Initial information from pilot sites suggest success.

II.B.2.c. Partnerships, Collaboration, and Coordination

C. Partnerships, Collaboration, and Coordination

Other MCHB investments:

MCH Epi utilizes the SSDI grant to assist with the development of the FIMR pilot in Fremont County. The grant supported work with the vital records systems including data validation for birth certificates, a system for entering fetal death certificates, and a linked infant birth and death export feature.

MCH partners with MIECHV to assure home visiting services are included within the Early Childhood system. The first systems meeting was held in May to work with a facilitator to define home visiting in WY. A second was held in June with a representative from each home visiting program within WY.

The ECCS grant is managed by the CHPM. The ECCS State Team, made up of child care program representatives, PHN, Early Intervention Services, staff from WDE, DWS, WDH, and DFS and other early childhood stakeholders, chose to expand developmental screening using the Ages and Stages Questionnaire (ASQ). ECCS has funded over 65 ASQ kits to child care centers and home visitors. Over 115 staff have attended nine regional ASQ trainings.

The AHPM has utilized National Adolescent and Young Adult Health Information Center (NAHIC) and the State Adolescent Health Resource Center (SAHRC) to develop a training for providers called "Adolescent Development and Communication For Health Care Providers".

The Infant Mortality CollN which has provided additional framework to work already begun in WY. State partners include the State Health Officer, providers, Medicaid, epidemiologists, MCH, Primary Care Association, Eastern Shoshone Tribal Health, March of Dimes, WHA, WMS, and WinHealth. The three foci chosen by the state team are tobacco cessation, pre-and early-term birth, and risk-appropriate care.

MCH partnered with Emergency Medical Services for Children in the WY Responders Safe Transport Initiative (WYRESTRAIN). The goal is to assure that all children are transported in the safest manner by ambulance. MCH funded 30 Ambulance Child Restraints (ACR) and 35 Baby ACRs.

Other Federal investments:

The AHPM partners with the Communicable Disease Unit to carry out PREP in WY. For the first year PREP was provided in the Boy and Girls Clubs. A total of 90 youth ages 12-15 completed the program with fidelity in three counties. Since that time, over 30 new facilitators have been trained including PHN, school nurses, school health teachers, juvenile justice staff, and Boys and Girls Club staff. MCH is also working with community mental health centers to implement Making Proud Choices for youth in out of home care.

MCH meets at least quarterly with WHC, the WY Title X grantee, to discuss current activities within both programs. Topics have included a Reproductive Life Plan, Long Acting Reversible Contraceptives (LARC), and discuss how the two programs can work together to improve family planning access throughout the state.

MCH is a member CDR. It is currently led by the WYCRP to review child maltreatment deaths and major injuries. The MCH CDC Assignee is also active with the leadership council.

The WIHPM is the Office of Women's Health representative and attends quarterly meetings which include state updates, resource sharing and presentations which respond to member inquiry and interest.

Other HRSA programs:

The Primary Care Association (PCA) is a member of the IM CollIN. The PCA is kept informed of activities occurring within the CollIN.

State and local MCH programs:

MCH contracts with 22 of the 23 county PHN offices with combined funding of TANF and SGF provided for reimbursement of MCH services, such as home visitation and care coordination for CYSCHN. The WIHPM partners with the MCH Nurse Consultant (PHN) to enhance the home visiting services and increase communication.

Other programs within WDH:

Currently MCH is partnering with Chronic Disease and WIC on an ASTHO project to increase access to professional and peer support for breastfeeding. The first step is an environmental scan to obtain a baseline of current support services.

The IM CollIN includes MCH, Medicaid, MCH Epi, and the Tobacco program.

The WIHPM works with the Behavioral Health Division's Part C (Early Intervention) Program Manager and the Governor's Early Intervention Council (EIC) to increase early referrals to services. The Part C Coordinator has also been involved in planning meetings for visits to tertiary care facilities. Other partners for tertiary facility visits include WIC, Medicaid, CSH, Vital Statistics, and PHN.

Other governmental agencies:

The MCH Needs Assessment advisory committee included representatives from DFS, DWS, the governor's office and WDE. MCH would like to partner with the Department of Corrections, specifically on their newly created mother/baby unit at one of the correction facilities in WY.

Tribes:

The FIMR planning committee involves county personnel, IHS, hospital, and the Eastern Shoshone and Northern Arapaho tribes. Both tribes are involved in the Tribal PRAMS project. Eastern Shoshone Tribal Health participates in WY's IM CollIN state team and the WAHP. The AHPM is an active member of the Wind River Wellness Coalition.

Public Health and Health professional educational programs and universities:

The AHPM confers monthly with the Society for Adolescent Health and Medicine (SAHM) to keep up with evidence-based and best practices for adolescent health.

The MCH Epi staff completed the University of Illinois Chicago and CDC course on administrative data sets and public health. The team used hospital discharge data to calculate severe maternal morbidity in WY.

Family/consumer partnership and leadership programs:

MCH provides funding and support for the expansion of the Parent Leadership Training Institute (PLTI), a strategy to increase parent engagement in communities. Current sites include the counties of Hot Springs, Natrona, Albany, and Laramie, and the Wind River Indian Reservation. Equipping parents with a “tool kit” of leadership skills through PLTI, especially those with CYSHCN, creates effective leaders at the family, community, and state level who can ensure positive health and safety outcomes for all WY children.

In spring 2014, the Kellogg Foundation awarded a grant to PLTI National Center which included funding to build a native literature piece into the Children’s Leadership Training Institute (CLTI).

The Kellogg grant also included funding to evaluate and modify the PLTI curriculum to create a Rural PLTI curriculum to be conducive to rural and frontier states. The CHPM will participate with the PLTI Director from Colorado to develop the curriculum modifications based on experiences from WY PLTI sites. Meetings are scheduled throughout 2015 and 2016 to pilot the Rural PLTI curriculum in fall 2016.

The AHPM is partnering with F2F to develop a position for adolescents selected for the WAHP.

Other state and local public and private organizations that serve the state’s MCH population:

The CHPM represents MCH on the Governor’s Early Childhood State Advisory Council (WECSAC). The goal of the council is to ensure children are ready for school and beyond.

The CHPM serves on the WY Afterschool Alliance. The Alliance is represented on the MCH advisory committee for the Needs Assessment. Both the CHPM and the AHPM will present at the WAA 2015 annual conference on increasing parent engagement and positive youth development.

The CHPM sits on the Wyoming Early Childhood Partnership (WECP) Advisory Committee. Within WECP is WY Kids First, an early childhood systems building initiative. MCH partners with the WECP and the WY Kids First Initiative on developing an early childhood system of quality-based early care and education, integrated family support services, and accessible and affordable healthcare.

The MCH Unit Manager represents MCH on the Governor’s Developmental Disabilities (DD) Council. In FY14, the council began to look at objectives and the need to be measureable and attainable.

II.C. State Selected Priorities

No.	Priority Need
1	Prevent Infant Mortality
2	Improve breastfeeding duration
3	Improve access to and promote use of effective family planning
4	Reduce and prevent childhood obesity
5	Promote preventive and quality care for children and adolescents
6	Promote healthy and safe relationships in adolescents
7	Prevent injury in children

3. State Selected Priorities

- 1) **Improve breastfeeding duration:** Breastfeeding is a continued priority. A greater emphasis is now placed on breastfeeding duration compared to initiation. Wyoming currently meets the Healthy People 2020 goal for breastfeeding initiation but falls behind the goal for duration and exclusivity.
- 2) **Promote Preventive & Quality Care for Children & Adolescents:** This priority contains separate foci for the child and adolescent populations. For the child population this priority will focus on ensuring children receive preventive care, specifically in regards to developmental screening, and have access to the medical home model. For the adolescent population, the priority expands upon the previous priority of transition, to include quality and access to care.
- 3) **Promote Healthy and Safe Relationships in Adolescents:** This priority builds on the previous priority “design and implement initiatives that address interpersonal violence (IPV).” The updated priority focuses on healthy relationships in a manner consistent with positive youth development and building on youth strengths. The priority will include focus beyond IPV to include prevention of risky sex behavior.
- 4) **Improve Access to and Promote Use of Effective Family Planning:** This is a new priority that will be shared between the Women and Infant Health Program and the Adolescent Health Program. There is a need for effective contraception and to address identified barriers that prevent women and youth of both genders from obtaining necessary education and supplies.
- 5) **Reduce and Prevent Childhood Obesity:** This priority continues from the previous needs assessment but is more focused. Childhood obesity has continued to increase in Wyoming. Further efforts are warranted to help address the negative life course effects from obesity.
- 6) **Reduce Infant Mortality:** Infant mortality reduction continues to be a priority for Wyoming MCH. Though infant mortality statewide is similar to the nation, the disparities between counties and sub-populations within the state are vast and unacceptable. Work to reduce the disparities is needed.
- 7) **Injury Prevention in Children:** Injury prevention in children continues as a priority. Injury represents three of the top five causes of death among children one to eleven in Wyoming. Unintentional injury is first. Homicide and

suicide are fourth and fifth, respectively.

II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

- NPM 2 - Percent of cesarean deliveries among low-risk first births
- NPM 4 - A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months
- NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool
- NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day
- NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
- NPM 11 - Percent of children with and without special health care needs having a medical home
- NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care
- NPM 14 - A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

4. Linkage of State Selected Priorities with National Performance (NPM) and Outcome Measures (NOM)

Wyoming has selected the 8 NPMs that closely match the selected priorities. For further data and capacity assessment please refer to the MCH Population Needs in the Findings section.

Women's/Maternal Health

- **Low-risk Cesarean: % of cesarean deliveries among low-risk first births (NPM 2)** Cesarean is more costly to the health care system. It is associated with increased risk for both mother and infant and has the potential to complicate subsequent pregnancies. This NPM aligns closely with the priority identified by the needs assessment to reduce infant mortality specifically by addressing preterm and early term births.

Perinatal/Infant Health

- **Breastfeeding: % infants who are ever breastfed (NPM 4a; % of infants breastfed exclusively through six months (NPM 4b)** While breastfeeding initiation rates continue to improve in Wyoming and are above the Healthy People 2020 goal, there is still a need for increased breastfeeding duration rates to improve other health outcomes for Wyoming moms and babies. Breastfeeding duration was chosen as a priority for Wyoming. Foundational work for this priority has begun with a grant through the Association of State and Territorial Health Officials (ASTHO) for an environmental scan of breastfeeding resources as the provision of breastfeeding support is essential to assist with improving duration of breastfeeding.

Children

- **Developmental Screening: % of children (10-71 months) receiving developmental screen using a parent-completed tool (NPM 6)** Early detection of developmental delays through screening is a cost-effective method to help address needs early and improve the health trajectory of children across the lifespan. Wyoming's priority to promote preventive and quality care for children and adolescents includes obtaining appropriate screening and preventive health interventions. A focus on developmental screening was already initiated through the Early Childhood Comprehensive Systems (ECCS) grant.
- **Physical Activity: % of children (6-11 years) who are physically active at least 60 minutes per day (NPM 8)** Prevention and reduction of childhood obesity was selected as a Wyoming priority. Physical activity is a key component in reducing the obesity rate.

Adolescent

- **Adolescent well-visit: % of adolescents (12-17 years) with a preventive medical visit in past year**

(NPM 10) Connecting youth to care is an integral step in promoting wellness. Adolescent well-visits are essential to providing quality and preventive care for adolescents. Additionally, well-visits are critical to adequate transition planning and access to contraception, two additional Wyoming MCH priorities.

CSHCN

- **Medical home: % of children with and without special health care needs having a medical home (NPM 11)** Children and youth with a medical home have access to a greater level of care coordination and family centered care leading to improved health outcomes. Medical homes were a topic associated with the selection of the priority to promote preventive and quality care for children and adolescents.
- **Transition: % of adolescents with and without special health care needs who received services necessary to make transitions to adult health care (NPM 12)** Adequate preparation for the transition to adulthood improves health outcomes for youth with special health care needs, in particular, but also has benefits for all youth. By promoting transition, MCH can help ensure positive health outcomes even after our intervention ends. Transition to adulthood is a component of the priority to promote preventive and quality care for children and adolescents.

Cross-cutting

- **Smoking: % of women who smoke during pregnancy (NPM 14A)** Wyoming's high rates of tobacco use make this measure an important one. Smoking among pregnant women in Wyoming is at about 16%. Maternal smoking contributes to infant mortality and is one of the focus areas of the infant mortality prevention priority selected in Wyoming. Wyoming participates in the Infant Mortality CoIN of which tobacco cessation is one of the three state priorities. Work is occurring in conjunction with the WDH Tobacco Program and the Wyoming Quitline to address tobacco cessation among pregnant American Indian women.

II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

- SPM 1 - Risk Appropriate Care
- SPM 2 - Childhood Injury
- SPM 3 - Family Planning
- SPM 4 - Healthy Relationships - Alcohol

5. Linkage of State Selected Priorities with State Performance and Outcome Measures Wyoming will use two additional NPMs as SPMs to measure identified priorities. A third SPM to measure the priority of increased use and access to effective family planning will be developed in year two.

Maternal

- **Improve Access to and Promote Use of Effective Family Planning: # of hospitals equipped to provide immediate postpartum long acting reversible contraceptives (LARC).** Access to effective contraception is essential to improve pregnancy timing and spacing, and in turn, the health outcomes for women and children. Wyoming has selected this measure to work towards decreased barriers to access of LARCs.

Perinatal

- **Perinatal regionalization: % of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU).** Wyoming has no level III obstetric or neonatal intensive care units within the state. This adds a layer of complexity to linking high risk pregnancies to appropriate hospitals and illustrates a need for Title V to improve the coordination of services. This will be used to measure a component of the infant mortality reduction priority.

Child

- **Injury: rate of hospitalization for (non-fatal) injury per 100,000 children (1-11 years).** Childhood injury prevention is a concern in Wyoming because of high rates of injury. The MCH Unit will continue to partner with the Injury Prevention Program (IPP) and the Safe Kids program to address this issue. This performance measure is associated with the identified childhood injury priority.

II.F. Five Year State Action Plan

II.F.1 State Action Plan and Strategies by MCH Population Domain

This section presents strategies and activities identified to address the 2016-2020 Maternal and Child Health (MCH) priorities. Final determination of strategies and their corresponding evidence-based/informed strategy measures (ESM), for at least the first year, were determined through strategic planning begun in early 2016.

Following the completion of the Needs Assessment and determination of Wyoming MCH priorities, program managers researched evidence-based strategies to address the performance measure assigned to each priority. Staff attended the two-day State Technical Assistance (TA) Meeting to assist with both an understanding and development of ESMs.

In 2016, the Wyoming MCH Unit began working with a contractor to initiate the plan for addressing the identified priorities. The Wyoming MCH Vision and Mission were revised to more appropriately define what we do and why. Core values were added to further define who Wyoming MCH is.

Program managers and epidemiology created a presentation of each group's proposed plan for a meeting with stakeholders. Feedback from the stakeholders was requested and, at the end of the day, both presenters and stakeholders voiced readiness to work together.

This action plan, a work-in-progress, will be reviewed once a quarter to determine that the work is still headed in the right direction. If not, adjustments will be made and work will continue with the ultimate goal of making progress in addressing the measure for each priority.

Women/Maternal Health

State Action Plan Table

State Action Plan Table - Women/Maternal Health - Entry 1

Priority Need

Prevent Infant Mortality

NPM

Percent of cesarean deliveries among low-risk first births

Objectives

Reduce the number of cesarean deliveries among low-risk first births

Strategies

Strategy 1: Support quality improvement efforts (e.g. patient safety bundles) to identify and address areas of improvement for hospitals to decrease % low risk cesarean deliveries.

Strategy 2: Provide payment disincentives for early elective, non-medically indicated and low-risk cesarean deliveries (e.g. equalize payment for low-risk vaginal and cesarean births)

ESMs

ESM 2.1 - Development of facility-specific prevalence data

ESM 2.2 - # of YouTube hits for HBWW video

NOMs

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

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

State Action Plan Table - Women/Maternal Health - Entry 2

Priority Need

Improve access to and promote use of effective family planning

SPM

Family Planning

Objectives

Increase access to provide immediate postpartum long acting reversible contraceptives (LARCs) in hospitals.

Strategies

Apply to participate in learning collaborative on LARC. • ESM: Convene stakeholder workgroup • ESM: Completed application

Work with Medicaid and private payers to increase education on coverage and reimbursement for immediate postpartum LARCs • ESM: Bulletin describing coverage and reimbursement created

Develop LARC toolkit and work with the Wyoming Hospital Association (WHA) for distribution. • ESM: Toolkit created • ESM: # toolkits distributed

Measures

NPM 2 - Percent of cesarean deliveries among low-risk first births

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	21	20	19	18	17	17

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	21.4 %	0.8 %	521	2,437
2013	22.4 %	0.8 %	567	2,530
2012	24.4 %	0.9 %	628	2,571
2011	21.1 %	0.8 %	515	2,447
2010	22.7 %	0.8 %	585	2,581
2009	22.8 %	0.8 %	600	2,637

Legends:

🚩 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

ESM 2.1 - Development of facility-specific prevalence data

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

ESM 2.2 - # of YouTube hits for HBWW video

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	100.0	100.0	100.0	100.0	100.0

Women/Maternal Health - Plan for the Application Year

Application Year Plan (FY17): This section presents strategies/activities for 2016-2020 MCH priorities related to Women/Maternal Health. See Five-Year State Action Plan Table for more information.

Two Wyoming MCH priorities are addressed in the Women/Maternal Domain including

1. Prevent Infant Mortality
2. Improve Access to and Use of Effective Family Planning

Priority: Prevent Infant Mortality

In spring 2015, the MCH Unit selected Prevent Infant Mortality as one of its 2016-2020 priorities. The specific topic addressed in this domain is the reduction of pre- and early-term birth. Maternal smoking and risk appropriate perinatal care will be addressed in the life course and perinatal/infant domain, respectively.

Current pre- and early-term birth prevention efforts are guided by the Collaborative Improvement and Innovation Network (CollIN) State Infant Mortality Reduction Team and the Coordinated Efforts to Reduce Preterm Birth Work group. These groups will continue to move strategies forward in FY17.

In FY17, we plan to impact National Performance Measure (NPM) 2, percent of cesarean deliveries among low-risk first births, by implementing the following selected strategies paired with their associated evidence-based/informed strategy measures, where applicable. In addition to addressing NPM 2, we will also continue efforts to decrease early, non-medically indicated deliveries or inductions:

1. Support quality improvement efforts (e.g. patient safety bundles, American College of Obstetricians and Gynecologists (ACOG) "Safe Prevention of Primary Cesarean Delivery") to identify and address areas of improvement for hospitals to decrease % low-risk cesarean deliveries.
 - a. Development of facility-specific prevalence data (Yes/No)
 - b. # of Wyoming hospitals implementing data-driven quality improvement efforts
2. Promote and distribute the March of Dimes (MOD) Healthy Babies Are Worth the Wait (HBWW) materials, including a Wyoming Department of Health (WDH) developed video on the importance of waiting 39 weeks to deliver, through community-level partners, such as PHN county offices and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).
 - a. # of HBWW materials distributed
 - b. # of YouTube hits for HBWW video
3. Provide payment disincentives for early elective, non-medically indicated and low-risk cesarean deliveries (e.g., equalize payment for low-risk vaginal and cesarean births).
 - a. # hard-stop policies developed by insurers

In addition to reducing low-risk cesarean deliveries among low-risk first births and reducing early, non-medically indicated deliveries, the Women and Infant Health Program (WIHP) will also strive to increase utilization of 17 Alpha-hydroxyprogesterone caproate (17P), and evidence-based strategy for reducing preterm births in women with a previous pre-term birth. The program will develop a provider's guide on the topic. This guide will cover use, eligibility, coverage, and billing of 17P. The Coordinated Efforts to Reduce Preterm Birth Workgroup, comprised of representatives of the Wyoming Hospital Association (WHA), Wyoming Medical Society (WMS), Medicaid, Wyoming Business Coalition on Health (WyBCH) and MOD, will guide this strategy.

The guide will be developed in partnership with Medicaid. A dissemination plan will be developed to assure the information is received and useful to all providers. The WIHP will track success of this strategy by documenting the successful development of the guide, the number of guides distributed, and the number of Grand Rounds sessions held on the topic of pre- and early-term birth. The first of the Grand Rounds is scheduled for fall 2016 and will feature information on 17P. The Coordinated Efforts group plans to obtain continuing education credits for this activity.

Priority: Improve Access to and Use of Effective Family Planning

In spring 2015, the MCH Unit selected Improve Access to and Use of Effective Family Planning as one of its 2016-2020 priorities. There is no available national performance measure for this priority. The state performance measure is the # of hospitals equipped to provide immediate post-partum (IPP) LARCs.

In FY17, we plan to impact this state performance measure by implementing the following selected strategies, paired with their associated evidence-based/informed strategy measures:

1. Apply to participate in the ASTHO learning collaborative on IPP LARCs.
 - a. Application completed (Yes/No)
2. Convene a priority-specific stakeholder work group to assist with application development and develop further buy-in for this new MCH priority.
 - a. Stakeholder work group convened (Yes/No and # meetings)
3. Work with Medicaid and private insurers to increase education on coverage and reimbursement of IPP LARCs.
 - a. Development of bulletin/memo describing Medicaid coverage and reimbursement (Yes/No)
 - b. Development of provider's guide (Yes/No)
4. Develop LARC Toolkit (South Carolina has an example) and work with Medicaid and WHA for distribution.
 - a. Developed toolkit (Yes/No)
 - b. # toolkits distributed

In addition to infant mortality topic areas covered through CoIIN and our state action plan table, the WIHP will continue to support the Fremont County Fetal and Infant Mortality Review (FIMR) Pilot Project. In FY17, the goal is for the Fremont County Case Review Team (CRT) to review all fetal and infant losses occurring to Fremont County residents and develop recommendations for prioritization and action planning by the Fremont County Community Action Team (CAT). We plan to measure success on this strategy by tracking the following:

- # of CRT/CAT meetings,
- # of cases reviewed, and
- # of community projects implemented by the CAT.

In preparation for the official launch of the FIMR project (i.e. first CRT/CAT meetings were held on June 7, 2016), a detailed proposal document was produced to help inform our partners and leadership about the FIMR planning process to date and next steps. This proposal was shared with the WDH leadership, the Attorney General's (AG) Office, and the Fremont County FIMR Planning Committee members and assisted the launch of FIMR teams on June 7th to become a reality.

During the pilot year, continuing into FY17, this proposal will be updated with the goal of it becoming a toolkit for the implementation of FIMR in Wyoming. It is anticipated that FIMR will expand to other Wyoming counties/communities with increased interest and understanding of the need for this type of intervention to reduce infant mortality and improve overall community health.

The Reproductive Health Program developed and managed by the Adolescent Health Program (AHP), will be assessed during strategic planning to determine if its purpose aligns with the current 2016-2020 priorities. The program, delivered through PHN offices in counties with no Title X services or where Title X services are limited, ensures access to basic reproductive health care services, which are pregnancy testing, condoms, multivitamins, counseling/education, and emergency contraceptives where permitted.

The WIHP manager and partners from the Public Health Nursing Unit will continue to participate in the Wyoming Home Visiting Network (WYHVN). This network of committed stakeholders promote quality home visiting from pregnancy through age three as a core early childhood service available to all Wyoming families. The WYHVN facilitates the following activities among its members:

- promote program collaboration and to raise public awareness about home visiting,
- expand and sustain home visiting services,
- provide supplemental home visiting training,
- collect and share data, and
- share relevant policy and research information.

The WYHVN is a forum for spreading best practices, especially those that the WIHP is planning to employ to reduce low-risk cesarean sections and early non-medically indicated deliveries and improve access and use of effective family planning.

The WIHP manager will continue to serve as the Office of Women's Health representative from the WDH. A representative from Wyoming Health Council, the Wyoming Title X grantee, also attends meetings to offer the perspective of the Title X clinics statewide.

A program evaluation of Wyoming's implementation of Nurse Family Partnership will be complete during FY17. The WIHP and Public Health Nursing will use the results to identify opportunities for quality improvement. An evaluation of Best Beginnings, Wyoming's homegrown home visiting model, will also begin in FY17.

Women/Maternal Health - Annual Report

Annual Report Narrative: This section provides a summary of FY15 activities, accomplishments, and challenges related to National Performance Measures (2010-2015) for the Women/Maternal Health Domain.

NPM17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates. 2014, 58.2% of very low birth weight (VLBW) infants were born at high-risk facilities. This does not represent a statistically significant change from 65.9% reported in 2013.

The Maternal High Risk (MHR) and Newborn Intensive Care (NBIC) Programs ensure high-risk pregnant women and high-risk infants have access to care coordination services and gap-filling financial assistance to enhance perinatal outcomes. Twenty-two MHR clients and 54 NBIC clients received services in FY15. To complement this program, the WIHP manager has visited tertiary care hospitals with Level III care in past years, with the most recent visits occurring in 2012. No tertiary care facility visits occurred in FY15 in anticipation of strategic planning which has provided further guidance on the infant mortality priority, specifically risk appropriate perinatal care activities. The WIHP manager may revisit plans to visit tertiary care facilities during the five-year cycle (2016-2020); however, no visits are planned for FY17. The focus of FY17 will be on working with in-state hospitals to reveal and discuss the results of the Levels of Care Assessment Tool (LOCATe).

MCH continued to coordinate efforts with the WHA, WMS, MOD, WyBCH, WINhealth, and other partners to reduce preterm birth. The focus of this group during FY15 was to reduce early, non-medically indicated deliveries before 39 weeks.

The group collaborated on writing a letter to all providers announcing the new Medicaid hard-stop policy stating that early non-medically indicated deliveries before 39 weeks would not be reimbursed by Medicaid. A similar policy was adopted by WINhealth and Blue Cross Blue Shield. Correspondence about the policy was distributed to membership.

The group also supported a Becoming a Dad project in which male-dominated businesses provided information about healthy pregnancies, the importance of waiting 39 weeks to deliver, and other important pregnancy information. The packets were distributed to Dads who inquired about their insurance and healthcare coverage benefits upon learning their spouse/partner was pregnant. The project was piloted in two businesses in Wyoming. At this time, there are no plans to expand this project.

In FY15-16, the Coordinated Efforts' group shifted focus to support the Wyoming State Infant Mortality Team in the COL process. Pre- and Early-Term Birth was one of three Learning Networks selected by the state team and the Coordinated Efforts group has been an integral part in developing strategies for FY17. They have also worked together to improve Risk Appropriate Perinatal Care, the third Learning Network of the COLIN.

Currently, hospital levels are self-determined and no state or national effort exists to ensure that self-designated levels meet certain standards based on level of care. Some states have legislation to guide hospitals to discern their appropriate levels for both neonatal and maternity care; Wyoming does not have such legislation. As a strategy to improve risk appropriate care, MCH Epidemiologists piloted the LOCATE tool in early FY16 to determine levels of care for Wyoming hospitals and hospitals which typically care for high-risk women and infants in surrounding states. Letter support for this project were obtained from WHA, WMS, MOD, and the WyBCH. All partners were regularly represented at the Coordinated Efforts to Reduce Preterm Birth group, as well as the Wyoming State Infant Mortality Team.

In FY15, MCH continued planning efforts for the Fremont County FIMR Pilot Project as a result of community-expressed concerns regarding high infant mortality rates. MCH began facilitating monthly planning meetings in early 2014. Since the project's inception, a vision and objectives were developed, letters of support were signed by all partners, including the local hospital, both tribes, local PHN and the Indian Health Service (IHS).

Community meetings occurred in February 2015 in which community members and stakeholders learned about the F process and were invited to apply to be part of either the Case Review (CRT) or Community Action (CAT) teams. A training for all team members occurred on June 30, 2015 and National FIMR model representatives presented.

Next steps were developed which included the following:

- Circumstances surrounding each infant and fetal loss will be reviewed by the CRT.
- When appropriate, information about mother's risk level, location of delivery will be collected and reviewed.
- This information would be used by CRT to identify systems-level strengths and weaknesses as related to risk appropriate perinatal care and recommendations developed.
- The CAT will review the recommendations to identify and implement action steps.

WDH continued to ensure access to home visiting services across the state by providing funding to each county for the delivery of the Healthy Baby Home Visitation Program (HBHV). When women are enrolled early, as is the goal of the program, nurse home visitors are well-positioned to identify high risk pregnancies and refer to additional resources early. The MHR program is one such resource. Some counties have developed strong relationships with both their local birthing hospital and their closest tertiary care facility. These relationships are key both before and after delivery, especially if the risk level of mom and infant require out-of-state delivery.

The AHP manager provided training on adolescent communication and development in FY15 specifically targeted toward providers. This training could enhance efforts to reduce infant mortality in families where the parent is an adolescent.

The WIHP manager served, and will continue to serve, on the Governor's Early Intervention Council as Vice Chair and MCH Representative. She will be appointed as Chair in July 2016. The WIHP manager also chairs the Early Referral Committee and has convened partners to develop messaging materials to promote earliest referrals to Early Intervention (EI) Services for pregnant women and families with young children. The goal is to coordinate these early referrals with existing home visiting programs across the state who share a commitment to early intervention and home visitation as strategies to improve perinatal, maternal and infant outcomes.

WIHP manager and MCH Unit Manager participate on the MOD Wyoming Community Mission Committee. This

group provides advice and monitoring for programs such as the NICU family backpack program which has provided backpacks to families transferred from a Wyoming hospital to an out-of-state tertiary care facility (Level III hospital). The backpacks include personal care and toiletry items to help with the inconvenience of being far from home, but also include educational resources and referral information to help ease the family's transition back to their home in Wyoming.

NPM18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

2014, 70.9% of infants were born to pregnant women who received prenatal care in the first trimester. This is a statistically significant decrease from 2013 when 73.7% of infants were born to women receiving prenatal care in the trimester.

The Department of Health continued to ensure access to home visiting services across the state by providing funding each county for the delivery of the Healthy Baby Home Visitation Program. When women are visited prenatally, public health nurses can encourage receipt of the recommended prenatal care visits with an obstetric and gynecologic (OB/GYN) or Family Practice provider in their community. The minimum number of prenatal home visits, under the current visit recommendations, is three. So, home visitors are well-positioned to promote prenatal care utilization during all of these visits. Some counties also collaborated with hospitals and local providers to ensure access to prenatal care and education through provider visits, group classes, etc. For example, Teton County offered group prenatal education and served a high percentage of Hispanic women through the use of a trained interpreter. Home visitors also offered care coordination as part of each home visit and provided assistance to families with applying for insurance and improving access to other needed services.

MCH continued to build and improve partnerships with Title X and WIC at the state level and encouraged the same relationships at the local level. For example, when a woman receives a positive pregnancy test at a Title X clinic, there often is a direct referral to the Healthy Baby Home Visitation program for home visiting services. WIC will also refer appropriately when serving a pregnant woman. The goal is to offer home visitation services to all women as early as possible. Title X and WIC programs are a great place to promote this service.

All public health nurses have been trained by Medicaid staff to promote and determine eligibility for the Presumptive Eligibility (PE) program for uninsured pregnant women. The PE is a Medicaid option designed to improve a pregnant woman's access to temporary outpatient services while her eligibility for Medicaid benefits is being determined. PE eligibility provides a pregnant woman with access to outpatient services through a Medicaid provider for up to 60 days. Title X clinics also received this training to further promote early access to prenatal care for uninsured or underinsured women.

MCH provided limited funds for reproductive health services to counties with little or no Title X services in their community. This activity promoted early entry into home visitation services if a woman, receiving reproductive health services from the clinic, became pregnant.

SPM 1: Percent of women gaining adequate weight during pregnancy. In 2013, 28.6% of women gained an adequate amount of weight during pregnancy, according to Institute of Medicine (IOM) Guidelines. This is not a statistically significant change from the 2012 percentage of 28.7%.

The Department of Health continued to ensure access to home visiting services across the state by providing funding each county for the delivery of the Healthy Baby Home Visitation Program. PHNs educated clients on the IOM recommendations for healthy weight gain during pregnancy and recorded, in the Best Beginnings Data System, when this education was provided.

SPM 2: Percent of postpartum women reporting multivitamin use four or more times per week in the month before getting pregnant. The percent of postpartum women reporting multivitamin use four or more times per week the month before becoming pregnant for 2013 was 40.0%. However, this was not statistically different from the 2012 prevalence of 39.2%.

MCH provided limited funds for reproductive health services to counties with little or no Title X services in their community. This activity promoted early entry into home visitation services if a woman receiving reproductive health

services from the clinic became pregnant. A portion of funds for this program supported the provision of multivitamins women receiving services.

Perinatal/Infant Health

State Action Plan Table

State Action Plan Table - Perinatal/Infant Health - Entry 1

Priority Need

Improve breastfeeding duration

NPM

A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Objectives

To increase the proportion of infants who are breastfed and who are breastfed at six months

Strategies

Potential strategies include environmental scan of breastfeeding resources in the state, home visiting, baby friendly hospitals, CLC and peer support trainings. Final determination to occur at strategic planning end of 2015.

ESMs

ESM 4.1 - Mini-grant program structure developed

ESM 4.2 - Completion of environmental scan and incorporation of findings into strategic planning

ESM 4.3 - Breastfeeding support resource map and web page with county level data developed

NOMs

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

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

State Action Plan Table - Perinatal/Infant Health - Entry 2

Priority Need

Prevent Infant Mortality

SPM

Risk Appropriate Care

Objectives

To ensure that higher risk mothers and newborns deliver at appropriate level hospitals

Strategies

Use LOCATe results to inform quality of improvement for identified hospitals, focusing on all levels.

Build capacity for development of a perinatal quality collaborative.

Measures

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	90.0	90.0	90.0	91.0	92.0	92.0

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	86.3 %	3.7 %	6,104	7,071
2011	87.6 %	2.8 %		
2010	85.5 %	2.9 %		
2009	83.7 %	3.0 %		
2008	79.5 %	2.8 %		
2007	80.8 %	2.5 %		

Legends:

🚩 Indicator has an unweighted denominator <50 and is not reportable

⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	26.0	27.0	27.0	28.0	29.0	30.0

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	25.8 %	3.9 %	1,759	6,810
2011	16.2 %	2.8 %		
2010	17.5 %	2.8 %		
2009	21.6 %	2.8 %		
2008	16.6 %	2.2 %		
2007	20.0 %	2.5 %		

Legends:

🚩 Indicator has an unweighted denominator <50 and is not reportable

⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 4.1 - Mini-grant program structure developed

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

ESM 4.2 - Completion of environmental scan and incorporation of findings into strategic planning

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

ESM 4.3 - Breastfeeding support resource map and web page with county level data developed

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

Perinatal/Infant Health - Plan for the Application Year

Application Year Plan (FY17): This section presents strategies/activities for 2016-2020 MCH priorities related to

Perinatal/Infant Health. See Five-Year State Action Plan Table for more information.

Two Wyoming MCH priorities are addressed in the Women/Maternal Domain including

1. Prevent Infant Mortality
2. Improve Breastfeeding (BF) Duration

Priority: Prevent Infant Mortality

In spring 2015, the MCH Unit selected Prevent Infant Mortality as one of its 2016-2020 priorities. The specific topic addressed in this domain is the improvement of risk appropriate perinatal care. Maternal smoking and pre- and early term birth will be addressed in the life course and women/maternal domains, respectively.

Current infant mortality prevention efforts are guided by the Collaborative Improvement and Innovation Network (CollIN) State Infant Mortality Team and the Coordinated Efforts to Reduce Preterm Birth (Coordinated Efforts) Work group.

In FY17, we plan to impact National Performance Measure (NPM) 3 (selected as a State Performance Measure (SPM) in Wyoming)—percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)—by implementing the following selected strategies paired with their associated evidence-based/informed strategy measures, where applicable:

- Administer Levels of Care Assessment Tool (LOCATe) to all Wyoming hospitals.
 - # of Wyoming hospitals completing survey
- Use LOCATE results to inform quality of care improvement for identified hospitals, focusing on all levels.
 - # of hospitals initiating action steps to improve level of care based on receipt of survey results.
For example, if the development of a policy is preventing a hospital from being a Level X, the hospital would pick this action step to 'improve' their level of care.
- Build capacity for development of a perinatal quality collaborative
 - To Be Determined (TBD); however, a toolkit does exist to help guide and further develop this strategy and associated ESMS
- Develop standard process for delivering appropriate perinatal care, including the use of an evidence-based screening tool (e.g. MOD Preterm Labor Assessment or Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) Maternal-Fetal Triage Index)
 - TBD in conjunction with partners.

In addition to implementing strategies determined through our strategic planning process for this priority, MCH will continue to support the Maternal High Risk (MHR) and Newborn Intensive Care (NBIC) Programs to ensure high-risk pregnant women and high-risk infants have access to care coordination services and gap-filling financial assistance to enhance perinatal outcomes. To complement this program in the past, the WIHP visited tertiary care hospitals with Level III care. The last visits occurred in 2012. In 2014 and 2015 the WIHP convened planning groups to develop consistent and clear messaging to take to the tertiary care hospitals including, but not limited to, intake processes, referrals, data sharing, etc. Next steps for this process will be determined following the LOCATE strategy.

As of June 1, 2016, all birthing hospitals in Wyoming completed LOCATE. Our next step will be to share results with individual hospitals and plan quality improvement activities. We will continue to partner with the WHA in these efforts.

Priority: Improve Breastfeeding Duration

In spring 2015, the MCH Unit selected Improve Breastfeeding Duration as one of its 2016-2020 priorities.

In FY17, we plan to impact NPM 4--A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months--by implementing the following selected strategies paired with their associated evidence-based/informed strategy measures, where applicable.

1. Complete an environmental scan of available state and local level breastfeeding support resources.
 - a. Completed scan (Yes/No); Anticipated completion date is August 2016
2. Develop and disseminate a resource directory of local lactation support services available to new mothers.
 - a. Development of web-page with county-level content (Yes/No)
3. Award mini-grants and provide ongoing technical assistance to hospitals for participation in the Baby Friendly Hospital Initiative or Colorado's Can Do 5 or Arizona's Baby Steps to Breastfeeding Success.

- a. Develop structure of "mini-grant" program
 - b. Mini-Grant application finalized and approved
 - c. # of applications received
 - d. # of mini-grants awarded
 - e. # of TA meetings
 - f. # of hospitals demonstrating improvement (survey)
4. Work with WHA to develop hospital recognition program.
 - a. TBD
5. Pilot a walk-in breastfeeding clinic staffed by trained breastfeeding professionals (e.g. trained lactation counselor and peer support counselor) (Ex. Expand Natrona/Casper Breastfeeding Clinic).
 - a. # of pilot sites identified to test breastfeeding clinics
 - b. # of women served at breastfeeding clinic
 - c. TBD (client survey)
6. Establish peer counseling programs for women not eligible for the Special Supplemental Nutrition Program for *Women, Infants, and Children* (WIC) and utilize Loving Support training curriculum
 - a. # of peer counselors trained (non-WIC)

Perinatal/Infant Health - Annual Report

Annual Report Narrative: This section will review FY15 activities, accomplishments and challenges related to National Performance Measures for the Women/Maternal Health Domain.

NPM 11: *The percent of mothers who breastfeed their infants at six months of age.*

The Healthy People 2020 objective is for 60.6% of mothers to breastfeed their infants at six months of age. Data from 2014 National Immunization Survey (NIS) show that 58.1% of Wyoming mothers breastfeed their infants at 6 months of age. This was not a statistically significant difference from 56.6% in 2013.

The Healthy Baby Home Visitation (HBHV) Program aligns with the MCH program priorities including breastfeeding promotion. Home visitation services are among the required activities of a contract held with each of the 23 counties in Wyoming. Through the contract, each county is required to ensure all PHNs delivering MCH services received annual breastfeeding training. Each County is also responsible for providing breastfeeding education/support as part of the home visiting curriculum and for collecting data on initiation and duration of breastfeeding. Data on the breastfeeding support provided by PHNs and breastfeeding outcomes are tracked quarterly and provided to the counties to aid in program improvement.

The MCH Unit continued to sponsor an annual Certified Lactation Counselor (CLC) Training. In May 2014, the CLC training was offered in Fremont County. Twenty PHNs completed the week-long training. Another four nurses attended CLC training sponsored by a partner organization in Rock Springs, Wyoming in September 2014. MCH provided, at minimum, registration scholarships for PHNs, who had not yet been trained, to attend the CLC training. Scholarships were also offered to hospital nurses, WIC staff, and other professionals in a position to promote breastfeeding. The most recent course supported by MCH was held in May 2016. Approximately 11 nurses received financial scholarships to attend. In addition to providing breastfeeding education and support, local PHN offices assisted families with access to breast pumps. Breast pumps are reimbursable if provided to Medicaid clients. WIC also provided breast pumps to its clients.

In FY15, MCH, with partners in WIC and Chronic Disease, applied for and received an ASTHO grant to support breastfeeding promotion which will continue during FY16 and may continue further into FY17. The project focus is to improve access to professional and peer support for breastfeeding. The ASTHO grant offers a virtual learning community which brings together multiple states working on similar breastfeeding-related goals to share best practices, strategic challenges and successes.

The Wyoming team's first objective was to conduct an environmental scan of all breastfeeding support resources available in Wyoming. This scan began at the end of FY15 through a contract with a local partner with expertise in

breastfeeding promotion, advocacy, policy development, and community assessments. The scan will be completed by August 2016 and will inform the development of a strategic plan related to improved access to breastfeeding resources as a strategy to improve breastfeeding duration. If a gap is identified with peer counseling for breastfeeding, the group has plans to expand training of peer counselors implementing the Loving Support model which is currently used only within WIC offices. The environmental scan will also highlight strengths and weaknesses within the statewide system related to breastfeeding. This data will inform the strategies employed to revive a Wyoming Breastfeeding Coalition. The contractor charged with completing the environmental scan will also provide consultation in support of efforts to revive the state coalition.

NPM 12: *Percentage of newborns who have been screened for hearing before hospital discharge.* In 2015, 98.6% of newborns were screened for hearing before hospital discharge. This is significantly higher than the 97.2% reported in 2014.

Wyoming's Newborn Screening (NBS) Program (part of the MCH Unit) partnered with the Early Hearing Detection and Intervention (EHDI) program to provide education about available services to members of the Wyoming Medical Society at their annual meeting in June 2015. The MCH Unit was, and remains, represented on the EHDI Advisory Board.

In FY15, EHDI and the NBS Program partnered on efforts to improve outreach to midwives. Statewide data showed an increase in Wyoming home births increasing the importance of outreach to midwives about newborn screening (bloodspot and hearing screening). EHDI offered training and free equipment to interested midwives to increase their capacity to perform hearing screenings of newborns.

SPM 4: *Percent of women who initiated breastfeeding at hospital discharge.* In 2014, 84.1% of mothers initiated breastfeeding prior to hospital discharge which is not a statistically significant difference from 2012 when 84.3% of mothers initiated.

Prenatal home visits, offered through the HBHV Program, help prepare pregnant women for delivery and beyond. Breastfeeding education was provided prenatally to promote initiation upon delivery. PHNs, in certain Wyoming counties, visit mothers in the hospital upon delivery and may be well-positioned to encourage initiation of breastfeeding soon after delivery.

The WIHP Manager visited with Iverson Memorial Hospital in 2014 to learn about their progress towards Baby Friendly and offer continued support. Their road to Baby Friendly is ongoing; however, financial constraints and leadership turnover has stalled progress. The goal is to increase WIHP-provided support to hospitals who are interested in becoming Baby Friendly, or who strive to increase their number of maternity care practices supportive of breastfeeding.

Child Health

State Action Plan Table

State Action Plan Table - Child Health - Entry 1

Priority Need

Reduce and prevent childhood obesity

NPM

Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Objectives

To increase the number of children and adolescents who are physically active

Strategies

Support development of a healthy schools coalition with a focus on improving nutrition, physical activity and overall child health.

ESMs

ESM 8.1 - # of meetings of the Wyoming School Health Coalition

NOMs

NOM 19 - Percent of children in excellent or very good health

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

State Action Plan Table - Child Health - Entry 2

Priority Need

Promote preventive and quality care for children and adolescents

NPM

Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Objectives

Increase the number of children who receive a developmental screening

Strategies

Support Help Me Grow activities to make developmental screening tools accessible to families

ESMs

ESM 6.1 - Help Me Grow contract to Wyoming 211, Inc. executed

ESM 6.2 - Help Me Grow Implementation plan developed

NOMs

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

NOM 19 - Percent of children in excellent or very good health

State Action Plan Table - Child Health - Entry 3

Priority Need

Prevent injury in children

SPM

Childhood Injury

Objectives

To decrease the number of hospital admissions for non-fatal injury among children ages 0 through 19

Strategies

Support Safe Kids with targeted interventions to address the three major causes of injury/hospitalizations in Wyoming.

Measures

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	32	32	32	35	35	36

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	28.8 %	2.8 %	10,655	36,969
2007	20.2 %	2.6 %	6,939	34,279

Legends:

🚩 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 6.1 - Help Me Grow contract to Wyoming 211, Inc. executed

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

ESM 6.2 - Help Me Grow Implementation plan developed

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day (Child Health)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	45	45	45	50	50	50

Data Source: National Survey of Children's Health (NSCH) - CHILD

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	39.7 %	2.6 %	16,986	42,831
2007	38.7 %	2.8 %	15,591	40,282
2003	32.4 %	2.2 %	12,403	38,329

Legends:

📌 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 8.1 - # of meetings of the Wyoming School Health Coalition

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	2.0	4.0	4.0	4.0

Child Health - Plan for the Application Year

Application Year Plan (FY17):

Three of the Wyoming Maternal and Child Health (MCH) 2016-2020 priorities selected following the recent Needs Assessment are included within the Child Health Domain. The three priorities include:

1. Promote Preventive and Quality Care for Children and Adolescents
2. Prevent Injury in Children
3. Reduce and Prevent Obesity in Children

Priority: Promote Preventive and Quality Care for Children and Adolescents

In the Child Health Domain, this priority will address preventive and quality care for children, one to 11 years of age. The specific topic area addressed within this domain is developmental screenings. Medical home for children will be discussed within the Children's Special Health Care Needs Domain.

In FY17, MCH plans to impact National Performance Measure (NPM) 6--the percent of children (10-71 months) receiving a developmental screen using a parent completed tool-- by implementing the following selected strategies paired with their associated evidence-based/informed strategy measures:

1. Support Help Me Grow (HMG) activities to increase access to developmental screening tools for families.
 - a. HMG contract executed between WDH and Wyoming 2-1-1, Inc. (Yes/No)
 - b. HMG implementation plan developed (Yes/No)

Current efforts surrounding the increase of developmental screenings were initiated with the Early Childhood Comprehensive Systems (ECCS) grant. This work will be carried on with continued trainings on the Ages and Stages Questionnaire (ASQ), as needed, and provision of ASQ materials for medical providers, PHN, home visitors, and early care and education providers.

Under the ECCS grant, development of a HMG initiative was begun to assist with increasing access to developmental screens. HMG includes the following four components:

- Outreach to child health care providers to support early detection and intervention.
- Outreach to communities to promote use of HMG and to provide networking opportunities among families and service providers.
- A centralized telephone access point for connecting children and their families to services and care coordination.
- Collection of data to understand all aspects of the HMG system, including the identification of gaps and barriers.

Through a Request for Proposals (RFP) process, Wyoming 2-1-1 was selected to be the centralized access point for HMG in Wyoming. The Child Health Program (CHP) manager and executive director of Wyoming 2-1-1 are currently finalizing the details of the HMG contract.

MCH will work with Medicaid and the Wyoming chapter of the American Association of Pediatricians (WY-AAP) to address the low number of Medicaid's well-child checks reported through the Early Periodic Screening Diagnosis and Treatment (EPSDT) program.

Priority: Prevent Injury in Children

This second priority has been continued from the 2010-2015 priorities. MCH plans to impact the Wyoming SPM--injury rate of hospitalization for (non-fatal) injury per 100,000 children (1-11 years)--by implementing the following selected strategies paired with their associated evidence-based/informed strategy measures:

- Provide Safe Kids Wyoming (SKW) with targeted evidence-based strategies to address the three major causes of injury/hospitalizations in Wyoming.
 - # of strategies implemented to address motor vehicle crashes
 - # of strategies implemented to address falls
 - # of strategies implemented to address poisonings

Safe Kids Wyoming (SKW) provides Child Passenger Safety Training, car seat installation, and car seat inspections statewide. Both MCH, through the CHP manager, and the Injury Prevention Program (IPP) manager represent WDH on the SKW Leadership Team. SKW is involved in the MCH strategic planning and meets with both MCH and the WDH Injury Prevention Program (IPP) to assure there is no duplication of effort.

MCH will continue collaboration with the WDH IPP and membership on the Wyoming Child Death Review and Prevention Team (WYCDRPT).

Priority: Reduce and Prevent Childhood Obesity

The third priority is also continued, but it will be focused on physical activity. MCH plans to impact NPM 8—percent of children (6-11 years of age) who are physically active at least 60 minutes per day--by implementing the following selected strategies paired with their associated evidence-based/informed strategy measures:

- Support development of a healthy schools coalition with a focus on improving physical activity, nutrition, and overall child health.
 - # of meetings of the Wyoming Healthy Schools Coalition
- District level school health profile data analyzed to determine current policies and practices and determine districts for targeted outreach.
 - Analysis of district level school health profile data completed(Yes/No)
 - Districts determined for targeted outreach (Yes/No)

These two strategies will assist MCH to build relationships with the Department of Education and identify appropriate strategies to pilot. MCH will work with communities to identify activities based on the community's need. The analysis of district level school health profile data will assist with the identification of districts for appropriate outreach.

One activity that will continue for this priority, in partnership with Indian Health Service (IHS), is Back in Whack!, a pilot clinic- and home-based exercise and nutrition program developed within Wyoming. Wyoming Medicaid is currently using the program for Medicaid eligible children and youth.

The target population, for the program, is rural and frontier children and youth with high BMI's as determined by their primary care provider. Families receive a Prescription for Health from the IHS physician. A Back in Whack! pack is provided which contains evidence-based nutrition and exercise information in printed and video format and provides children and youth with an incentive after 4 months participation. Data will be collected on participants at the beginning of the program, after 4 months, and again after 12 months in the program to determine the program's effectiveness for increasing fruit and vegetable consumption, increasing physical activity, decreasing screen time, and decreasing consumption of sugary beverages. This pilot activity will carry into FY17.

Child Health - Annual Report

Annual Report Narrative: This section will review past (FY15) and current (year to date FY16) activities, accomplishments and challenges related to National Performance Measures for the Child Health Domain.

NPM 7: Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza and Hepatitis B.

The proportion of 19-35 month olds who received the full schedule of age appropriate immunizations (4:3:1:3:3) decreased significantly from 71.60% in 2011 to 67.20% in 2012. –Newer data is not currently available.

The Wyoming Immunization Program is a Unit within the PHD of the WDH. The program's goal is Bringing Immunity to Every Community! It is this Unit that provides education and clinical guidance regarding vaccines.

Within the MCH Unit, immunizations are encouraged through various programs. Families of children with special health care needs received reminders of their child's well-child checks. This is an opportune time to receive necessary immunizations. Children with special health care needs often have so many appointments; the well-child check can easily be overlooked.

The Adolescent Health Program (AHP) manager joined with the Immunization Program to encourage the human papillomavirus (HPV) vaccine at regional immunization trainings. Immunization staff provided the vaccine information while the AHP manager provided training on the adolescent brain and adolescent-friendly settings.

The Healthy Baby Home Visitation Program, which receives funding and support from MCH, provided immunization information to pregnant and postpartum women. The flu vaccine was encouraged for pregnant and new mothers, as well as the schedule of immunizations for young children.

NPM 9: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

The results of the 2009-2010 Oral Health (OH) Survey indicated that 49.1% of Wyoming third graders had dental sealant on at least one permanent molar. Due to survey methodology, data from 2009-2010 survey are not comparable to data from previous years. The survey has not been repeated.

Four Community Oral Health Coordinators (COHC) provided services to children in ten of Wyoming's 23 counties. Preventive services included oral health education programs, fluoride varnish programs, dental screenings, and referrals.

MCH funded 6,051 sealants for 1,186 children. The total spent on sealants provided through Wyoming Dental offices, when not covered by insurance, was \$96,816.

The Oral Health Program, in conjunction with the Wyoming Dental Association (WDA), prepared Healthy Mouth Healthy Me (HMHM) packets. Distribution of 8,000 packets to new parents occurred through Wyoming Hospitals.

The packets included an oral health pamphlet, a Pregnancy Risk Assessment Monitoring System (PRAMS) book mark, finger cots, Xylitol, and an infant toothbrush.

Since early 2012, Wyoming's OH Program had been under the Community Health Section of the Public Health Division. A contracted dentist provided oversight for the COHCs. The gap filling programs continued with minimal support. At the beginning of FY15, the OH Program was moved into the MCH Unit. A part-time State Dentist and a full time OH program manager soon joined the team and began putting structure around the COHC and gap-filling oral health programs.

On January 5, 2015, the Sheridan community began water fluoridation. One of the COHCs was nominated, by the Campaign for Dental Health Nominations Committee, for an annual Determination Award. The receipt of this reward demonstrated her advocacy and dedication to promoting community water fluoridation.

In FY16, due to a suffering economy, Wyoming State agencies had to make budget reductions for FY17-18. Within these budget reductions was the elimination of the Public Health OH Program.

NPM 13: Percent of children without health insurance

In 2013, 9.5% of Wyoming children under 18 were uninsured. This proportion is unchanged from 2012. In 2014, 5.9% Wyoming children under 18 were uninsured. This is a significant decrease from 9.5% of children uninsured in 2012.

The Children's Special Health (CSH) program provided gap-filling and care coordination services to children who qualified based on medical diagnosis and income eligibility. The CSH staff required applicants to apply to the Federal Marketplace, Medicaid, and CHIP. This has resulted in very few enrolled children needing to rely solely on CSH for financial assistance. The majority of enrolled children have private insurance, Medicaid, or CHIP.

MCH contracted with the University of Utah to provide Genetics Clinics around Wyoming and offer consultation to Wyoming providers. Genetic consultation is offered at no charge to families which allowed families, with inadequate or no insurance, to receive services.

A Cleft Palate Clinic, staffed by audiologist, oral maxillofacial surgeons, orthodontist, otolaryngologists, pediatric dentist, plastic surgeon, speech/language pathologist, community oral health provider and MCH staff, provided multidisciplinary evaluations for 46 children and youth in FY15. The Oral Health staff, assisted by CSH staff, completed preparations for the two annual clinics and provided dictation services after the clinics. With elimination of the OH program for FY17-18, MCH staff is evaluating how to proceed regarding the cleft palate clinic.

NPM 14: Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th and the 95th percentile

In 2014, 22.5% of WIC recipient's ages 2 to 5 years had a BMI at or above the 85th percentile. This is significantly higher than the 20.5% reported in 2013. In 2015, 21.7% of the WIC recipients', ages 2 to 5 years, had a BMI at or above the 85th percentile. This is not significantly different than the 22.5% reported in 2014.

MCH worked with WIC staff to review and update the Strong and Healthy Bodies section of the [Wyoming Early Learning Guidelines](#) (ELG) for Children Ages 0-3 years. The goal of the review was to assure current, evidence-based information was included in ELGs which provide:

- A guide to observe young children's development and learning;
- Evidence that sharing responsibility for early child care and education is key to success;
- Educational tools that help teachers and administrators assess school readiness; and
- A framework to help communities guide children from early childhood settings to kindergarten.

The CHP, with the AHP, contracted with the University of Wyoming to expand the Healthy Pokes program. Healthy Pokes, targeted at children and youth in urban areas who are paired with a college-age mentor, focuses on the areas of physical activity, nutrition, behavioral health and mentoring. Developed at the University of Wyoming, in the Kinesiology Department, Healthy Pokes provided a comprehensive approach to addressing child health and obesity. At this point, the CHP has chosen not to continue contracting with the Healthy Pokes program in exchange for a more

population-based approach to increasing physical activity.

NPM 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes (MVC) per 100,000 children.

The rate of deaths to children age 14 and under due to MVC was 3.2 deaths per 100,000 children age 14 years and under in 2013. This was not significantly different than the 2.4 deaths per 100,000 children age 14 years and under in 2012. Three-year averages were utilized due to the small number of deaths each year. The rate of deaths to children age 14 and under due to MVC was 3.8 deaths per 100,000 children age 14 years and under in 2014. This was not significantly different than the 3.2 deaths per 100,000 children age 14 years and under in 2013. Three-year averages were utilized due to the small number of deaths each year.

SPM 7: Rate of deaths to children ages 1 to 24 due to unintentional injuries (Rate per 100,000).

In 2013 there were 22.2 deaths to children ages 1 to 24 years per 100,000. This does not represent a statistically significant decrease from 24.8 per 100,000 in 2012.

The Senior MCH Epidemiologist participated on the WYCDRPT which reviewed motor vehicle crashes once a year. There were 12 child fatalities and 42 children with major injuries due to motor vehicle crashes in FY15. Of the fatalities, 67% had improper seatbelt/car seat use and half of the major injuries were found to have improper use of child safety restraints. Recommendations from the WYCDRPT included:

- The Wyoming Safety Belt Law should become a primary offense, at least for children up to 18 years of age.
- If the Wyoming Safety Belt law remains a secondary offense, children under the age of 14 should be covered under the Wyoming Child Restraint Law. Those children above the size and age requirements of a booster seat should be required to wear a safety belt up to the age of 14.
- Educational programs surrounding child safety restraints, including SKW programming reaching all of Wyoming should be continued and supported to ensure all Wyoming drivers know the proper restraints needed when traveling with children.

MCH provided financial support to SKW. Programmatic support was provided by the CHP manager as member of the SKW Leadership Team. SKW coalitions, across the state, worked to reduce child and adolescent deaths caused by motor vehicle crashes through a variety of activities. Local Child Passenger Safety events, Traveling Safely with Newborn classes, and informational packets for expectant and new parents containing information on seatbelts and pregnancy seat installation, and inspection station appointments were among some of the activities provided across the state.

Regional trauma profiles were provided to coordinators which included information on the causes of child major injuries including Motor Vehicle Crashes and Restraint Use, Helmet use/bicycles, gun safety, drowning, falls, burns, poisoning, hyperthermia, dog bites, and furniture tip over. Going forward with the new MCH strategies, these profiles will be used to assist local SKW coalitions direct their programming efforts.

MCH participated on the Wyoming Emergency Medical Services for Children (EMS-C) advisory committee for the Wyoming Responders Safe Transport Initiative (WYRESTRAIN). MCH provided funding for the purchase of 133 Ambulance Child Restraints (ACR) which safely secure children, between 4 and 99 lbs, on stretchers for transport in the State's air and ground ambulances. SKW disseminated information about the ACRs through Child Passenger Safety Certification classes. EMS-C was able to certify 80 trainers within the state.

Adolescent Health

State Action Plan Table

State Action Plan Table - Adolescent Health - Entry 1

Priority Need

Promote preventive and quality care for children and adolescents

NPM

Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Objectives

Increase the number of adolescents with a preventive medical visit in the past year.

Strategies

Promote the Adolescent Champion Model through mini-grants to health care providers

ESMs

ESM 10.1 - Partnership with University of Michigan developed

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children in excellent or very good health

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

State Action Plan Table - Adolescent Health - Entry 2

Priority Need

Promote healthy and safe relationships in adolescents

SPM

Healthy Relationships - Alcohol

Objectives

Increase the number of teens reporting 0 occasions of alcohol use in the past 30 days

Strategies

Implement Communities That Care Program in select Wyoming communities

Measures

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

Annual Objectives

	2016	2017	2018	2019	2020	2021
Annual Objective	85	85	85	87	87	88

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	81.1 %	2.2 %	36,230	44,669
2007	84.8 %	1.8 %	35,345	41,678
2003	73.6 %	1.8 %	32,783	44,573

Legends:

📌 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 10.1 - Partnership with University of Michigan developed

Annual Objectives

	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

Adolescent Health - Plan for the Application Year

Application Year Plan (FY17): This section presents the initial strategies for the 2016-2020 MCH priorities related to Adolescent Health. See Five-Year State Action Plan Table for more information.

Two Wyoming MCH priorities are addressed in the Adolescent Health Domain which are:

1. Promote Preventive & Quality Care for Children and Adolescents
2. Promote Healthy & Safe Relationships in Adolescents

Priority: Promote Preventive & Quality Care for Children & Adolescents

In spring 2015, the MCH Unit selected Promote Preventive and Quality Care for Children and Adolescents as one of its 2016-2020 priorities. The specific topic areas addressed in this domain include quality of care, access to care, and preventive health and screening. Transition to Adulthood and medical home will be addressed in the CSHCN domain. As this priority relates to children (1-11 years), some topics will be addressed in the Child Health Domain.

In FY17, we plan to address NPM 10, percent of adolescents with a preventive services visit in the last year, by implementing the following strategy paired with the associated evidence-based/informed strategy measures:

- Promote the Adolescent Champion Model (ACM)
 - Partnership with the University of Michigan developed
 - Mini-grant process and Request for Applications (RFA) developed

Other activities planned for FY17 to address this priority include the following:

- Apply for the Adolescent and Young Adult Health CoIIN in 2016.
- Maintain the inclusion of health within transition conversations with entities that include, but are not limited to, Departments of Education, Family Services, and Workforce Services.
- Continue building relationships with the Society for Adolescent Health and Medicine (SAHM) member partners to further integrate public health with primary care.

Priority: Promote Healthy & Safe Relationships in Adolescents

In spring 2015, the MCH Unit selected Promote Healthy and Safe Relationships in Adolescents as one of its 2016-2020 priorities. The specific topic areas addressed in this domain include teen births, risky sex behaviors and intimate partner violence.

In FY17, we plan to address this state performance measure, percent of teens reporting zero occasions of alcohol use in the past 30 days, by implementing the following strategy paired with the associated evidence-based/informed strategy measure:

- Implement the Communities that Care (CTC) model in select Wyoming communities to increase protective factors and decrease risk factors related to healthy and safe relationships in adolescents.
 - Collaboration with the University of Washington
 - Implementation plan and RFA for CTC, including collaborating with the University of Washington, developed.

Adolescent Health - Annual Report

Annual Report Narrative: This section will review past (FY15) activities, accomplishments, and challenges related to the National Performance Measures for the Adolescent Health Domain.

NPM 8: The rate of birth (per 1000) for teenagers aged 15 through 17 years.

The rate of birth per 1,000 for teens age 15-17 years significantly decreased from 14.7 births per 1,000 teens age girls 15-17 years in 2013 to 11.9 births per 1,000 teens age girls 15-17 years in 2014.

Through the MCH Reproductive Health Program contraceptives were provided to seven counties that received little to no Title X funding. MCH served an average of 300 clients in FY15, 150 were adolescents. In addition to hormonal birth control pills, MCH provided emergency contraception, Depo-Provera, nuva-ring, the patch, and birth control pills that can be used while breastfeeding.

MCH provided pregnancy tests to 14 counties that receive little to no Title X funding. Nurses in these public health offices provided preconception counseling and referrals to family planning services if such services are not available at public health nursing clinics.

The AHP manager is a Trainer of Trainers for Reducing the Risk, Making Proud Choices, Making Proud Choices for Youth in Out of Home Care, and Friendships and Dating, a curriculum specifically for youth and young adults with special health care needs. The implementation of these curricula is funded by the Personal Responsibility Education Program (PREP) in Boys and Girls Clubs. In FY16, over 439 adolescents and 30 young adults with special health care needs completed the PREP program with fidelity. In addition, another 40 facilitators were trained in the curricula and several new school districts approved evidence-based sexual health curricula for their schools. All facilitators receive additional training in “Unlocking the Mysteries of the Adolescent Brain”. The potential exists to support this work through MCH funds in the future, if necessary.

The AHP developed a program in January of 2014 called Engaging Providers for Adolescent and Young Adult Health (EPAYAH). The AHP manager worked with national partners, including the State Adolescent Health Resource Center (SAHRC) and the National Adolescent Health Information Center (NAHIC), to develop training for providers called “Adolescent Development and Communication for Health Care Providers”. In FY15 new evidence-based information was added to the training and it was renamed “Unlocking the Mysteries of the Adolescent Brain for Health Care Providers.” which includes education on adolescent development and communication, transition, youth friendly-clinic services, and the importance of the adolescent well-visit. The AHP Manager trained 195 health care providers in FY 15, including mental health professionals, medical students, nurse practitioners, physicians, physician assistants, nurses, and other clinic staff.

The AHP partnered with the WIHP, the Wyoming Health Council, PHN, school nursing, and an adolescent counseling organization to create a Wyoming Reproductive Life Plan. Although still in development, the goal for this document is guide adolescents in thinking about reproductive life goals and serve as a counseling document in the reproductive health setting.

NPM16: The rate (per 100,000) of suicide deaths among youths aged 15-19.

The rate for 2014 (data from 2012-2014) was 22.5 per 100,000, a statistically significant increase from 20.5 for 2013 (data from 2011-2013). Three-year rates were used to improve data reliability in measuring this performance measure due to the small numbers of annual suicide deaths.

The AHP manager is an active member of the Wyoming Suicide Prevention Advisory Council (WYSPAC). Prior to involvement of the AHP, a major focus of WYSPAC was on middle-aged men. The AHP manager elevated the issue of adolescent suicide prevention to the WYSPAC and ensured the State Suicide Prevention Plan continue to include adolescent suicide prevention as a priority. The AHP manager also educated WYSPAC on authentic youth engagement in prevention efforts. As of FY15, and with leadership from the AHP manager, the Wyoming youth suicide prevention website is being updated with adolescent input on design and content.

The AHP manager serves on the Clinical Competencies Work group of WYSPAC. This group focuses on engaging providers in the suicide prevention effort and providing educational opportunities for providers.

The AHP manager also worked with a group of high school students interested in conducting their own focus group on youth suicide. The goal was to see how they could better help their peers, and the adults in their lives, prevent youth suicide. Training was provided for the youth on conducting youth focus groups, helped them verify the questions they planned to ask, and helped with data assessment.

SPM 5: Percent of Wyoming high school students who ate fruits and vegetables less than five times per day.

Data from the 2013 Youth Risk Behavior Surveillance System (YRBSS) show that 78.3% of Wyoming high school students ate fruits and vegetables less than five times per day. This is not a statistically significant change from the 2011 YRBS in which 77.9% of Wyoming high school students ate fruits and vegetables less than five times per day. 2015 data for this measure is not yet available from the Wyoming Department of Education (WDE).

SPM 6: Percent of high school students were physically active at least 60 minutes per day.

In 2015, 50.6% of high school students were physically active at least 60 minutes per day. This represents a statistically significant increase from 47.8% in 2013. This measure is assessed every other year.

Back in Whack! is a joint venture between the AHP and the CHP. It is described in detail in the application year plan of the Child Health Domain.

Healthy Pokes was developed at the University of Wyoming in the Kinesiology Department. Healthy Pokes provided a comprehensive approach to addressing child health. The University initiated Healthy Pokes in Laramie and then approached MCH. MCH contracted with the University of Wyoming to expand the Healthy Pokes program to a second community, Cheyenne. The target audience was children and youth in urban areas. Children were paired with a college age mentor to focus on physical activity, nutrition, behavioral health and mentoring. This activity will not be continued with the priority, Reduce and Prevent Childhood Obesity.

The AHP manager, a member of the WY Outside steering committee, co-chaired the WY Outside Advocacy Committee. A Wyoming Youth Outdoor Bill of Rights (YOBR) was developed with input from children and youth in Wyoming. The YOBR was recognized in a proclamation by Governor Matt Mead. The AHP ensured all activities listed on the YOBR were accessible by youth of differing abilities. WY Outside, an affiliation of nonprofits and state and federal agencies, works to encourage youth and families in Wyoming to spend more time outdoors. The mission is to foster the mind, body, and spirit of youth and families by inspiring a long-term appreciation of the Wyoming outdoors through education, experience, and adventure. The vision is for all Wyoming youth and families to live an active lifestyle through experiences that lead to understanding, valuing, and caring for the outdoors. WY Outside provided an opportunity to encourage inclusion of CYSHCN in planned activities of the organization.

SPM 8: Percent of high school students reporting that they were hit, slapped, or physically hurt by their boyfriend/girlfriend.

In 2015, 9.9% of Wyoming high school students who were dating reported that they had experienced physical dating violence in the past year. This is not significantly different from 2013 (10.3%).

The Rape Prevention and Education (RPE) grant is managed by the AHP. The contract with the Wyoming Coalition Against Domestic Violence and Sexual Assault (WCADVSA) was amended to include training on the Public Health Model and Adolescent Development as part of the contract requirements. In FY15, a new data collection and reporting system was developed to improve the quality and quantity of new data collected and provides a platform for continuous quality improvement (CQI). The AHP manager, with the WCADVSA, is developing a statewide violence prevention plan focused on the protective factor of youth/adult connectedness and promoting the statewide media campaign "Be the Solution".

As a member of the Wyoming Sexual Violence Prevention Council (WSVPC) steering committee the AHP manager utilized the collective impact concept to increase effectiveness of the council's efforts. The WSVPC received training in collective impact, the importance of connectedness, and use of the new data collection and reporting system.

Intimate partner violence and teen dating violence were included in facilitator trainings for the PREP comprehensive reproductive health curriculum. Both response and prevention topics were covered. Providers were encouraged to screen for signs of violence through the EPAYAH training.

The AHP developed an online Community of Practice (CoP) via Google Sites for prevention professionals throughout the state to share strategies and ideas about sexual violence prevention. The CoP is moderated by the AHP manager and prevention professionals from the WCADVSA.

The AHP assisted public health nurses (PHN) in Uinta, Sweetwater, Laramie, and Hot Springs counties to create healthy relationship messages and provided printed materials from the CDC's Choose Respect campaign for local middle and high school health fairs. Over 600 students were served in FY15.

Children with Special Health Care Needs

State Action Plan Table

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

Priority Need

Promote preventive and quality care for children and adolescents

NPM

Percent of children with and without special health care needs having a medical home

Objectives

Increase number of children with and without special health care needs having a medical home

Strategies

Support medical practices with technical assistance to develop and implement Family Engagement policies
Conduct outreach to families about availability and benefits of the medical home through Parent Leadership Training Institute.

ESMs

ESM 11.1 - Completed environmental scan of Medical Homes in WY and what their family engagement policies are in partnership with Medicaid.

ESM 11.2 - Medical Home module created and implemented into PLTI Curriculum

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM 19 - Percent of children in excellent or very good health

NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

State Action Plan Table - Children with Special Health Care Needs - Entry 2

Priority Need

Promote preventive and quality care for children and adolescents

NPM

Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Objectives

Increase percent of children with and without special health care needs who received services necessary to make transitions to adult health care

Strategies

Develop a state-level adolescent provider team.

ESMs

ESM 12.1 - # of meetings of the State Level Adolescent Provider Team in the last year (with Transition sub committee meeting)

ESM 12.2 - # of provider champions participating on team

ESM 12.3 - # of adolescents participating on team

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM 19 - Percent of children in excellent or very good health



Measures

NPM 11 - Percent of children with and without special health care needs having a medical home

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	50	50	50	55	55	55



Data Source: National Survey of Children's Health (NSCH) - CSHCN

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	42.8 %	3.7 %	11,052	25,796
2007	43.0 %	3.4 %	11,288	26,226

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH) - NONCSHCN

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	63.5 %	1.7 %	66,584	104,917
2007	63.7 %	1.7 %	60,718	95,301

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 11.1 - Completed environmental scan of Medical Homes in WY and what their family engagement policies are in partnership with Medicaid.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

ESM 11.2 - Medical Home module created and implemented into PLTI Curriculum

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	45	45	50	50	50	52

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	47.4 %	4.8 %	3,609	7,613
2005_2006	47.0 %	3.0 %	3,082	6,561

Legends:

🚩 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 12.1 - # of meetings of the State Level Adolescent Provider Team in the last year (with Transition sub committee meeting)

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	2.0	4.0	4.0	4.0	4.0

ESM 12.2 - # of provider champions participating on team

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	2.0	3.0	3.0	3.0

ESM 12.3 - # of adolescents participating on team

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	2.0	3.0	3.0	3.0

Children with Special Health Care Needs - Plan for the Application Year

Application Year Plan (FY16): This section presents the initial strategies for the 2016-2020 MCH priorities related to Adolescent Health. See Five-Year State Action Plan Table for more information.

One Wyoming MCH priority is addressed in the Children with Special Health Care Needs Domain and one on-going program:

- Promote Preventive and Quality Care for Children and Adolescents
- Newborn Screening

Priority: Promote Preventive and Quality Care for Children and Adolescents

In spring 2015, the MCH Unit selected Promote Preventive and Quality Care for Children and Adolescents as one of the 2016-2020 priorities. The specific topic areas addressed in this domain include medical home and transition to adulthood.

In FY17, we plan to impact NPM 11--percent of children with and without special health care needs having a medical home--by implementing the following selected strategy paired with its associated evidence-based/informed strategy measure:

- Support medical practices with technical assistance (TA) to develop and implement family engagement policies
 - Environmental scan of Medical Homes in Wyoming completed.
 - Family engagement policies identified within medical practices which are in partnership with Medicaid.
- Conduct outreach to Parent Leadership Training Institute (PLTI) enrollees and graduates regarding availability and benefits of the medical home
 - Medical Home module created
 - Medical Home module implemented into PLTI curriculum

In FY17, we plan to impact NPM 12--percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care--by implementing the following selected strategies paired with their associated evidence-based/informed strategy measures:

- Develop a state-level adolescent provider team that includes a transition sub-committee. Membership on the team will include medical and mental health providers, parents, and adolescents.
 - # of meetings of the State Level Adolescent Provider Team in the last year
 - # of Transition sub-committee meetings
 - # of provider champions participating on team
 - # of adolescents participating on team

In addition to the above strategy, MCH will continue to uphold health within transition conversations with entities such as, but not limited to, the Wyoming Departments of Education, Family Services and Workforce Services.

Ongoing program: Newborn Screening

In FY17, the Wyoming Newborn Screening (NBS) Program will continue participation in the NewSTEPs 360, which is a national project providing technical assistance (TA) and access to data to improve NBS timeliness. NewSTEPs 360 is an extension of the national Collaborative Improvement and Innovation Network (CoIIN) focused on improving NBS timeliness. The project provides Wyoming and Colorado (Wyoming's partner in a multi-state project team) with the tools and data needed to drive forward quality improvement efforts. The Wyoming/Colorado team will partner with a local video production team to develop a 20-minute video on the importance of NBS and NBS timeliness. The target audience for the video are hospitals, providers, and any individual who comes into contact with a newborn screen along its journey from hospital (or home, in the case of a home birth) to laboratory testing, analysis, and 'call out' of results. The video will be completed by October 2016. The next step of the project will be to develop a complete educational module, inclusive of the video, and obtain continuing education credits.

In May 2016, the Wyoming NBS Panel Advisory Committee met to discuss the potential addition of critical congenital heart disease (CCHD) to the Wyoming NBS panel. By unanimous vote, the committee decided to add CCHD to the panel via rules promulgation. The committee recommended that the change take effect on January 1, 2017. Therefore, during FY17, the Wyoming NBS Program will work closely with the WHA to prepare hospitals for this change through training and education. In addition, MCH Epidemiology, the WIHP and Vital Statistics Services

(VSS) will partner to add CCHD screening fields to the maternal worksheet of the Wyoming birth certificate to track and monitor CCHD screening.

The MCH NBS Program statute was updated in February 2016 to align with best practice recommendations that say NBS should occur between 24-48 hours after delivery. The clean-up bill removed the recommended timing for NBS so that this change can be updated in rules. Rules promulgation will begin during FY17 to make this update.

Additional updates will be made to clarify the role of midwives in the NBS process.

Children with Special Health Care Needs - Annual Report

Annual Report Narrative: This section will review past (FY15) activities, accomplishments, and challenges related to National Performance Measures for Children and Youth with Special Health Care Needs (CYSHCN).

NPM 1: The percent of screen positive newborns who received timely follow-up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

In 2015, 100% of screen positive newborns received timely follow-up to determine a definitive diagnosis and clinical management for their conditions. This proportion did not change significantly from the 2014 level of 100%.

In FY15, MCH continued to contract with out-of-state contractors to provide follow-up services for NBS. University Physicians, Inc. provided follow up for hemoglobinopathy and metabolic conditions while National Jewish Health provided follow up for Severe Combined Immunodeficiency (SCID). When confirmatory testing was required as a follow-up measure, the NBS Program covered tests if not otherwise covered. This coverage assists in ruling out the condition, reaching diagnosis by eliminating the financial concern of parents and primary care providers.

MCH tracked the percent of occurrent births with a first newborn screen completed and the number and percent of screen positive newborns who received timely follow-up.

MCH continued to cover metabolic formula for children and youth eligible for the CSH program and will work with Medicaid to determine its role related to the passing of House Bill No. HB0145 (insurance-coverage of phenylketonuria).

MCH began to work with the Wyoming Board of Midwifery to clarify rules and regulations surrounding midwives' ability to draw newborn screens. Under current rules interpretation, midwives are responsible for ensuring access to newborn screens for families attended by a midwife but cannot draw the screen themselves. Due to the increasing number of home births in Wyoming and data that suggests a majority of home births do not have a newborn screen drawn, MCH began to build a partnership with certified midwives to improve the percentage of home births receiving a newborn screen between the recommended time period of 24 to 48 hours. Follow-up to definitive diagnosis for abnormal screens from a midwife-attended birth must include the midwives as part of the process. In home births, the screening card is often completed by a midwife and taken by the family to the laboratory where the screen is drawn. If the midwife is the only provider listed on the screening card, the abnormal result is called out to the midwife. Midwives must understand the importance of contacting a provider to help ensure the family can access quick and effective follow up services.

In FY15, MCH met with partners in the NBS process (hospital, courier, laboratory) to discuss quality improvement (QI) with the goal of improving timeliness. The project initially focused on understanding the process via a flow chart. Opportunities for improvement were identified.

As the QI project progressed, a national request for proposals was released. It invited states to participate in a NBS CoIIN and focused on improving timeliness of NBS. This project aligned with the goals of the MCH QI project and provided an opportunity for additional TA and resources. In November 2014, Colorado and Wyoming submitted a joint application to participate in the CoIIN and were accepted. Biweekly meetings were held with the project team.

Projects included improving quarterly hospital report cards, improving outreach to midwives, and developing an online NBS toolkit to help providers/hospitals/stakeholders improve timeliness of NBS.

Wyoming continued to send a "Submitter Report Card" to NBS providers evaluating facilities on important specimen parameters, including submission time, specimen quality, and NBS form completion. These reports, provided quarterly, are to improve the specimen submission process, accuracy of reports, and timeliness of follow-up. Currently, the Colorado Department of Public Health and Environment (CDPHE) is working with their database contractor, Perkin Elmer, to improve these report cards as part of the CoIIN project.

MCH co-sponsored a booth with the Early Hearing Detection and Intervention (EHDI) program during FY14 and FY15 the Wyoming Medical Society meeting and provided NBS pamphlets and educational information to providers in attendance.

In FY15, the NBS Coordinator presented to nurses and laboratory personnel at Cheyenne Regional Medical Center (CRMC) on NBS and focused on the importance of timeliness and accurate completion of NBS submitter cards. An updated presentation including hospital-specific data on timeliness measures has been prepared to conduct future educational outreach targeted at hospitals. The CDPHE will assist in this work as part of the CollIN efforts to increase provider education.

MCH increased their role in managing the courier contract in FY15 by taking over contract writing and management responsibilities. As of April 2015, the CDPHE began running laboratory samples on Saturdays, increasing their operation to six days a week. In order to ensure that Wyoming samples can benefit from this increase in available operations, Wyoming's courier began dropping off samples picked up from birthing hospitals on Fridays by 7:00 am on Saturday morning. This change will improve timeliness of samples drawn on Fridays by 2-3 days, as prior to this change Friday samples were dropped off at CDPHE on Monday morning or later further delaying the tests from occurring.

Colorado, Wyoming and other high-altitude states have expressed concerns regarding the possibility of increased false positives with screens for Critical Congenital Heart Disease (CCHD) due to high altitude. Multiple pilot studies with hospitals were conducted. In 2014, the CCHD Implementation Task Force determined that Colorado should implement universal screening for all babies born below 7000 feet. The CDPHE Legal Department advised the Task Force that legislation would be necessary in order to require hospitals to implement CCHD screening.

In 2015, the American Heart Association (AHA) introduced legislation in Colorado to require that on and after January 1, 2016, birthing facilities below an elevation of 7,000 feet shall test all infants born in the health facility for CCHD using pulse oximetry. The bill stated that the rules regarding screening would be set by the CDPHE NBS Follow-up program. The bill passed House and Senate and was signed by the Governor. Wyoming and Colorado are inextricably connected regarding NBS. Wyoming does not have a laboratory capable of processing newborn screens so WDH contracts with CDPHE for laboratory services. Wyoming has participated with Colorado's NBS Advisory Board and CCHD Implementation Task Force meetings. Once Colorado passed CCHD legislation, Wyoming became one of the last remaining states without CCHD legislation in place.

In May 2016, the Wyoming NBS Panel Advisory Committee met to discuss the potential addition of CCHD to the Wyoming NBS panel. By unanimous vote, the committee decided to add CCHD to the panel via rules promulgation. The committee recommended that the change take effect on January 1, 2017.

NPM 2: The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive (CSHCN Survey).

Data from the 2009-2010 National Survey of CSHCN show that 70.0% of Wyoming CYSHCN ages 0 to 18 years have families who partner in decision making at all levels and are satisfied with the services they receive. This measure is not comparable to the question asked in previous survey years.

NPM 3: The percent of children with special health care needs age 0 to 18 years who receive coordinated, ongoing, comprehensive care within a medical home (CSHCN Survey).

Data from the 2009-2010 National Survey of CSHCN show that 44.6% of Wyoming CYSHCN ages 0 to 18 years receive coordinated, ongoing, comprehensive care within a medical home. This does not represent a statistically significant change from the 2005-2006 percentage of 49.1%

NPM 4: The percent of children with special health care needs age 0 to 18 years whose families have adequate private and/or public insurance to pay for the services they need (CSHCN Survey).

Data from the 2009-2010 National Survey of CSHCN show that 58.0% of the families of Wyoming CYSHCN ages 0 to 18 years have adequate private and/or public insurance to pay for the services they need. This does not represent a statistically significant change from the 2005-2006 percentage of 59.9%.

NPM 5: The percent of children with special health care needs age 0 to 18 years whose families report the community-based service systems are organized so they can use them easily (CSHCN Survey).

Data from the 2009-2010 National Survey of CSHCN show 63.9% of the families of Wyoming CYSHCN ages 0 to 18 years report that community-based service systems are organized so they can use them easily.

NPM 6: The percent of children with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult healthcare, work, and independence.

Data from the 2009-2010 National Survey of CSHCN show that 47.4% of youth with special health care needs received the services necessary to make transitions to all aspects of adult life, including adult healthcare, work, and independence. This is not statistically significant from the percent reported from the last survey in 2005-2006 (47.0%).

MCH continued to support the Parent Leadership Training Institute (PLTI) to assist with increasing parent engagement. PLTI provides interpersonal skills and leadership training. Refer back to Child Health for more in-depth information.

The Adolescent Health Program (AHP) developed a program in January of 2014 called Engaging Providers for Adolescent and Young Adult Health (EPAYAH). The AHP manager worked with national partners, including the State Adolescent Health Resource Center (SAHRC) and the National Adolescent Health Information Center (NAHIC), to develop training for providers called "Adolescent Development and Communication for Health Care Providers". In FY new evidence-based information was added to the training and it was renamed "Unlocking the Mysteries of the Adolescent Brain for Health Care Providers." which includes education on adolescent development and communication transition, youth friendly-clinic services, and the importance of the adolescent well-visit. The AHP manager trained 19 health care providers in FY 16 including mental health professionals, medical students, nurse practitioners, MD's, physician assistants, nurses, and other clinic staff. Providers are committing to participate in the Adolescent-Centered Environment (ACE) Assessment process and to serve on the state-level provider team.

MCH partnered with the Mountain States Genetic Regional Collaborative (MSGRC) and the Parent Partner Project to implement the Parent Partner Project in four clinics in Wyoming. The program provides trained parent partners in clinics to help parents navigate the systems required to provide services for their CSHCN. MCH EPI worked with the University of North Texas Health Science Center on evaluation of the project.

Evaluation of the Parent Partner Project has continued. The results will be important in determining next steps.

MCH continued to assist eligible families, both medically and financially, with medical equipment and supplies, traveling out-of-state for appointments with specialists, and other qualified expenses. Care coordination was provided to eligible CSHCN families (based on income and medical diagnosis) by PHNs in the local community in conjunction with state CSH staff. In FY15, the program began taking a serious look at the CSHCN Standards and, specifically, care coordination. It was determined that Wyoming MCH needs to better define what care coordination services are.

MCH developed partnerships to increase the discussion of medical transition at the forefront of transition conversations occurring throughout Wyoming organizations and agencies.

- MCH partnered with the Wyoming Institute for Disabilities (WIND) and Uplift, Wyoming's Family to Family Health Information Center (F2FHIC).
- MCH participated extensively in the Foster Care Health Oversight Committee assisting with continuity of medical information for children and youth who enter the Foster Care system.
- The AHP manager served on the Youth Leadership Forum planning committee. Sponsored by the Governor's Council on Developmental Disabilities, the week-long event provided self-advocacy and leadership training for CYSHCN. This particular training will be revamped to be more inclusive in the future. The AHP manager attended the Continuum of Care Coalition Meetings to raise awareness of the medical aspect of adolescent transition.

SPM 9: The capacity to collect, analyze, and report on data for children with special health care needs.

SPM 9 is a process measure to track progress in five areas: identifying data sources for CYSHCN and analyzing

existing data, creating a comprehensive report on CYSHCN, identifying data gaps, assessing capacity to address data gaps, and creating a plan to address data gaps. Each area was scored, and the scores were totaled. In 2013, the overall score remained at 7, the same as in 2012.

MCH EPI began working with the CSH staff to identify necessary changes to the data system for improved program reporting of MCH outcomes. This was begun in FY15, but was slowed due to vacant MCH epidemiology positions.

Cross-Cutting/Life Course

State Action Plan Table

State Action Plan Table - Cross-Cutting/Life Course - Entry 1

Priority Need

Prevent Infant Mortality

NPM

A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Objectives

1. Decrease number of women who smoke during pregnancy 2. Decrease number of households where someone smokes

Strategies

Work with WDH Tobacco Program and the WY Quitline to inform development of pregnancy and American Indian-focused Quitline media materials

Work with tribal tobacco program to develop strategies for smoking cessation during pregnancy.

ESMs

ESM 14.1 - # maternal smoking'-focused meetings between the MCH and Tobacco Programs

ESM 14.2 - # pregnant women enrolled in the WY Quitline services

NOMs

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

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

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

NOM 5.1 - Percent of preterm births (<37 weeks)

NOM 5.2 - Percent of early preterm births (<34 weeks)

NOM 5.3 - Percent of late preterm births (34-36 weeks)

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

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

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

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

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

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

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

NOM 19 - Percent of children in excellent or very good health

Measures

NPM-14 A) Percent of women who smoke during pregnancy

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	15.0	14.0	13.0	12.0	12.0	10.0

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	16.9 %	0.4 %	1,263	7,492
2013	17.0 %	0.4 %	1,261	7,400
2012	17.6 %	0.4 %	1,299	7,366
2011	17.7 %	0.5 %	1,289	7,277
2010	19.1 %	0.5 %	1,349	7,049
2009	19.3 %	0.5 %	1,452	7,512

Legends:

📌 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NPM-14 B) Percent of children who live in households where someone smokes

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	25.0	25.0	22.0	22.0	20.0	18.0

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	27.0 %	1.4 %	35,902	132,791
2007	31.2 %	1.5 %	39,228	125,625
2003	32.6 %	1.3 %	33,745	103,509

Legends:

📌 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 14.1 - # maternal smoking'-focused meetings between the MCH and Tobacco Programs

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	4.0	4.0	4.0	4.0	4.0

ESM 14.2 - # pregnant women enrolled in the WY Quitline services

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	30.0	32.0	34.0	36.0	38.0

Cross-Cutting/Life Course - Plan for the Application Year

Application Year Plan (FY17): This section presents strategies/activities for 2016-2020 MCH priorities related to Cross-Cutting/Life Course. See Five-Year State Action Plan Table for more information.

One Wyoming MCH priority will be addressed in the Cross-Cutting/Life Course Domain: Prevent Infant Mortality

Priority: Prevent Infant Mortality

In spring 2015, the MCH Unit selected Prevent Infant Mortality as one of its 2016-2020 priorities. The specific topic addressed in this domain is the reduction of maternal smoking. Pre- and early-term birth and risk appropriate perinatal care will be addressed in the women/maternal and perinatal/infant domains, respectively.

A Maternal Smoking Work group, led by the Tobacco Prevention and Control Program, contains much of the work of this topic within infant mortality prevention efforts. The goal is to convene this workgroup at least quarterly to assure the work of the strategic plan around this topic area is accomplished.

Beginning in FY17, we plan to impact NPM 14a--percent of women who smoke during pregnancy--by implementing the following selected strategies paired with their associated evidence-based/informed strategy measures, where applicable:

1. Work with Tobacco Program and Wyoming Quitline to inform development of pregnancy and American-Indian focused media materials.
 - a. # of 'maternal smoking'-focused work group meetings
 - b. # of pregnant women calling Wyoming Quitline (monthly)
2. Work with tribal tobacco program to develop strategies for smoking cessation during pregnancy
 - a. To Be Determined

Further details on the strategic plan for this topic will be discussed and refined during a future Maternal Smoking Workgroup. In the meanwhile, work has begun on strategy #1. In June 2016, the WIHP, MCH Epidemiology, Tobacco Cessation Program, Warehouse 21 (local media/marketing contractor) and National Jewish Health (contractor delivering Wyoming's Quitline) met to discuss development of media materials specific to Wyoming's pregnancy Quitline protocol and the American Indian Commercial Tobacco Program. PRAMS data, specifically information about methods for quitting and barriers to quitting and staying quit, has been shared and will help guide messaging.

Cross-Cutting/Life Course - Annual Report

Annual Report Narrative: This section will review FY15 activities, accomplishments and challenges related to Natic

Performance Measures for Cross-Cutting/Life Course Domain.

NPM15: Percentage of women who report smoking in the last three months of pregnancy.

Data from 2013 PRAMS indicate 13.1% of women reporting smoking during the last three months of pregnancy. This is a statistically significant decrease from 2012 with 15.9% of women reporting smoking during the last three months of pregnancy.

SPM 3: Percentage of infants born to women who smoked during pregnancy.

In 2014, 15.8% of women reported smoking during pregnancy. This was not a statistically significant decrease from 2013 when 15.6% reported smoking during pregnancy.

Through an MCH services contract held with all counties, MCH required PHNs ask about smoking status at every home visit. Revision of the Best Beginnings (BB) Database was rolled out during the beginning of FY14. Documentation of question was included on each form within the newly updated BB database. This requirement is in line with best practice recommendations for smoking cessation.

Nurses have continued to receive training on both the Wyoming Quitline, specifically around use of the fax referral form and SBIRT (Screening, Referral, Brief Intervention, and Referral to Treatment). Medicaid reimbursement is available for PHNs for use of SBIRT.

MCH was represented regularly on work groups within the Department of Health focused on tobacco prevention and was highly involved in groups which emphasized the importance of reducing maternal smoking. Tobacco prevention was, and remains, an area of focus and coordination within the PHD's strategic planning map. Meetings were held quarterly on this topic. Representatives from MCH, Chronic Disease Prevention, WIC, Public Health Nursing, Epidemiology, Medicaid, etc. attended with the goal of sharing resources and tracking collective progress.

Smoking/Tobacco Cessation was selected by the Wyoming State Infant Mortality Team as one of three learning network topics to focus on for the COLLN project work. It was decided the focus of the work would be to investigate processes around use of the Quitline fax referral form in offices such as Title X, PHN, WIC, etc.

Other Programmatic Activities

The WIHP manager, MCH Epidemiologist and MCH Public Health Nurse Consultant have worked during FY14 and FY15 to make improvements to the HBHV Program and corresponding data system. In August 2014, a new data system was launched to improve data collection on key objectives of the home visiting program including breastfeeding, safe sleep, smoking cessation, etc. A database manual was developed and continual technical assistance (TA) has been provided. In early 2015, one-hour TA calls were held with each county to discuss challenges, successes, and questions/comments regarding the program and database. Information from these calls has been used to make further system improvements as well as drive quality improvement efforts.

In September 2015, the WIHP sponsored a second in-person training on the Partners for a Healthy Baby curriculum. This home visiting curriculum was developed at the Florida State University. The previous MCH-sponsored training took place in September 2013. Since that training, many new nurses have joined Public Health Nurses. Approximately 30 nurses attended the 2015 training. This activity aligned with efforts to improve the standardization of Wyoming's homegrown home visiting program called Best Beginnings.

For many years, there has been increasing pressure from leadership to increase our ability to demonstrate outcomes of Wyoming's home visiting program, Healthy Baby Home Visitation Program. During FY15, discussions regarding program evaluation began and an application to participate in the CDC/Harvard School of Public Health Evaluation Practicum was submitted by MCH Epidemiology and the WIHP.

MCH continued to facilitate the development of a pilot FIMR program in Fremont County as a result of community-expressed concerns regarding high infant mortality rates. MCH began facilitating monthly planning meetings in early 2014. Since the project's inception, a vision and objectives were developed and letters of support were signed by all

partners including the local hospital, both tribes, PHN, and Indian Health Service (IHS). Community meetings occurred in February 2015 in which community members and stakeholders learned about the FIMR process and were invited to apply to participate on either the Case Review (CRT) or Community Action (CAT) teams. National FIMR program representatives assisted with a training for all team members in June of 2015.

The AHP provided training on adolescent communication and development specifically targeted toward providers. This training could enhance efforts to reduce infant mortality in families where the parent is an adolescent.

The WIHP will continue to support the Governor's Wyoming Early Intervention Council (EIC). She was appointed to Vice Chair and will assume Chair duties in FY 17. This role has helped to improve the partnership between MCH and Wyoming's Part C (Early Intervention) Program.

On the EIC, the WIHP Manager also chaired the Early Referral Committee and convened partners to develop message materials to promote earliest referrals to Early Intervention Services for pregnant women and families with young children. The goal is to coordinate these early referrals with existing home visiting programs, across the states, who share a commitment to early intervention and home visitation as strategies to improve perinatal, maternal and infant outcomes.

In FY15, MCH Epidemiology, the WIHP and the Wyoming Citizens Review Panel (WYCRP) partnered with a local OB/GYN office to pilot a safe sleep project. During the Institutional Review Board (IRB)-approved project period, OB/GYN nurses provided safe sleep education and sleep sacks at the 28-week prenatal visit for 80 women. Participants were given a pre-test and immediate post-test to evaluate change in knowledge. The project looked at subsequent use of sleep sacks and awareness of safe sleep messaging as self-reported at 6 weeks postpartum. Our findings will be presented at the 2016 MCH Epidemiology/City MatCH Conference in September. We are also developing a report to distribute to our partners and post on our website discussing the results. Safe sleep was not identified as a priority/focus area for 2016-2020. There will be no continuation of this project in FY17. Our efforts will focus instead on maternal smoking, pre- and early-term birth, and risk appropriate perinatal care.

In FY15, MCH partnered with WYCRP to distribute sleep sacks and safe sleep educational materials to all county public health offices. The next distribution was to include a plan to obtain more informative data regarding distribution methods and target audiences, as well as, information from consumers about use of the sleep sack and if they considered the sleep educational messaging when deciding how to put their baby to sleep. This activity will not continue in FY17.

In FY15, the MCH Unit contracted with the University of Utah to deliver genetics clinic services in Casper, Cheyenne, Cody, Gillette, Jackson, Riverton, Rock Springs and Sheridan. This service has been provided in Wyoming for over 20 years. The future of this program will be formally discussed by the MCH team during strategic planning in 2016.

The ECCS grant, in 2013, focused on coordinating the expansion of developmental screening activities in early care and education settings statewide. The Wyoming ECCS State Team consisted of child care providers/programs, PHNs, Child Developmental Centers, and early childhood staff located in the Wyoming Departments of Education, Workforce Services, Health and Family Services, as well as other early childhood stakeholders.

The two areas involved in the expansion included increasing use of a parent completed developmental screening tool and exploring the Help Me Grow (HMG) framework. To increase the use of a parent completed screening tool, the Ages and Stages Questionnaire (ASQ) was selected and kits were made available, along with ASQ regional trainings. Since FY15, the ECCS Grant has funded over 65 ASQ3 and over 50 ASQ/SE Starter Kits to child care centers and home visitors in Wyoming. Over 115 individuals were trained on the ASQ3/Social Emotional (SE) in nine regional trainings throughout the state, in partnership with MIECHV.

To assure resources are available and create awareness of providers and parents, the Team chose HMG. The framework will increase access to early childhood services through a centralized telephone number which can increase awareness in a large state with a small population.

To ensure a comprehensive systems approach for early childhood, the Wyoming HMG Leadership team were recruited from the WDH (both MCH and Early Intervention), DFS (Resource and Referral), the Governor's Early Childhood State Advisory Council, Wyoming 211, and the Institute for Population Health at Cheyenne Regional Medical Center (also on the Board of 211) and the Wyoming Early Childhood Partnership (Ellbogen Foundation).

The HMG team implemented the following work groups: Centralized Intake, Community Outreach, Provider Outreach, Sustainability, and Data.

The CHP manager planned a site visit/Peer to Peer learning opportunity to the HMG Utah program in November 2014 utilizing Maternal and Child Health Bureau (MCHB) Technical Assistance (TA) in conjunction with ECCS funds. The goals of the TA included the following:

- Learn about Utah's approach to implementation and expansion of HMG in a rural state.
- Learn about Utah's data system and any possibility of linking Wyoming.

Seven members of the state HMG Leadership Team attended the site visit and reported back to the Team. The vote was to move forward with development of a HMG system in Wyoming.

MCH partnered with the Wyoming Institute for Disabilities (WIND) through the established Wyoming Coalition for Early Childhood Vision Screening. The goal of the Early Childhood Vision Screening Coalition has been to provide leadership and training, facilitate discussions, and implement a statewide plan for Wyoming to increase vision screening and referral processes for early detection of early childhood vision problems.

In October 2014, the Children's Vision Summit was held with the assistance of the National Center for Children's Vision and Eye Health and Prevent Blindness America. Key leaders in children's vision and eye health met in this one-day summit to share and discuss children's vision screening, eye health education and the continuum of eye care for the purpose of coordinating and maximizing services.

Following the Children's Vision Summit, the Early Childhood Vision Screening Coalition began a strategic planning process with TA provided by the National Center for Children's Vision and Eye Health, funded through the Maternal Child Health Bureau (MCHB). The goal was to establish a state protocol for vision screening. Once a protocol is established, information will be distributed to provide community education and stakeholder buy in within a cohesive plan.

MCH assisted several communities to sponsor the Parent Leadership Training Institute (PLTI) model. It is a strategy to increase parent engagement at the local level. The Wind River Indian Reservation (WRIR) and four counties: Hot Springs, Natrona, Albany and Laramie participated in conference calls during FY15 and several offered the training within their community.

Natrona County, a new PLTI site, established strong partners and an active Civic Design Team (CDT) in order to embed PLTI into the community prior to their first class. This was an important step for sustainability. The pilot class began in January 2015.

The Hot Springs County PLTI site chose to take a year and focus on supporting parent leader alumni with their projects. A third class will begin in FY16.

In December 2015, facilitators from Natrona County and Uinta County attended the National PLTI training in Washington. Uinta County began establishment of a local CDT in 2015. The pilot class is scheduled for September 2016.

Training attendees, which include families of children with special health care needs (CSHCN), are equipped with a 'kit' of leadership skills and provided opportunities to put those skills into practice through a project during the 20 week course. Leadership skills and interpersonal skills provide attendees with information and empowerment to address the needs of children, within their family and their community.

The CHP manager served on the Governor's Wyoming Early Childhood State Advisory Council (WECSAC) as the MCH/WDH Early Childhood representative. The council struggled due to a lack of funding throughout FY15. Various members worked to keep it going due to their desire to improve the early childhood system and the importance of the partnerships within the council.

MCH serves as the backbone organization for the collective impact partnership of the Wyoming Adolescent Health

Partnership (WAHP). Formed in May of 2014, the WAHP Steering Committee includes: Wyoming Department of Health (WDH) Adolescent Health Program (AHP), WDH Immunizations, Department of Workforce Services (DWS) Division of Vocational Rehabilitation Transition Specialist, Department of Family Services (DFS), WDE, Magellan (Medicaid Contractor), Wyoming Coalition Against Domestic Violence and Sexual Assault (WCADVSA), Eastern Shoshone Health Staff, Uplift/Family Voices, Prevention Management Organization (PMO) of Wyoming, and an adolescent who was involved with Colorado's youth advisory council and currently attends the University of Wyoming. The steering committee is trained in Understanding Adolescence: Seeing Youth through a Developmental Lens developed by the Konopka Institute and the State Adolescent Health Resource Center (SAHRC).

The WAHP Vision is that empowered youth reach their full potential in an environment that fosters physical, mental, community, and spiritual wellness. The **mission** of the WAHP Steering Committee is to inspire and mobilize youth-adult partnerships by fostering environments for Wyoming youth to exercise their voice and choice. The steering committee is tasked with supporting the WDH Youth team that will be developed in 2016; serve as the Adolescent Advisory Group for the MCH Needs Assessment; and participate in strategic planning for adolescent health.

A young adult will be hired, in conjunction with Wyoming State Parks (WSP), to manage logistics, compensation, and support for the State Level Youth and Young Adult Advisory Council. This is the interim name until the youth select a name for the Council. The purpose of this council is to involve youth and young adults to assure that the strategies are relevant in WDH and WSP programs that target adolescents.

The AHP manager will continue to train professionals throughout the state of Wyoming in Adolescent Brain Development, Adolescent Resiliency, and Positive Youth Development. Two hundred and forty-nine people have been trained since January 2015 including prevention professionals, teachers, Eastern Shoshone and Arapaho Tribal members, juvenile justice and foster care professionals, military personnel, health care providers, community organizers, and parents. The next step in relation to this training is to develop a similar training for parents in communities throughout Wyoming.

The AHP will continue to partner with the Communicable Disease Program on the Personal Responsibility and Education Program (PREP) grant to train facilitators and increase reach for implementation of evidence-based reproductive health education to the adolescent population.

The Reproductive Health Program will be assessed during the strategic planning process and with the FY17 budget regarding how it aligns with MCH priorities.

Provider education in Adolescent Development and Communication, Transition, and Youth Friendly Clinic Services will continue to be offered. These efforts are targeted at increasing accessibility of services to youth throughout Wyoming improving communication between youth and health care providers. Education also includes the importance of the adolescent well-visit, capturing missed opportunities, and transition.

The AHP will continue to partner with the Wyoming Coalition Against Domestic Violence and Sexual Assault in implementation of the Rape Prevention and Education (RPE) grant and youth/adult connectedness activities in Wyoming among the adolescent population.

Depending on availability of resources, a future overall goal of the AHP is to establish a trainer contract. The goal would be to train communities in all 23 counties in Positive Youth Development. The purpose is to increase youth/adult connectedness in Wyoming.

MCH participated in the Association of Maternal and Child Health Programs (AMCHP) Life Course Project in which we received TA to create a communication product about a selection of life course measures. Wyoming's project focused on communicating about the connection between Adverse Childhood Experiences (ACEs), Early Childhood Development, and Community Prosperity. The project goals were developed in partnership with a coalition in Sheridan, WY called "Building Communities Where Children and Families Thrive."

The communication product is currently a comprehensive PowerPoint presentation targeted at business leaders and policy makers. MCH Epidemiology will transfer the content of the PowerPoint into web content to publish on our

Department of Health website. The web content will include all life course indicators for which we have Wyoming data available.

MCH participated in an AMCHP Return on Investment (ROI) Project in which we received TA to conduct an ROI on our Nurse Family Partnership (NFP) program. The work on the ROI project resulted in a more in depth look at our NFP data than we had previously conducted. We determined a more thorough analysis of the inputs and outputs we needed for the ROI were needed before publishing an ROI analysis. We have begun a process evaluation of our NFP program to analyze how well we implement NFP in Wyoming according to the prescribed Wyoming NFP model elements.

The Senior Epidemiology Adviser to MCH, the WIHP manager, the NFP State Nurse Consultant participated in the MCH Program Evaluation Practicum with Harvard T.H. Chan School of Public Health and the Centers for Disease Control and Prevention (CDC) in January 2016. The Aim of the process evaluation was to examine the NFP program's implementation fidelity to the prescribed Wyoming NFP model with a goal of determining the Wyoming program's impact.

II.F.2 MCH Workforce Development and Capacity

The MCH Unit has a current staff of nine: Unit Manager, Women and Infant Health Program Manager, Adolescent Health Program Manager, Child Health Program Manager, four Benefit/Eligibility Specialists (BES), and an Administrative Assistant. At the beginning of FY15, the Oral Health Program (OHP) was placed within the MCH Unit bringing four Community Oral Health Coordinators (COHC) and a contract dentist. By the middle of the fiscal year, a part-time dentist and full-time program manager were hired. The OHP manager was able to put structure around the safety-net financial assistance programs and created guidelines for the work of the COHCs.

Currently, Wyoming is in a difficult financial situation and the Wyoming Department of Health has had to make difficult decisions to address decreasing state revenues. As a result, the Public Health OHP is being eliminated as part of the Department's budget reduction. This will result in the elimination of the following programs:

- Dental Sealants
- Public Health Severe Malocclusion Program
- Marginal Dental Program
- Community Oral Health Coordinator Program (Public Health Dental Hygienists)
- Healthy Mouth Healthy Me

The Cleft Palate Clinic funding within the Public Health OHP is also being eliminated. A meeting with the Cleft Palate Team members on June 27 is being held to discuss options for continuation of these twice annual clinics.

MCH works very closely with epidemiologists. In FY 15, MCH had three epidemiologists, one permanent position within the MCH budget and an At-Will Employment Contract (AWEC) with braided funding from MCH and other units. The AWEC position provides support to the WDH Injury Prevention Program (IPP) and, also, supports the PRAMS program. MCH benefits from having an MCH CDC Assignee.

As FY15 began, a permanent position and the AWEC position became vacant as the individuals were able to take advantage of advancement within another division and within the CDC. Despite a hiring freeze, the positions were approved to be filled.

The Adolescent Health Program (AHP) began in FY 2014 and the Wyoming Adolescent Health Partnership (WAHP) was created. This partnership contains representation from WDH, DWS, DFS, WDE, WYHealth (Medicaid Contractor), WCADVSA, Eastern Shoshone Health Staff, Uplift (F2F), Prevention Management Organization (PMO), and an adolescent. The partnership has continued to work toward adding an adolescent component to the team. The AHP Manager partnered with State Parks to create a position that will work with adolescents as both agencies work toward establishing the authentic adolescent voice within their work.

The AHP manager works closely with the Communicable Disease Unit on the PREP grant and with the Prevention and Health Promotion Unit regarding Suicide. The Immunization Program and AHP have collaborated on different projects. In FY14, the AHP manager and Immunization co-led a workshop entitled “Adolescent Development and Communication for Health Care Providers.” Since that time the workshop has morphed into “Unlocking the Mysteries of the Adolescent Brain.”

The Child Health Program (CHP) separated from the Adolescent program in FY 2014 and has focused on developing partnerships surrounding developmental and vision screenings through both the Title V MCH Block and the ECCS grants. The CHP Manager continues to be a member of the Early Childhood Governor’s Council and, with the Maternal, Infant and Early Childhood Home Visiting (MIECHV) grantee, has assisted with creating a committee of the Governor’s council to serve as the MIECHV Advisory. The work with the Governor’s Council and MIECHV, during FY15, has developed into the Wyoming Home Visiting Network (WYHVN). It includes representatives from different home visiting programs—PAT, NFP, BB, Early Head Start—and has a goal of creating a singular home visiting message.

The Women and Infant Health Program (WIHP) gained a new program manager in FY14, which brought new insights. The WIHP manager works closely with Public Health Nursing (PHN) on the implementation of the Healthy Baby Home Visitation (HBHV) Program, as well as through management and monitoring of 22 contracts with counties to deliver MCH services. The WIHP manager meets weekly with the PHN MCH Consultant, who is also the NFP State Nurse Consultant, to improve the communication between MCH and PHN. The WIHP manager, NFP state nurse consultant, and MCH Epidemiology developed a database to capture measures from the HBHV program related to MCH priorities and home visitation outcomes. The WIHP manager also partnered with the WIC program to begin development of breastfeeding-focused activities through an Association of State and Territorial Health Officials (ASTHO) initiative. WIHP and AHP work together on activities related to family planning and the reduction of teen pregnancy. The WIHP supported CHP activities to increase developmental screening by becoming an Ages and Stages Questionnaire trainer. The WIHP manager is also involved with two ColINs. The Infant Mortality ColIN involves three activities addressing a WIHP priority. The Newborn Screening ColIN, in collaboration with Colorado, has provided an opportunity to work closely on improving timeliness, with the Colorado laboratory which processes the Wyoming newborn screens.

Several years ago Wyoming initiated the Performance Management Instrument (PMI). It is a tool to define performance goals and standards. All employees are evaluated on required competencies of communication, customer service, judgement and decision making, team work, and personal effectiveness. Staff also set goals for their personal and professional development. The most important aspect of the tool is that it is to increase communication between supervisor and employee. It provides a consistent way, across agencies, to evaluate the professionalism of the staff.

MCH program managers and unit manager all included Financial Planning and Management Skill, a core competency for public health professionals, as an individual goal for FY16. MCH Navigator was used to identify webinars and courses that would help increase knowledge regarding public health budgets.

The WDH HealthStat Initiative was instituted several years ago. It has been continuously reviewed and revised to improve its effectiveness of managing program performance through increased data-driven decision making. Originally, program staff completed a program snapshot with basic financial information about the program and a program performance document. This latter document provided the program’s purpose, a few outcomes, outputs and pertinent information about the program.

The two documents continue to be completed and a dashboard template has been initiated to assist with continuously reviewing the data to measure progress. This year, MCH is combining the Title V priority data (performance measures, strategies and evidence-based strategy measures) into the dashboard. The hope is that it will be useful as the strategic plan is implemented.

The WIHP manager applied and was accepted into the Next Generation MCH Leaders of the AMCHP Leadership Lab. This is a ten-month program geared towards next generation professionals (age 45 or less) that want to develop their leadership skills at the state and/or national level. It is designed to help expand their Title V network,

MCH knowledge, and skills.

The MCH Unit manager joined the Leadership Institute for CYSHCN Directors. This institute provides a forum for state CYSHCN Directors to develop and enhance leadership skills at the state and national level.

The AHP manager has begun work towards a doctorate with a focus to assist the work she is currently doing within the AHP.

II.F.3. Family Consumer Partnership

MCH participates on three Governor's Councils which are Early Intervention (EIC), Early Childhood, and Developmental Disabilities (DD). The EIC is mandated to have parents of children involved with early intervention on the council. The DD council is required to have family members and individuals with DD. This provides the opportunity to receive input from the people most affected by the programs developed and supported.

Parents were included in the Needs Assessment community meetings. Families involved with Wyoming's CSH program and living in the designated communities received information directly from MCH. Parent groups, such as Uplift, and PHN, shared the information with families and communities. Five communities had at least one parent sign in as "parent" for the meeting. Other attendees included nurses, physicians, teachers, child care providers, WIC, Tribal Health, Tribal liaison, dental hygienist, various community organizations/services, faith groups, hospitals and other interested community members. The local communities that MCH visited appreciated that the State was there to listen and promised to provide feedback to them about the needs assessment, priorities, and strategies.

The community meetings provided MCH staff with insight as to how individuals viewed the challenges and successes to being healthy in their communities. Attendees learned they had similar concerns and sometimes learned they were unaware of services available. A frequent theme was people not knowing where to turn for assistance with various health concerns.

MCH has been involved for several years with the planning of the annual Community and School Health Pediatric Conference (CSHPC) sponsored by Children's Hospital Colorado. This year, as in previous years, limited scholarships were offered to school and public health nurses within Wyoming. Two school nurses applied and received scholarships. They have agreed to review the Title V application when it is completed and provide feedback to MCH.

MCH is seeing increased interest from communities, including families and providers, regarding health. Since FY14 there has been more intention on the part of MCH to seek input from providers and other groups who work with the same population. The past 18 months have made the need for local input evident as MCH has worked on the following:

- Development of Help Me Grow, a resource for obtaining and providing information to both providers and families;
- Increasing interest in youth friendly clinics and understanding adolescent development to assist in providing care; and
- Including health in discussions of transition from youth to adulthood, including preparing youth, their families, and medical practices.

The AHP has been working diligently with the Wyoming Adolescent Health Partnership to create a youth application. The goal is to have an authentic adolescent voice in 100% of the programs that target adolescents at the Wyoming Department of Health. The youth council will be representative of Wyoming demographics such as rural/frontier, gender, American Indian, and Latino.

When the AHP manager learned of State Parks' interest in having a youth advisory group, they worked together to create a position that will be the youth/young adult liaison. This person will be the link between program and youth/young adult and handle all logistics.

As MCH moves forward it is necessary to include strategies on how to continue and increase involvement of family members to provide their perspective. All three population groups for the Needs Assessment Advisory meetings included parent representatives.

MCH will also need to find ways to make it equitable for providers to be involved in strategic planning, the various CollNs, and general implementation of the MCH program.

The Preventive and Quality Care priority provides much opportunity for engaging families. MCH programs realize with the new priorities it will be necessary to involve families—women (regarding contraception), women and hopefully the fathers (regarding breastfeeding), youth (regarding the well-visit), parents (regarding medical home and developmental screening)—in all areas of the work.

WDH released a new [website](#) in June. Program managers are currently creating pages specific to their programs. The goal is to provide easier access to information for partners, families and the general public.

II.F.4. Health Reform

Medicaid expansion in Wyoming has not been approved by the state legislature. WDH created the Strategy for Health, Access, Responsibility, and Employment (SHARE) plan to expand Medicaid to adults with incomes up to 138% of the Federal Poverty Level (FPL), but it was not passed during the 2015 Wyoming Legislative session. More discussions regarding healthcare for Wyoming's uninsured continued into FY16. During the 2016 legislative session, with the Governor's support of Medicaid expansion, the legislature refused to pass expansion.

Wyoming had two health plans in the Federal Health Insurance Marketplace, Blue Cross Blue Shield (BCBS) of Wyoming and WINhealth. As of January 2016, WINhealth, the second largest Wyoming health insurance company had closed. This leaves BCBS as the sole carrier offering individual and small group plans in the Wyoming exchange for 2016. Of those enrolled in coverage through the Wyoming exchange during the 2016 open enrollment period, 90% received subsidies (healthinsurance.org).

Title V offers the Children's Special Health (CSH) program as a payer of last resort. Families that apply to the CSH program must first apply for Medicaid, Kid Care Children's Health Insurance Program (CHIP) and the Federal Marketplace. The CSH program assists with coordination of care for children with special health care needs (CSHCN) and provides gap-filling resources. The program provides reimbursement for certain services based on financial and medical eligibility. CSH staff work with families and/or PHN to ensure attendance at specialty appointments and well-child appointments. All enrolled children are sent reminders for well child visits based on the Bright Futures periodicity chart.

Beginning in January 2015, eligibility and enrollment for both Medicaid and CHIP were assumed by the WDH Division of Healthcare Financing, a function previously performed by the DFS. This change, along with a new requirement to provide proof of income, caused delays in eligibility determination and much frustration on the part of professionals, state employees, and families. To assure continuity of care for the clients renewing Medicaid, CSH staff worked closely with Medicaid staff and occasionally covered Medicaid eligible services for clients whose eligibility determination was pending and would later be reimbursed by Medicaid.

The State of Wyoming benefits from two Affordable Care Act (ACA) grants related to MCH, the PREP grant awarded to WDH and the Maternal, Infant, Early Childhood Home Visiting (MIECHV) grant awarded to a non-profit organization, Parents as Teachers National Center (PATNC). Wyoming Citizen Review Panel (WYCRP) is the implementing agency for the MIECHV grant in Wyoming.

PREP was granted to the Communicable Disease (CD) Unit within WDH. The MCH Adolescent Health Program (AHP) manager devotes a quarter of her time to the PREP grant.

MIECHV was granted to a non-profit, PATNC, in conjunction with the WYCRP. The work in the first couple years has focused on implementation of the home visiting program. Recently, work has begun with MCH, PHN, Tribal MIECHV and Head Start to integrate home visiting within Wyoming's early childhood system.

II.F.5. Emerging Issues

Infant mortality is not an emerging issue. However, what is becoming more apparent is the interest of stakeholders in helping to address this issue. Research about LARC use and barriers to access is a focus of MCH. Newborn Screening is addressing the timeliness of screening the collected specimens and looking at how to address CCHD.

An emerging issue for MCH is the awareness of and the need for a relationship with medical providers. Following a learning collaborative on MCH, the WY-AAP president and the MCH Unit Manager are to set up a meeting to discuss how AAP can work in conjunction with MCH. It is important to create a relationship with the obstetric and family practice physicians.

Another emerging issue is the state budget reduction. The budget reduction for the MCH state general fund budget was 17%. MCH will continue to meet the maintenance of effort (MOE). In light of Wyoming's economy and the history of boom and bust, as MCH proceeds with evidence-based strategies, the economy and how best to work within it, must be continuously assessed.

II.F.6. Public Input

Needs Assessment community meeting attendees who provided contact information will receive a brief report on the final priorities and the strategies to address the priorities. They will also be provided an opportunity to contribute their insights regarding this application and the strategic plan to be developed. It is important that we maintain communication back to the communities. Attendees frequently stated that their help is often sought, but they do not receive follow-up information to let them know the outcome.

Advisory group members will also be provided the opportunity to provide feedback on the application/annual report.

The WDH new website was unveiled towards the end of June. MCH program managers were given the authority to edit their pages. This is currently in process. The goal will be to provide current information regarding MCH programs.

Several school nurses received scholarships to attend the 2016 Community and School Health Pediatric Conference and, in return, have agreed to provide feedback to sections of this application/annual report.

Wyoming will continue to look at opportunities to share the annual report and, as we move forward, the strategic plan.

As part of the strategic planning contract, TA will be provided to assist with engaging stakeholders and maintaining continual communication.

II.F.7. Technical Assistance

An AMCHP webinar presentation on the new Title V reporting format had a presentation by Iowa on their action table for their CSHCN domain. As Wyoming works to improve the CSH program and how it provides care coordination, it might be helpful to spend time with the Iowa CSH staff. The different levels of care coordination and how the state interacts with families could help move Wyoming from having a focus on financial and medical requirements to how best to assist the family as it moves through the health care system.

Another area MCH is considering a TA request concerns how best to assist rural public health offices provide culturally competent services. The most challenging aspect is language and how to meet the needs of interpretation. The numbers of families requiring interpretive services are small in number and often far apart. Programs, such as

Best Beginnings and Nurse Family Partnership, require multiple sessions/visits which can devour a small budget.

A difficulty with requesting TA is sometimes not knowing the right questions to ask in order to obtain the needed support.

III. Budget Narrative

	2013		2014	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$1,164,966	\$1,117,686	\$1,125,000	\$1,156,063
Unobligated Balance	\$0	\$0	\$0	\$0
State Funds	\$1,917,462	\$1,869,786	\$2,034,862	\$1,809,026
Local Funds	\$0	\$0	\$0	\$0
Other Funds	\$458,129	\$505,805	\$599,483	\$566,565
Program Funds	\$0	\$0	\$0	\$0
SubTotal	\$3,540,557	\$3,493,277	\$3,759,345	\$3,531,654
Other Federal Funds	\$2,135,729	\$1,484,162	\$2,141,855	
Total	\$5,676,286	\$4,977,439	\$5,901,200	\$3,531,654

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2015		2016	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$1,117,686	\$1,122,915	\$1,100,000	
Unobligated Balance	\$0	\$0	\$0	
State Funds	\$1,869,786	\$1,995,605	\$1,951,264	
Local Funds	\$0	\$0	\$0	
Other Funds	\$505,805	\$514,865	\$599,192	
Program Funds	\$0	\$0	\$0	
SubTotal	\$3,493,277	\$3,633,385	\$3,650,456	
Other Federal Funds	\$1,484,162	\$1,511,035	\$2,192,704	
Total	\$4,977,439	\$5,144,420	\$5,843,160	

	2017	
	Budgeted	Expended
Federal Allocation	\$1,125,000	
Unobligated Balance	\$0	
State Funds	\$1,775,473	
Local Funds	\$0	
Other Funds	\$600,119	
Program Funds	\$0	
SubTotal	\$3,500,592	
Other Federal Funds	\$2,179,510	
Total	\$5,680,102	

III.A. Expenditures

MCH Block Grant expenditures for FY15 were categorized into the following categories: Prevention and Primary Care for Children (30%), Children with Special Health Care Needs (43%), Administrative (6%) and Family (21%). The Family category includes the Women and Infant Health Program (WIHP) and the Adolescent Health Program (AHP). The WIHP works closely with public health nurses (PHN) for the provision of MCH services at the local level.

In FY14, the program, epidemiology and PHNs worked to improve the data system and data collection to present an accurate picture of the work done at the local level to address the MCH state health priorities.

The AHP actually began in FY14 with the hiring of a program manager to focus on the 12- to 24-year-olds. A training was developed to address adolescent development and how understanding the adolescent can assist providers to meet the needs of this population. The training has been well-received and sets a course toward encouraging youth-friendly clinics. It also provides the foundation for understanding the need to assist with transition, for those with and without special health care needs.

MCH continued to provide support for the development of a local Fetal Infant Mortality Review (FIMR). Monthly travel by state staff continued throughout FY14 and into FY15. Case Review and Community Action teams were identified and training for both teams was provided in June 2015 by the National FIMR staff in conjunction with the MCH WIHP manager and the MCH Senior Epidemiologist. In FY16, MCH learned that we had the authority to move forward with FIMR. In June, the CRT was able to review their first couple cases. The WIHP manager and CDC Assignee will return on a quarterly basis for continued support and assessment of the process.

The needs assessment provided an opportunity for travel to communities and listen to what they considered to be challenges to being healthy and what they were doing that was successful. Travel into communities was seen as a necessary step to building relationships.

The direct services provided with Title V funds included genetic clinics offered by the University of Utah throughout the year and around the state. Wyoming does not have a geneticist and families are often referred out-of-state. These clinics decrease the travel often required with out-of-state visits and Wyoming physicians can consult with the clinic staff. Dental sealants are also offered to low income children and funded by the block grant. Although Title V funds are not used for the two cleft palate clinics, CSH staff provided support to assure the clinic takes place,

coordinating follow-up with the specialists and transcribing for the physicians. The clinics provide the opportunity for families to attend one clinic with multiple specialists, including a community oral health coordinator who can follow-up with the family and assist with following clinic recommendations.

A large part of the Title V expenditures is the funding for the MCH staff--program and epidemiologists--that assess and analyze the needs and develop programs for a healthy Wyoming MCH population. These funds also provide Wyoming the opportunity to have a CDC assignee, an epidemiologist to assist with both the epidemiology and program aspects of MCH.

III.B. Budget

The Needs Assessment has provided a platform to direct how MCH utilizes resources. The strategic planning process is assisting even more with determining resources, capacity, population-based health and considering how to leverage other funding. Title V dollars, combined with other federal dollars provide the funding for all positions within MCH, including a CDC assignee. Three positions, MCH administrative assistant, unit manager and one epidemiologist, are funded with state dollars. Title V funds are used in conjunction with state dollars to fund the Injury Prevention Program Manager. To further augment the state MCH staff, the block grant is used to fund contracts with Safe Kids Wyoming for development and oversight of Safe Kids coalitions around the state and with the Wyoming Institute for Disabilities to increase access and improve standards for early childhood vision screening.

Wyoming's required maintenance of effort is greater than the legislatively-required match. Several programs assist in maintaining this effort. The Newborn Screening program is managed within MCH. Hospitals are charged a fee set by the Newborn Screening advisory committee. From this fee, MCH contracts with the Colorado Department of Health Laboratory to run the Wyoming screens and with various providers to provide confirmatory testing and follow-up care, as needed, to diagnosis. The fees also fund a courier to pick up screens from hospitals around the state and deliver them to the Colorado lab.

State funds are utilized for direct services to CSHCN families. While Title V dollars fund three benefits and eligibility specialist positions for the provision of care coordination from the state level for children and youth with special health care needs, state funds provide gap filling services for those children who qualify financially and medically.

Public health nurses provide care coordination at the local level for CSH clients, pregnant women, infants and families. They are reimbursed for services provided through home visits, clinics and classes with state and TANF funds.

Reclassifying the CSH Program Manager to the AHP manager changed CSH expenditures as the AHP manager does not deal solely with CSH. This has increased dollars within the CSH budget available for parent engagement and the development of the Help Me Grow (HMG) program within Wyoming. A concern mentioned frequently by parents and providers in the community meetings held for the needs assessment was that people weren't aware of services; of what resources are available. HMG can assist with the connection of families, providers, and program through the 2-1-1 system.

Currently, Wyoming is facing an economic downturn and the Wyoming Department of Health has had to make difficult decisions to address decreasing state revenues. As a result, the Public Health Oral Health Program is being eliminated as part of the Department's budget reduction. In addition, 17% of the MCH SGF, part of the Title V Maintenance of Effort (MOE), was cut. The state general funds used for the infant immunization, Prevnar, will continue to assist with meeting the MOE.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - [MCH Intra agency agreement with Division of Healthcare Financing.pdf](#)

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - [funnel.pdf](#)

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Wyoming

	FY17 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 1,125,000	
A. Preventive and Primary Care for Children	\$ 360,000	(32%)
B. Children with Special Health Care Needs	\$ 360,000	(32%)
C. Title V Administrative Costs	\$ 45,000	(4%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	\$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 1,775,473	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 600,119	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 2,375,592	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 2,375,591		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	\$ 3,500,592	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	\$ 2,179,510	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 5,680,102	

OTHER FEDERAL FUNDS	FY17 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	\$ 1,757,750
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	\$ 128,539
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	\$ 192,665
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 100,556

	FY15 Application Budgeted		FY15 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 1,117,686		\$ 1,122,915	
A. Preventive and Primary Care for Children	\$ 377,617	(33.8%)	\$ 421,906	(37.6%)
B. Children with Special Health Care Needs	\$ 446,520	(40%)	\$ 442,857	(39.4%)
C. Title V Administrative Costs	\$ 59,806	(5.4%)	\$ 66,470	(5.9%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	\$ 0		\$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 1,869,786		\$ 1,995,605	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0		\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 505,805		\$ 514,865	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 0		\$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 2,375,591		\$ 2,510,470	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 2,375,591				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	\$ 3,493,277		\$ 3,633,385	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	\$ 1,484,162		\$ 1,511,035	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 4,977,439		\$ 5,144,420	

OTHER FEDERAL FUNDS	FY15 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	\$ 1,085,080
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	\$ 119,456
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	\$ 130,030
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	\$ 110,434
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 66,035

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	Field Name:	Federal Allocation, A. Preventive and Primary Care for Children:
	Fiscal Year:	2015
	Column Name:	Annual Report Expended
	Field Note: Dental sealants have been included within preventive and primary care for children. Since FY12, the program manager position overseeing the dental program was vacant. By FY15, the oral health program was moved within MCH and a dental hygienist was hired as the program manager. This provided increased knowledge of reading dental invoices which avoided inappropriate expenditures.	
2.	Field Name:	Federal Allocation, C. Title V Administrative Costs:
	Fiscal Year:	2015
	Column Name:	Annual Report Expended
	Field Note: The expenditures were greater than the budgeted amount due to lack of the use of function codes and expenditures often being relegated to the administrative phase if unclear to the purpose of the expenditure. As of the middle of FY15, function codes were created for MCH and usage has increased.	

Data Alerts: None

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

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	\$ 152,000	\$ 37,117
2. Infants < 1 year	\$ 152,000	\$ 56,530
3. Children 1-22 years	\$ 360,000	\$ 421,906
4. CSHCN	\$ 360,000	\$ 442,857
5. All Others	\$ 100,000	\$ 53,784
Federal Total of Individuals Served	\$ 1,124,000	\$ 1,012,194

IB. Non Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	\$ 177,265	\$ 123,873
2. Infants < 1 year	\$ 1,211,914	\$ 474,894
3. Children 1-22 years	\$ 147,702	\$ 97,051
4. CSHCN	\$ 390,411	\$ 520,317
5. All Others	\$ 163,470	\$ 125,532
Non Federal Total of Individuals Served	\$ 2,090,762	\$ 1,341,667
Federal State MCH Block Grant Partnership Total	\$ 3,214,762	\$ 2,353,861

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services
State: Wyoming

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Direct Services	\$ 144,000	\$ 304,031
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 60,000	\$ 53,331
B. Preventive and Primary Care Services for Children	\$ 0	\$ 91,624
C. Services for CSHCN	\$ 84,000	\$ 159,076
2. Enabling Services	\$ 374,680	\$ 318,969
3. Public Health Services and Systems	\$ 606,320	\$ 499,915
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 53,331
Physician/Office Services		\$ 360
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 0
Dental Care (Does Not Include Orthodontic Services)		\$ 91,624
Durable Medical Equipment and Supplies		\$ 0
Laboratory Services		\$ 0
Other		
Genetic Clinics		\$ 154,500
Client medical travel		\$ 4,216
Direct Services Line 4 Expended Total		\$ 304,031
Federal Total	\$ 1,125,000	\$ 1,122,915

IIB. Non-Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Direct Services	\$ 206,012	\$ 170,335
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 156,012	\$ 19,412
B. Preventive and Primary Care Services for Children	\$ 0	\$ 0
C. Services for CSHCN	\$ 50,000	\$ 150,923
2. Enabling Services	\$ 1,631,666	\$ 1,205,735
3. Public Health Services and Systems	\$ 537,913	\$ 796,034
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 23,874
Physician/Office Services		\$ 44,948
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 12,278
Dental Care (Does Not Include Orthodontic Services)		\$ 0
Durable Medical Equipment and Supplies		\$ 1,237
Laboratory Services		\$ 2,305
Other		
infant sleep sacks		\$ 19,413
Genetics Clinics		\$ 51,500
Non-classified items, therapy, travel, translation		\$ 14,780
Direct Services Line 4 Expended Total		\$ 170,335
Non-Federal Total	\$ 2,375,591	\$ 2,172,104

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

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

Total Births by Occurrence: 7,113

1. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Core RUSP Conditions	6,920 (97.3%)	9	9	9 (100.0%)

Program Name(s)				
Propionic acidemia	Methylmalonic acidemia (methylmalonyl-CoA mutase)	Methylmalonic acidemia (cobalamin disorders)	Isovaleric acidemia	3-Methylcrotonyl-CoA carboxylase deficiency
3-Hydroxy-3-methylglutaric aciduria	Holocarboxylase synthase deficiency	β -Ketothiolase deficiency	Glutaric acidemia type I	Carnitine uptake defect/carnitine transport defect
Medium-chain acyl-CoA dehydrogenase deficiency	Very long-chain acyl-CoA dehydrogenase deficiency	Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	Trifunctional protein deficiency	Argininosuccinic aciduria
Citrullinemia, type I	Maple syrup urine disease	Homocystinuria	Classic phenylketonuria	Tyrosinemia, type I
Primary congenital hypothyroidism	Congenital adrenal hyperplasia	S,S disease (Sickle cell anemia)	S, β -thalassemia	S,C disease
Biotinidase deficiency	Cystic fibrosis	Severe combined immunodeficiencies	Classic galactosemia	Mucopolysaccharidosis, type I

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Hearing	7,016 (98.6%)	51	30	30 (100.0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Infants with a confirmed diagnoses are referred for treatment. If they meet eligibility criteria they may be enrolled and tracked through our Children's Special Health Program.

Form Notes for Form 4:

Our newborn screening for hearing is done separately and tracked separately then screens conducted using the heel prick. It is possible that an infant may have received one or the other and therefore we are presenting them separately.

Field Level Notes for Form 4:

None

Data Alerts: None

Form 5a
Unduplicated Count of Individuals Served under Title V
State: Wyoming

Reporting Year 2015

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	984	30.4	0.0	0.0	0.0	69.6
2. Infants < 1 Year of Age	1,201	58.0	0.0	1.3	0.0	40.7
3. Children 1 to 22 Years of Age	1,173	0.0	0.0	0.0	0.0	100.0
4. Children with Special Health Care Needs	801	70.9	3.1	25.3	0.7	0.0
5. Others	1,096	37.9	0.0	0.0	0.0	62.1
Total	5,255					

Form Notes for Form 5a:

None

Field Level Notes for Form 5a:

1.	Field Name:	Pregnant Women Total Served
	Fiscal Year:	2015
Field Note: Pregnant women served by Title V include: 27 women served through the Maternal High Risk Program; 718 women served through prenatal visits in our Best Beginnings Home Visitation Program; and 239 women served through the Nurse Family Partnership Home Visitation Program.		
2.	Field Name:	Infants Less Than One YearTotal Served
	Fiscal Year:	2015
Field Note: Infants served by the Title V program are served by the following: 105 infants through the Newborn Intensive Care Program; and 1,096 infants served through the Best Beginnings Home Visitation Program.		
3.	Field Name:	Children 1 to 22 Years of Age
	Fiscal Year:	2015
Field Note: Children aged 1 to 22 are served by Title V through the following: 36 by the Genetics clinics; 1186 through the sealant program; and 551 adolescents were provided contraceptives through Public Health Nursing services funded by Title V.		
4.	Field Name:	Children with Special Health Care Needs
	Fiscal Year:	2015
Field Note: Children with Special Healthcare Needs are served by the Title V grant through the Children's Special Health Program.		
5.	Field Name:	Others
	Fiscal Year:	2015
Field Note: Postpartum women are served by the Title V program through postnatal visits through the Best Beginnings Program.		

Form 5b
Total Recipient Count of Individuals Served by Title V
State: Wyoming

Reporting Year 2015

Types Of Individuals Served	Total Served
1. Pregnant Women	984
2. Infants < 1 Year of Age	7,894
3. Children 1 to 22 Years of Age	22,689
4. Children with Special Health Care Needs	801
5. Others	1,271
Total	33,639

Form Notes for Form 5b:

None

Field Level Notes for Form 5b:

1.	Field Name:	Pregnant Women
	Fiscal Year:	2015
	Field Note: Pregnant women are served through the Maternal High Risk Program and the Nurse Home Visitation Program (Best Beginnings and Nurse Family Partnership).	
2.	Field Name:	Infants Less Than One Year
	Fiscal Year:	2015
	Field Note: Infants are served through the Newborn Intensive Care Program, Nurse Home Visitation, and Newborn Screening.	
3.	Field Name:	Children 1 to 22 Year of Age
	Fiscal Year:	2015
	Field Note: Children are served through the Genetics Clinics, Sealant Program, Safe Kids Events, ASQ Screening Program and Contraceptive Program. We are awaiting completed data from our Community Oral Health Program to determine the number of children with an oral health screen.	
4.	Field Name:	Children With Special Health Care Needs
	Fiscal Year:	2015
	Field Note: Children and Youth with Special Health Care Needs are served through our Children's Special Health Program.	
5.	Field Name:	Others
	Fiscal Year:	2015
	Field Note: New mothers are served through our Nurse Home Visiting Program. Families are served through our Parent Partner Program.	

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

Reporting Year 2015

I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	7,693	6,735	75	261	87	2	0	533
Title V Served	718	0	0	0	0	0	0	718
Eligible for Title XIX	0	0	0	0	0	0	0	0
2. Total Infants in State	8,102	7,541	561	0	0	0	0	0
Title V Served	1,096	0	0	0	0	0	0	1,096
Eligible for Title XIX	0	0	0	0	0	0	0	0

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	6,705	988	0	7,693
Title V Served	0	0	718	718
Eligible for Title XIX	0	0	0	0
2. Total Infants in State	6,684	1,418	0	8,102
Title V Served	0	0	1,096	1,096

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
Eligible for Title XIX	0	0	0	0

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	Field Name:	1. Total Deliveries in State
	Fiscal Year:	2014
	Column Name:	Total All Races
	Field Note:	Total deliveries based on 2014 Wyoming birth records.
2.	Field Name:	1. Title V Served
	Fiscal Year:	2014
	Column Name:	Total All Races
	Field Note:	718 pregnant women were served by the Best Beginnings Home Visiting program during the FY 2015.
3.	Field Name:	1. Eligible for Title XIX
	Fiscal Year:	2014
	Column Name:	Total All Races
	Field Note:	A Medicaid report will be completed detailing the Medicaid paid deliveries prior to the final application.
4.	Field Name:	2. Total Infants in State
	Fiscal Year:	2014
	Column Name:	Total All Races
	Field Note:	Based on 2014 Wyoming Current Population Survey. Several race categories were not available.
5.	Field Name:	2. Title V Served
	Fiscal Year:	2014
	Column Name:	Total All Races
	Field Note:	Infants served through the Best Beginnings Home Visiting Program.
6.	Field Name:	2. Eligible for Title XIX

Fiscal Year:	2014
---------------------	-------------

Column Name:	Total All Races
---------------------	------------------------

Field Note:

A Medicaid report will be completed detailing the infants covered by Medicaid prior to the final application.

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

A. State MCH Toll-Free Telephone Lines	2017 Application Year	2015 Reporting Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 438-5795	(800) 438-5795
2. State MCH Toll-Free "Hotline" Name	Maternal and Family Health	Maternal and Family Health
3. Name of Contact Person for State MCH "Hotline"	Linda McElwain	Linda McElwain
4. Contact Person's Telephone Number	(307) 777-6326	(307) 777-6326
5. Number of Calls Received on the State MCH "Hotline"		409

B. Other Appropriate Methods	2017 Application Year	2015 Reporting Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	https://health.wyo.gov/publichealth/mch/	
4. Number of Hits to the State Title V Program Website		
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information
State: Wyoming

1. Title V Maternal and Child Health (MCH) Director

Name	Linda McElwain
Title	Unit Manager, Maternal and Child Health
Address 1	6101 Yellowstone Road
Address 2	Suite 420
City/State/Zip	Cheyenne / WY / 82002
Telephone	(307) 777-6326
Extension	
Email	linda.mcelwain@wyo.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director

Name	Linda McElwain
Title	Unit Manager, Maternal and Child Health
Address 1	6101 Yellowstone Road
Address 2	Suite 420
City/State/Zip	Cheyenne / WY / 82002
Telephone	(307) 777-6326
Extension	
Email	linda.mcelwain@wyo.gov

3. State Family or Youth Leader (Optional)

Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs
State: Wyoming

Application Year 2017

No.	Priority Need
1.	Prevent Infant Mortality
2.	Improve breastfeeding duration
3.	Improve access to and promote use of effective family planning
4.	Reduce and prevent childhood obesity
5.	Promote preventive and quality care for children and adolescents
6.	Promote healthy and safe relationships in adolescents
7.	Prevent injury in children

Form 9 State Priorities-Needs Assessment Year - Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Prevent Infant Mortality	New	
2.	Improve breastfeeding duration	Continued	
3.	Improve access to and promote use of effective family planning	New	
4.	Reduce and prevent childhood obesity	New	
5.	Promote preventive and quality care for children and adolescents	New	
6.	Promote healthy and safe relationships in adolescents	New	
7.	Prevent injury in children	Continued	

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10a
National Outcome Measures (NOMs)

State: Wyoming

Form Notes for Form 10a NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester


Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	75.4 %	0.5 %	5,578	7,396
2013	72.0 %	0.5 %	5,452	7,571
2012	73.9 %	0.5 %	5,554	7,516
2011	74.4 %	0.5 %	5,477	7,360
2010	75.4 %	0.5 %	5,630	7,468
2009	73.9 %	0.5 %	5,682	7,691

Legends:

 Indicator has a numerator <10 and is not reportable

 Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

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

Data Source: State Inpatient Databases (SID)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	91.7	11.9 %	60	6,540
2012	131.4	14.4 %	85	6,469
2011	104.4	12.7 %	68	6,512
2010	103.6	13.4 %	60	5,791
2009	110.1	12.6 %	77	6,996
2008	98.9	12.0 %	69	6,974

Legends:

- Indicator has a numerator ≤ 10 and is not reportable
- Indicator has a numerator < 20 and should be interpreted with caution

NOM 2 - Notes:

























None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2010_2014	NR 	NR 	NR 	NR 
2009_2013	NR 	NR 	NR 	NR 
2008_2012	NR 	NR 	NR 	NR 
2007_2011	NR 	NR 	NR 	NR 
2006_2010	28.2 	8.5 % 	11 	39,040 
2005_2009	33.6 	9.3 % 	13 	38,723 


Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 3 - Notes:**

None

Data Alerts: None

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)**Data Source: National Vital Statistics System (NVSS)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	9.2 %	0.3 %	704	7,687
2013	8.6 %	0.3 %	660	7,636
2012	8.5 %	0.3 %	645	7,565
2011	8.1 %	0.3 %	600	7,393
2010	9.0 %	0.3 %	679	7,552
2009	8.4 %	0.3 %	661	7,873


Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution**NOM 4.1 - Notes:**

None

Data Alerts: None

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)**Data Source: National Vital Statistics System (NVSS)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	1.3 %	0.1 %	103	7,687
2013	1.2 %	0.1 %	89	7,636
2012	1.2 %	0.1 %	87	7,565
2011	1.1 %	0.1 %	81	7,393
2010	1.1 %	0.1 %	83	7,552
2009	1.1 %	0.1 %	90	7,873

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution**NOM 4.2 - Notes:**

None

Data Alerts: None

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	7.8 %	0.3 %	601	7,687
2013	7.5 %	0.3 %	571	7,636
2012	7.4 %	0.3 %	558	7,565
2011	7.0 %	0.3 %	519	7,393
2010	7.9 %	0.3 %	596	7,552
2009	7.3 %	0.3 %	571	7,873

Legends:

🚩 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution


NOM 4.3 - Notes:

None

Data Alerts: None

NOM 5.1 - Percent of preterm births (<37 weeks)**Data Source: National Vital Statistics System (NVSS)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	11.2 %	0.4 %	863	7,691
2013	10.4 %	0.4 %	792	7,643
2012	9.1 %	0.3 %	685	7,571
2011	9.9 %	0.4 %	731	7,398
2010	10.5 %	0.4 %	794	7,556
2009	9.9 %	0.3 %	780	7,851


Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution**NOM 5.1 - Notes:**

None

Data Alerts: None

NOM 5.2 - Percent of early preterm births (<34 weeks)**Data Source: National Vital Statistics System (NVSS)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	3.6 %	0.2 %	276	7,691
2013	2.7 %	0.2 %	208	7,643
2012	2.3 %	0.2 %	175	7,571
2011	2.2 %	0.2 %	166	7,398
2010	2.6 %	0.2 %	196	7,556
2009	2.3 %	0.2 %	180	7,851


Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution**NOM 5.2 - Notes:**

None

Data Alerts: None

NOM 5.3 - Percent of late preterm births (34-36 weeks)**Data Source: National Vital Statistics System (NVSS)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	7.6 %	0.3 %	587	7,691
2013	7.6 %	0.3 %	584	7,643
2012	6.7 %	0.3 %	510	7,571
2011	7.6 %	0.3 %	565	7,398
2010	7.9 %	0.3 %	598	7,556
2009	7.6 %	0.3 %	600	7,851

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution**NOM 5.3 - Notes:**

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)**Data Source: National Vital Statistics System (NVSS)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	25.6 %	0.5 %	1,965	7,691
2013	25.5 %	0.5 %	1,945	7,643
2012	27.6 %	0.5 %	2,087	7,571
2011	27.8 %	0.5 %	2,058	7,398
2010	29.8 %	0.5 %	2,254	7,556
2009	30.9 %	0.5 %	2,429	7,851

Legends:

🚩 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014/Q2-2015/Q1	6.0 %			
2014/Q1-2014/Q4	6.0 %			
2013/Q4-2014/Q3	6.0 %			
2013/Q3-2014/Q2	5.0 %			
2013/Q2-2014/Q1	6.0 %			

Legends: Indicator results were based on a shorter time period than required for reporting**NOM 7 - Notes:**

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	4.6	0.8 %	35	7,662
2012	5.4	0.9 %	41	7,591
2011	6.5	0.9 %	48	7,424
2010	5.9	0.9 %	45	7,578
2009	6.5	0.9 %	51	7,909

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	4.8	0.8 %	37	7,644
2012	5.6	0.9 %	42	7,572
2011	6.6	1.0 %	49	7,399
2010	6.9	1.0 %	52	7,556
2009	6.0	0.9 %	47	7,881

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	3.0	0.6 %	23	7,644
2012	3.4	0.7 %	26	7,572
2011	4.1	0.7 %	30	7,399
2010	4.1	0.7 %	31	7,556
2009	3.7	0.7 %	29	7,881

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	1.8 ⚡	0.5 % ⚡	14 ⚡	7,644 ⚡
2012	2.1 ⚡	0.5 % ⚡	16 ⚡	7,572 ⚡
2011	2.6 ⚡	0.6 % ⚡	19 ⚡	7,399 ⚡
2010	2.8	0.6 %	21	7,556
2009	2.3 ⚡	0.5 % ⚡	18 ⚡	7,881 ⚡

Legends:
🚩 Indicator has a numerator <10 and is not reportable
⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	143.9 ⚡	43.4 % ⚡	11 ⚡	7,644 ⚡
2012	184.9 ⚡	49.5 % ⚡	14 ⚡	7,572 ⚡
2011	NR 🚩	NR 🚩	NR 🚩	NR 🚩
2010	198.5 ⚡	51.3 % ⚡	15 ⚡	7,556 ⚡
2009	177.6 ⚡	47.5 % ⚡	14 ⚡	7,881 ⚡





















Legends:
🚩 Indicator has a numerator <10 and is not reportable
⚡ Indicator has a numerator <20 and should be interpreted with caution



NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births**Data Source: National Vital Statistics System (NVSS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	NR 	NR 	NR 	NR 
2012	NR 	NR 	NR 	NR 
2011	NR 	NR 	NR 	NR 
2010	NR 	NR 	NR 	NR 
2009	165.0 	45.8 % 	13 	7,881 

Legends:
 Indicator has a numerator <10 and is not reportable
 Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	4.9 %	1.0 %	362	7,343
2012	6.9 %	1.3 %	511	7,368
2011	5.5 %	1.0 %	396	7,164
2010	4.9 %	0.8 %	361	7,311
2009	6.6 %	1.1 %	503	7,622
2008	5.3 %	0.8 %	409	7,762
2007	6.5 %	0.9 %	491	7,579

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has an unweighted denominator between 30 and 59 or has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations**Data Source: State Inpatient Databases (SID)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	2.3 ⚡	0.6 % ⚡	15 ⚡	6,540 ⚡
2012	4.3	0.8 %	28	6,469
2011	2.3 ⚡	0.6 % ⚡	15 ⚡	6,512 ⚡
2010	1.9 ⚡	0.6 % ⚡	11 ⚡	5,791 ⚡
2009	2.0 ⚡	0.5 % ⚡	14 ⚡	6,997 ⚡
2008	NR 🚩	NR 🚩	NR 🚩	NR 🚩

Legends:
🚩 Indicator has a numerator ≤ 10 and is not reportable
⚡ Indicator has a numerator < 20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	18.7 %	1.3 %	23,502	125,912

Legends:

- 🚩 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9 per 100,000**Data Source: National Vital Statistics System (NVSS)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	22.6 ⚡	5.7 % ⚡	16 ⚡	70,803 ⚡
2013	22.6 ⚡	5.6 % ⚡	16 ⚡	70,960 ⚡
2012	24.3 ⚡	5.9 % ⚡	17 ⚡	70,037 ⚡
2011	21.5 ⚡	5.6 % ⚡	15 ⚡	69,796 ⚡
2010	17.2 ⚡	5.0 % ⚡	12 ⚡	69,630 ⚡
2009	23.4 ⚡	5.8 % ⚡	16 ⚡	68,449 ⚡

Legends:

🚩 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000**Data Source: National Vital Statistics System (NVSS)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	41.5	7.5 %	31	74,698
2013	41.5	7.5 %	31	74,696
2012	32.6	6.7 %	24	73,556
2011	60.0	9.1 %	44	73,287
2010	45.9	7.9 %	34	74,097
2009	66.8	9.5 %	50	74,834

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 16.1 - Notes:**

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012_2014	19.5	4.2 %	22	112,773
2011_2013	25.8	4.8 %	29	112,344
2010_2012	24.0	4.6 %	27	112,581
2009_2011	34.1	5.5 %	39	114,373
2008_2010	30.2	5.1 %	35	116,043
2007_2009	37.8	5.7 %	44	116,541

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000**Data Source: National Vital Statistics System (NVSS)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012_2014	22.2	4.4 %	25	112,773
2011_2013	20.5	4.3 %	23	112,344
2010_2012	20.4	4.3 %	23	112,581
2009_2011	22.7	4.5 %	26	114,373
2008_2010	20.7	4.2 %	24	116,043
2007_2009	18.0	3.9 %	21	116,541

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 16.3 - Notes:**

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	19.6 %	1.3 %	26,368	134,238
2007	21.1 %	1.3 %	26,684	126,287
2003	16.7 %	1.0 %	20,101	120,356

Legends:

🚩 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% and should be interpreted with caution



NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	19.7 %	2.3 %	3,206	16,258
Legends:  Indicator has an unweighted denominator <30 and is not reportable  Indicator has a confidence interval width >20% and should be interpreted with caution				

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	2.0 %	0.4 %	2,221	113,085
2007	1.1 %	0.3 %	1,158	102,794

Legends:

- 🚩 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	6.6 %	0.9 %	7,483	112,833
2007	6.3 %	0.8 %	6,477	102,610

Legends:

- 🚩 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	68.9 %	5.1 %	8,824	12,810
2007	67.7 % ⚡	5.7 % ⚡	6,764 ⚡	9,994 ⚡
2003	78.1 %	4.3 %	5,117	6,553

Legends:

🚩 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	87.0 %	1.1 %	116,747	134,180
2007	87.7 %	1.0 %	110,793	126,287
2003	89.2 %	0.8 %	107,300	120,356

Legends:

 Indicator has an unweighted denominator <30 and is not reportable

 Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	26.7 %	2.1 %	15,047	56,418
2007	25.7 %	2.1 %	13,953	54,304
2003	22.9 %	1.6 %	12,959	56,629

Legends:

🚩 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: WIC

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	26.1 %	0.7 %	1,096	4,199

Legends:

🚩 Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable

⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	23.6 %	0.9 %	5,600	23,783
2011	23.1 %	1.1 %	5,781	25,025
2009	22.1 %	0.8 %	5,586	25,250
2007	20.5 %	0.9 %	5,332	26,024
2005	20.4 %	0.8 %	5,389	26,439

Legends:

🚩 Indicator has an unweighted denominator <100 and is not reportable

⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	6.7 %	1.1 %	9,200	137,343
2013	6.3 %	0.9 %	8,827	140,268
2012	9.9 %	1.2 %	13,426	136,250
2011	8.8 %	1.3 %	11,773	134,617
2010	7.3 %	1.1 %	10,014	136,499
2009	9.0 %	1.6 %	11,586	129,393

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 21 - Notes:

None


Data Alerts: None


NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	64.0 %	4.7 %	6,859	10,724
2013	70.0 %	3.9 %	7,386	10,551
2012	67.2 %	3.5 %	7,710	11,473
2011	59.1 %	4.9 %	6,858	11,595
2010	52.0 %	4.0 %	6,097	11,726
2009	43.6 %	3.5 %	4,776	10,961

Legends:

 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

 Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2015	45.6 %	2.2 %	59,103	129,498
2013_2014	42.1 %	2.5 %	53,704	127,561
2012_2013	46.0 %	3.0 %	58,498	127,308
2011_2012	45.2 %	3.4 %	55,904	123,614
2010_2011	49.0 % ⚡	5.5 % ⚡	60,314 ⚡	123,090 ⚡
2009_2010	44.1 %	2.7 %	55,091	124,923

Legends:

📌 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Female

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	50.3 %	4.2 %	8,945	17,799
2013	54.3 %	4.8 %	9,664	17,795
2012	53.9 %	5.1 %	9,544	17,714
2011	60.9 % ⚡	5.4 % ⚡	10,760 ⚡	17,666 ⚡
2010	53.2 %	4.6 %	9,341	17,575
2009	43.6 %	4.1 %	7,539	17,287

Legends:

🚩 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Male

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	29.3 %	3.8 %	5,553	18,945
2013	16.6 %	3.1 %	3,160	18,985
2012	11.2 %	2.5 %	2,106	18,798
2011	NR 🚩	NR 🚩	NR 🚩	NR 🚩

Legends:

🚩 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	89.1 %	1.8 %	32,738	36,744
2013	92.3 %	1.5 %	33,957	36,780
2012	85.4 %	2.5 %	31,167	36,512
2011	86.2 %	2.5 %	31,319	36,319
2010	65.0 %	3.2 %	23,566	36,267
2009	48.2 %	3.0 %	17,231	35,752

Legends:

- 📌 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
- ⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	55.6 %	2.9 %	20,431	36,744
2013	63.1 %	3.2 %	23,216	36,780
2012	59.1 %	3.4 %	21,559	36,512
2011	60.8 %	4.1 %	22,068	36,319
2010	51.5 %	3.3 %	18,667	36,267
2009	47.8 %	3.0 %	17,074	35,752

Legends:

- 📌 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
- ⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

Form 10a
National Performance Measures (NPMs)
State: Wyoming

NPM 2 - Percent of cesarean deliveries among low-risk first births

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	21.0	20.0	19.0	18.0	17.0	17.0

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	21.4 %	0.8 %	521	2,437
2013	22.4 %	0.8 %	567	2,530
2012	24.4 %	0.9 %	628	2,571
2011	21.1 %	0.8 %	515	2,447
2010	22.7 %	0.8 %	585	2,581
2009	22.8 %	0.8 %	600	2,637

Legends:

🚫 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 4 - A) Percent of infants who are ever breastfed

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	90.0	90.0	90.0	91.0	92.0	92.0

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	86.3 %	3.7 %	6,104	7,071
2011	87.6 %	2.8 %		
2010	85.5 %	2.9 %		
2009	83.7 %	3.0 %		
2008	79.5 %	2.8 %		
2007	80.8 %	2.5 %		

Legends:

🚩 Indicator has an unweighted denominator <50 and is not reportable

⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	26.0	27.0	27.0	28.0	29.0	30.0

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	25.8 %	3.9 %	1,759	6,810
2011	16.2 %	2.8 %		
2010	17.5 %	2.8 %		
2009	21.6 %	2.8 %		
2008	16.6 %	2.2 %		
2007	20.0 %	2.5 %		

Legends:

🚩 Indicator has an unweighted denominator <50 and is not reportable

⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	32.0	32.0	32.0	35.0	35.0	36.0

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	28.8 %	2.8 %	10,655	36,969
2007	20.2 %	2.6 %	6,939	34,279

Legends:

🚩 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day (Child Health)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	45.0	45.0	45.0	50.0	50.0	50.0

Data Source: National Survey of Children's Health (NSCH) - CHILD

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	39.7 %	2.6 %	16,986	42,831
2007	38.7 %	2.8 %	15,591	40,282
2003	32.4 %	2.2 %	12,403	38,329

Legends:

🚩 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	85.0	85.0	85.0	87.0	87.0	88.0

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	81.1 %	2.2 %	36,230	44,669
2007	84.8 %	1.8 %	35,345	41,678
2003	73.6 %	1.8 %	32,783	44,573

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% and should be interpreted with caution



Field Level Notes for Form 10a NPMs:

None



NPM 11 - Percent of children with and without special health care needs having a medical home

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	50.0	50.0	50.0	55.0	55.0	55.0

Data Source: National Survey of Children's Health (NSCH) - CSHCN

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	42.8 %	3.7 %	11,052	25,796
2007	43.0 %	3.4 %	11,288	26,226
Legends:  Indicator has an unweighted denominator <30 and is not reportable  Indicator has a confidence interval width >20% and should be interpreted with caution				

Data Source: National Survey of Children's Health (NSCH) - NONCSHCN

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	63.5 %	1.7 %	66,584	104,917
2007	63.7 %	1.7 %	60,718	95,301
Legends:  Indicator has an unweighted denominator <30 and is not reportable  Indicator has a confidence interval width >20% and should be interpreted with caution				

Field Level Notes for Form 10a NPMs:

None

NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	45.0	45.0	50.0	50.0	50.0	52.0

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	47.4 %	4.8 %	3,609	7,613
2005_2006	47.0 %	3.0 %	3,082	6,561

Legends:

🚩 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 14 - A) Percent of women who smoke during pregnancy

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	15.0	14.0	13.0	12.0	12.0	10.0

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	16.9 %	0.4 %	1,263	7,492
2013	17.0 %	0.4 %	1,261	7,400
2012	17.6 %	0.4 %	1,299	7,366
2011	17.7 %	0.5 %	1,289	7,277
2010	19.1 %	0.5 %	1,349	7,049
2009	19.3 %	0.5 %	1,452	7,512

Legends:

🚩 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 14 - B) Percent of children who live in households where someone smokes

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	25.0	25.0	22.0	22.0	20.0	18.0

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	27.0 %	1.4 %	35,902	132,791
2007	31.2 %	1.5 %	39,228	125,625
2003	32.6 %	1.3 %	33,745	103,509

Legends:

🚫 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

Form 10a
State Performance Measures (SPMs)

State: Wyoming

SPM 1 - Risk Appropriate Care

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	70.0	70.0	72.0	72.0	75.0

Field Level Notes for Form 10a SPMs:

1.	Field Name:	2017
<p>Field Note:</p> <p>In 2015, 58.2% of Wyoming infants born at a very low birth rate were delivered in a level II+ NICU facility. This is down from 69.2% in 2012. We hope through focusing on this measure to return the previous levels in the next two years and improve beyond that in the next five years.</p> <p>The first step in this measure is more accurate reporting through completion of the LOCATe tool by birthing hospitals in Wyoming and surrounding states to accurately depict the levels of care provided by each facility.</p>		

SPM 2 - Childhood Injury

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	90.0	88.0	86.0	83.0	81.0

Field Level Notes for Form 10a SPMs:

1.	Field Name:	2017
<p>Field Note:</p> <p>Currently available data for childhood injury are for children aged 1-14 instead of 1-11 as this indicator will be measured going forward. The rate of unintentional injury hospitalization for children aged 1-14 in Wyoming was 93.6 per 100,000. These objectives are based on this number and may be revised with the rate for 1-11 year olds is calculated.</p>		

SPM 3 - Family Planning

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	20.0	40.0	50.0	70.0	80.0

Field Level Notes for Form 10a SPMs:

1. **Field Name:** 2017

Field Note:

This measure is still underdevelopment. There is no baseline data available at this time. These objectives will be revised when baseline data becomes available.

SPM 4 - Healthy Relationships - Alcohol

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	80.0	80.0	82.0	84.0	86.0

Field Level Notes for Form 10a SPMs:

1. **Field Name:** 2017

Field Note:

The 2014 Prevention Needs Assessment indicates that 78.6% of high school students reported 0 occasions of alcohol use in the last 30 days.

Form 10a
Evidence-Based or-Informed Strategy Measures (ESMs)
State: Wyoming

ESM 2.1 - Development of facility-specific prevalence data

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 2.2 - # of YouTube hits for HBWW video

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10a ESMs:

1. **Field Name:** 2017

Field Note:

Our objective is to have 100 new views of the video each year.

ESM 4.1 - Mini-grant program structure developed

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 4.2 - Completion of environmental scan and incorporation of findings into strategic planning

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 4.3 - Breastfeeding support resource map and web page with county level data developed

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 6.1 - Help Me Grow contract to Wyoming 211, Inc. executed

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 6.2 - Help Me Grow Implementation plan developed

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 8.1 - # of meetings of the Wyoming School Health Coalition

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	2.0	4.0	4.0	4.0

Field Level Notes for Form 10a ESMs:

None

ESM 10.1 - Partnership with University of Michigan developed

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 11.1 - Completed environmental scan of Medical Homes in WY and what their family engagement policies are in partnership with Medicaid.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 11.2 - Medical Home module created and implemented into PLTI Curriculum

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 12.1 - # of meetings of the State Level Adolescent Provider Team in the last year (with Transition sub committee meeting)

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	2.0	4.0	4.0	4.0	4.0

Field Level Notes for Form 10a ESMs:

None

ESM 12.2 - # of provider champions participating on team

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	2.0	3.0	3.0	3.0

Field Level Notes for Form 10a ESMs:

None

ESM 12.3 - # of adolescents participating on team

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	2.0	3.0	3.0	3.0

Field Level Notes for Form 10a ESMs:

None

ESM 14.1 - # maternal smoking'-focused meetings between the MCH and Tobacco Programs

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	4.0	4.0	4.0	4.0	4.0

Field Level Notes for Form 10a ESMs:

1. **Field Name:** 2017

Field Note:

We will have four maternal smoking work group meetings per year.

ESM 14.2 - # pregnant women enrolled in the WY Quitline services

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	30.0	32.0	34.0	36.0	38.0

Field Level Notes for Form 10a ESMs:

None

Form 10b
State Performance Measure (SPM) Detail Sheets
State: Wyoming

SPM 1 - Risk Appropriate Care

Population Domain(s) – Perinatal/Infant Health

Goal:	Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)	
Definition:	Numerator:	Number of VLBW infants born in a hospital with a Level III+ NICU
	Denominator:	Number of VLBW infants
	Unit Type:	Percentage
	Unit Number:	100
Healthy People 2020 Objective:	MICH-33: 83.7%	
Data Sources and Data Issues:	Numerator: Vital Records-number of VLBW infants delivered; delivery hospital Denominator: Vital Records- number of VLBW infants delivered Limitation: LOCATe has not been completed in all states where Wyoming babies are delivered.	
Significance:	Neonatal intensive care has improved the outcomes of high risk infants who were born too early or with serious medical conditions. The American Academy of Pediatrics defines levels of neonatal care to allow for regionalization of efforts to ensure that babies born preterm or with serious medical conditions receive the neonatal services they need to address the often severe morbidity they endure. Most infant deaths occur in the United States among very preterm infants in the first days of life. This measure captures the ability for these babies to access necessary services through a regionalized system. (Levels of Neonatal Care: Policy Statement, Pediatrics, 130(3), September 2012)	

SPM 2 - Childhood Injury

Population Domain(s) – Child Health

Goal:	Reduce the rate of hospitalization for non-fatal injury per 100,000 children ages 1 through 11	
Definition:	Numerator:	Inpatient hospitalizations for non-fatal injuries in Wyoming hospitals for children aged 1 through 11
	Denominator:	Children aged 1 through 11 in Wyoming
	Unit Type:	Rate
	Unit Number:	100,000
Data Sources and Data Issues:	<p>Numerator: Hospital Discharge Data (HDD) Denominator: Census population estimates</p> <p>Limitation: HDD is only available for Wyoming hospitals. It is possible that individuals with more severe injuries may be taken immediately out of state for treatment as there are no Level I trauma centers in Wyoming.</p>	
Significance:	Injury is the number one cause of death and hospitalization among children 1-11 in Wyoming and nationally. Wyoming's rates of injury are consistently higher than the national rates.	

SPM 3 - Family Planning

Population Domain(s) – Women/Maternal Health

Goal:	Percent of Wyoming birthing hospitals equipped to provide immediate postpartum long acting reversible contraception (LARC) insertion	
Definition:	Numerator:	Number of Wyoming birthing hospitals equipped to provide immediate LARC insertion
	Denominator:	Number of Wyoming birthing hospitals
	Unit Type:	Percentage
	Unit Number:	100
Data Sources and Data Issues:	Numerator: Hospital survey Denominator: Wyoming Hospital Association Issue: Potential issue for non-response	
Significance:	'The immediate postpartum period is a particularly favorable time for IUD or implant insertion. Women who have recently given birth are often highly motivated to use contraception, they are known not to be pregnant, and the hospital setting offers convenience for both the patient and the health care provider.' (ACOG Practice Bulletin, Number 121, July 2011, http://www.acog.org/Resources-And-Publications/Practice-Bulletins/Committee-on-Practice-Bulletins-Gynecology/Long-Acting-Reversible-Contraception-Implants-and-Intrauterine-Devices)	
	This indicator measures a woman's access to this service across Wyoming. The goal of the title V program is to ensure access and education on immediate postpartum LARC insertion for the patient if she chooses this method of contraception.	

SPM 4 - Healthy Relationships - Alcohol
Population Domain(s) – Adolescent Health

Goal:	Increase the number of teens reporting 0 occasions of alcohol use in the past 30 days	
Definition:	Numerator:	total # of high school students reporting 0 occasions of alcohol use in the past 30 days
	Denominator:	total # of high school students
	Unit Type:	Percentage
	Unit Number:	100
Data Sources and Data Issues:	Wyoming Prevention Needs Assessment	
Significance:	In February 2016, legislation was passed to no longer accept federal funding to conduct the Youth Risk Behavior Surveillance System (YRBSS). This SPM was selected as alcohol is a risk factor related to adolescents having safe and healthy relationships and is available through another state source.	

Form 10b
State Outcome Measure (SOM) Detail Sheets
State: Wyoming

No State Outcome Measures were created by the State.

Form 10c
Evidence-Based or –Informed Strategy Measure (ESM) Detail Sheets
State: Wyoming

ESM 2.1 - Development of facility-specific prevalence data

NPM 2 – Percent of cesarean deliveries among low-risk first births

Goal:	Develop facility-specific low-risk cesarean delivery prevalence									
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Yes/No</td> </tr> <tr> <td>Denominator:</td> <td>n/a</td> </tr> <tr> <td>Unit Type:</td> <td>Text</td> </tr> <tr> <td>Unit Number:</td> <td>Yes/No</td> </tr> </table>		Numerator:	Yes/No	Denominator:	n/a	Unit Type:	Text	Unit Number:	Yes/No
Numerator:	Yes/No									
Denominator:	n/a									
Unit Type:	Text									
Unit Number:	Yes/No									
Data Sources and Data Issues:	Women and Infant Program									
Significance:	The first step in reducing the number of low risk cesareans is to identify disparities that exist by hospital in the state. This information will help the program learn from hospitals that are doing well and identify potential places for engagement with hospitals that are lower performing.									

ESM 2.2 - # of YouTube hits for HBWW video**NPM 2 – Percent of cesarean deliveries among low-risk first births**

Goal:	Promotion and distribution of Healthy Babies Are Worth the Wait (MOD) through community-level partners	
Definition:	Numerator:	# of YouTube hits for HBWW video
	Denominator:	n/a
	Unit Type:	Count
	Unit Number:	100
Data Sources and Data Issues:	YouTube	
Significance:	The Women and Infant Program in partnership with the March of Dimes, the Wyoming State Health Officer, and a local OBGYN practice developed a Health Babies are Worth the Wait educational video. Promotion of this resource to community level partners is the next step. This measure will capture the number of times this video has been viewed on YouTube.	

ESM 4.1 - Mini-grant program structure developed

NPM 4 – A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Goal:	Award mini-grants and provide technical assistance to hospitals for participation in Baby Friendly Hospital Initiative, or a scaled back version like Can Do Five or Baby Steps	
Definition:	Numerator:	Yes/No
	Denominator:	n/a
	Unit Type:	Text
	Unit Number:	Yes/No
Data Sources and Data Issues:	Women and Infant Program	
Significance:	The Baby Friendly Hospital Initiative provides ten practices that hospitals can implement to improve breastfeeding rates in their hospital. To support hospitals understanding and adopting these practices the Women and Infant Health Program will provide mini-grants for hospitals interested in pursuing these practices. This indicator measures the success in developing and gaining approval for this process.	

ESM 4.2 - Completion of environmental scan and incorporation of findings into strategic planning
NPM 4 – A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Goal:	Complete an environmental scan of available state and local level breastfeeding support resources	
Definition:	Numerator:	Yes/No
	Denominator:	n/a
	Unit Type:	Text
	Unit Number:	Yes/No
Data Sources and Data Issues:	Women and Infant Health Program	
Significance:	An environmental scan of the practices and supports available to breastfeeding women throughout our state will provide a starting point for identifying areas where the Women and Infant Health Program can expand upon or establish needs supports to encourage the continuation of breastfeeding to 6 months postpartum.	

ESM 4.3 - Breastfeeding support resource map and web page with county level data developed
NPM 4 – A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Goal:	Develop and disseminate a resource directory of local lactation support services available to new mothers	
Definition:	Numerator:	yes/no
	Denominator:	n/a
	Unit Type:	Text
	Unit Number:	Yes/No
Data Sources and Data Issues:	Women and Infant Health Program	
Significance:	An environmental scan of the practices and supports available to breastfeeding women throughout our state will provide a starting point for identifying areas where the Women and Infant Health Program can expand upon or establish needs supports to encourage the continuation of breastfeeding to 6 months postpartum.	

ESM 6.1 - Help Me Grow contract to Wyoming 211, Inc. executed

NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Goal:	Support Help Me Grow activities to make developmental screening tools accessible to families - 1									
Definition:	<table><tr><td>Numerator:</td><td>Yes/No</td></tr><tr><td>Denominator:</td><td>n/a</td></tr><tr><td>Unit Type:</td><td>Text</td></tr><tr><td>Unit Number:</td><td>Yes/No</td></tr></table>		Numerator:	Yes/No	Denominator:	n/a	Unit Type:	Text	Unit Number:	Yes/No
Numerator:	Yes/No									
Denominator:	n/a									
Unit Type:	Text									
Unit Number:	Yes/No									
Data Sources and Data Issues:	The Wyoming Child Health program is responsible for executing the contract and will be responsible for updating this measure.									
Significance:	Wyoming 211, Inc. is the selected vendor to run the Wyoming Help Me Grow program. They will be the call center that provides screening tools and resources to families. Additionally Wyoming 211 will work with the Wyoming Child Health Program/Title V to improve advertising and education around the importance of developmental screens. Without the execution of the contract the Wyoming Help Me Grow program is on hold.									

ESM 6.2 - Help Me Grow Implementation plan developed

NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Goal:	Support Help Me Grow activities to make developmental screening tools accessible to families	
Definition:	Numerator:	Yes/No
	Denominator:	n/a
	Unit Type:	Text
	Unit Number:	Yes/No
Data Sources and Data Issues:	Wyoming Child Health Program	
Significance:	The Wyoming Child Health Program is responsible for the Wyoming Help Me Grow program and leads a steering committee to implement the strategy in Wyoming. The committee has secured funding, released an RFP, and found a vendor to provide the core services of Help Me Grow. The committee must now work on an implementation plan that will educate providers and parents about the benefits of the program, develop bench marks for success with calls and screens, and follow-up for the program.	

ESM 8.1 - # of meetings of the Wyoming School Health Coalition

NPM 8 – Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Goal:	Support development of a healthy schools coalition with a focus on improving nutrition, physical activity and overall child health.	
Definition:	Numerator:	Number of meeting of the Wyoming School Health Coalition
	Denominator:	n/a
	Unit Type:	Count
	Unit Number:	10
Data Sources and Data Issues:	Wyoming School Health Coalition meeting minutes	
Significance:	Partnership with the Wyoming Department of Education was considered crucial to the success of any efforts aimed at physical activity among school aged children. The Child Health Program manager will be responsible for assembling a Wyoming School Health Coalition. The aim of this committee will be to collaborate on initiatives aimed at improving school health in Wyoming. The Child Health Program manager will lead discussion around physical activity in schools.	

ESM 10.1 - Partnership with University of Michigan developed**NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

Goal:	Promote the Adolescent Champion Model through mini-grants to health care providers	
Definition:	Numerator:	Yes/No
	Denominator:	n/a
	Unit Type:	Text
	Unit Number:	Yes/No
Data Sources and Data Issues:	Adolescent Health Program	
Significance:	The Adolescent Health Program will partner with the University of Michigan to bring the Adolescent Champion Model to Wyoming. The goal of this program is to train adolescent and family providers and their staffs to create a more adolescent friendly environment in their clinics. By increasing the knowledge of providers and their staffs of caring for adolescents is that more adolescents will receive their recommended annual well visit.	

ESM 11.1 - Completed environmental scan of Medical Homes in WY and what their family engagement policies are in partnership with Medicaid.

NPM 11 – Percent of children with and without special health care needs having a medical home

Goal:	Support practices with TA to develop and implement Family Engagement policies	
Definition:	Numerator:	Yes/No
	Denominator:	n/a
	Unit Type:	Text
	Unit Number:	Yes/No
Data Sources and Data Issues:	Child Health Program	
Significance:	<p>There are many initiatives in Wyoming addressing the development of Medical Homes. Title V wants to ensure that it is able to add to the efforts without duplicating services. The Wyoming Medicaid program is a driver of the medical home movement and a key partner in this process. Wyoming Title V has identified family centered component of the medical home as a potential starting point for its efforts. The completion of an environmental scan will inform efforts throughout the five year implementation cycle.</p>	

ESM 11.2 - Medical Home module created and implemented into PLTI Curriculum**NPM 11 – Percent of children with and without special health care needs having a medical home**

Goal:	Conduct outreach to Parent Leadership Training Institute (PLTI) families about availability and benefits of the medical home	
Definition:	Numerator:	Yes/No
	Denominator:	n/a
	Unit Type:	Text
	Unit Number:	Yes/No
Data Sources and Data Issues:	PLTI Coordinator	
Significance:	PLTI is a program that empowers parents to make the change that they see their community needs. Parents learn the components of civic engagement and become proponents for change in their communities. By developing a teaching module on medical homes we hope to inform parents of the benefits of this type of care and encourage them to spark/engage in medical home development and expansion in their communities.	

ESM 12.1 - # of meetings of the State Level Adolescent Provider Team in the last year (with Transition sub committee meeting)

NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Goal:	Develop a State-Level Adolescent Provider Team	
Definition:	Numerator:	# of meetings of the State Level Adolescent Provider Team in the last year (with Transition sub committee meeting)
	Denominator:	n/a
	Unit Type:	Count
	Unit Number:	10
Data Sources and Data Issues:	Adolescent Provider Team meeting minutes	
Significance:	The development of an Adolescent Provider Team will provide a Wyoming perspective on the needs of youth with special health care needs when transitioning to adult health care. This team will have a subcommittee tasked with developing a transition team to address the identified needs in the state.	

ESM 12.2 - # of provider champions participating on team

NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Goal:	Develop a State-Level Adolescent Provider Team	
Definition:	Numerator:	# of provider champions participating on team
	Denominator:	n/a
	Unit Type:	Count
	Unit Number:	10
Data Sources and Data Issues:	Adolescent Provider Team meeting minutes	
Significance:	The provider perspective will be critical to the success of the adolescent provider team meetings. Providers will contribute the realities of their clinics, identify limitations, and provide potential solutions to solve problems related to transition.	

ESM 12.3 - # of adolescents participating on team

NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Goal:	Develop a State-Level Adolescent Provider Team	
Definition:	Numerator:	# of adolescents participating on team
	Denominator:	n/a
	Unit Type:	Count
	Unit Number:	10
Data Sources and Data Issues:	Adolescent Provider Team meeting minutes	
Significance:	The adolescent perspective will be critical to the success of the adolescent provider team meetings. Adolescents will contribute the realities of their lives and experiences with clinics, identify needs for this transition time, and provide realistic and feasible solutions to solve problems related to transition.	

ESM 14.1 - # maternal smoking'-focused meetings between the MCH and Tobacco Programs
NPM 14 – A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Goal:	Work with Tobacco Program and WY Quitline to inform development of pregnancy-focused Quitline media materials (Promote increased use of state-funded Quitline)	
Definition:	Numerator:	# of 'maternal smoking'-focused meetings
	Denominator:	n/a
	Unit Type:	Count
	Unit Number:	10
Data Sources and Data Issues:	Maternal Smoking Group meeting minutes	
Significance:	The Wyoming Quit Tobacco Program is focused on increasing the number of pregnant women that call the Wyoming Quitline. The Quitline is an evidenced based strategy for quitting tobacco. Wyoming has an incentive program for enrollment in the program during pregnancy. Partnership and sharing information and resources to address the high smoking rates among this population in Wyoming is necessary. This indicator provides a measure on the level of partnership between the programs on this issue.	

ESM 14.2 - # pregnant women enrolled in the WY Quitline services

NPM 14 – A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Goal:	Work with Tobacco Program and WY Quitline to inform development of pregnancy-focused Quitline media materials (Promote increased use of state-funded Quitline)	
Definition:	Numerator:	# of pregnant women enrolled in the WY Quitline services
	Denominator:	n/a
	Unit Type:	Count
	Unit Number:	100
Data Sources and Data Issues:	Wyoming Quitline Monthly Reports	
Significance:	The Wyoming Quit Tobacco Program is focused on increasing the number of pregnant women that call the Wyoming Quitline. The Quitline is an evidenced based strategy for quitting tobacco. Wyoming has an incentive program for enrollment in the program during pregnancy. This indicator will measure the success of the partnership in getting women who smoke during pregnancy to enroll in the Quitline services.	

Form 10d
National Performance Measures (NPMs) (Reporting Year 2014 & 2015)
State: Wyoming

Form Notes for Form 10d NPMs and SPMs

None

NPM 01 - The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	16	19	16	14	17
Denominator	16	19	16	14	17
Data Source	Children's Special Health	Children's Special Health	Children's Special Health	Children's Special Health	Children's Special Health
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2015
	Field Note:	The numerator is defined as the number of confirmed cases who had a follow-up visit with their primary care doctor. 3 years (2012-2014) are combined for a rolling 3-year percentage since the numerator is <20.
2.	Field Name:	2014
	Field Note:	The numerator is defined as the number of confirmed cases who had a follow-up visit with their primary care doctor. 3 years (2012-2014) are combined for a rolling 3-year percentage since the numerator is <20.
3.	Field Name:	2013

Field Note:

The numerator is defined as the number of confirmed cases who had a follow-up visit with their primary care doctor. 3 years (2011-2013) are combined for a rolling 3-year percentage since the numerator is <20.

4. **Field Name:** **2012**

Field Note:

The numerator is defined as the number of confirmed cases who had a follow-up visit with their primary care doctor. 3 years (2010-2012) are combined for a rolling 3-year percentage since the numerator is <20.

5. **Field Name:** **2011**

Field Note:

Timely follow-up has not been defined by CSH, as a result the numerator is defined as the number of confirmed cases who had a follow-up visit with their primary care doctor. Three years (2009-2011) are combined for a rolling three-year percentage since the numerator is <20. All data are reported for the current year with a notation of the year for which the data was obtained.

Data Alerts: None

NPM 02 - The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)

	2011	2012	2013	2014	2015
Annual Objective	60.0	70.0	70.0	75.0	75.0
Annual Indicator	70.0	70.0	70.0	70.0	70.0
Numerator					
Denominator					
Data Source	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2015
	<p>Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.</p>	
2.	Field Name:	2014
	<p>Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.</p>	
3.	Field Name:	2013

Field Note:

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5. **Field Name:** **2011**

Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts: None

NPM 03 - The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	50.0	44.6	44.6	45.0	45.5
Annual Indicator	44.6	44.6	44.6	44.6	44.6
Numerator					
Denominator					
Data Source	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2015
	<p>Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.</p>	
2.	Field Name:	2014
	<p>Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.</p>	
3.	Field Name:	2013

Field Note:

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5. **Field Name:** **2011**

Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts: None

NPM 04 - The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	65.0	58.2	58.2	60.0	60.0
Annual Indicator	58.2	58.2	58.2	58.2	58.2
Numerator					
Denominator					
Data Source	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2015
	<p>Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.</p>	
2.	Field Name:	2014
	<p>Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.</p>	
3.	Field Name:	2013

Field Note:

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5. **Field Name:** **2011**

Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts: None

NPM 05 - Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	90.0	63.9	63.9	65.0	65.0
Annual Indicator	63.9	63.9	63.9	63.9	63.9
Numerator					
Denominator					
Data Source	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2014**

Field Note:

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2013**

Field Note:

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5. **Field Name:** **2011**

Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts: None

NPM 06 - The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

	2011	2012	2013	2014	2015
Annual Objective	50.0	47.4	47.4	50.0	50.0
Annual Indicator	47.4	47.4	47.4	47.4	47.4
Numerator					
Denominator					
Data Source	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2015
	<p>Field Note:</p> <p>For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.</p> <p>All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.</p>	
2.	Field Name:	2014

Field Note:

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2013**

Field Note:

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5. **Field Name:** **2011**

Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts: None

NPM 07 - Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

	2011	2012	2013	2014	2015
Annual Objective	70.0	75.0	75.5	76.0	76.5
Annual Indicator	74.6	71.6	71.6	64.0	0.0
Numerator	14,083	13,813	13,194	6,859	0
Denominator	18,878	19,292	18,428	10,724	10,724
Data Source	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2015
	Field Note:	2015 data is not yet available.
2.	Field Name:	2014
	Field Note:	Data are from the National Immunization Survey as reported in NOM 22. (NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)) This is a change in the series that has been reported to this point by Wyoming and should not be compared to previous years.
3.	Field Name:	2013
	Field Note:	4 or more doses of DTaP, 3 or more doses of poliovirus vaccine, 1 or more doses of any MMR vaccine, 3 or more doses of Haemophilus influenzae type b (Hib) vaccine, and 3 or more doses of hepatitis B vaccine. 4:3:1:3:3 series coverage is based on the original definition for this series. It is not recommended for comparison to years prior to 2009 because of the changes made in the way the Hib vaccine is now measured and the vaccine shortage that affected a large percent of children that were included in the 2009 and 2010 samples.
4.	Field Name:	2012

Field Note:

4 or more doses of DTaP, 3 or more doses of poliovirus vaccine, 1 or more doses of any MMR vaccine, 3 or more doses of Haemophilus influenzae type b (Hib) vaccine, and 3 or more doses of hepatitis B vaccine. 4:3:1:3:3 series coverage is based on the original definition for this series. It is not recommended for comparison to years prior to 2009 because of the changes made in the way the Hib vaccine is now measured and the vaccine shortage that affected a large percent of children that were included in the 2009 and 2010 samples.

5. **Field Name:** 2011

Field Note:

4 or more doses of DTaP, 3 or more doses of poliovirus vaccine, 1 or more doses of any MMR vaccine, 3 or more doses of Haemophilus influenzae type b (Hib) vaccine, and 3 or more doses of hepatitis B vaccine. 4:3:1:3:3 series coverage is based on the original definition for this series. It is not recommended for comparison to years prior to 2009 because of the changes made in the way the Hib vaccine is now measured and the vaccine shortage that affected a large percent of children that were included in the 2009 and 2010 samples.

Data Alerts: None

NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

	2011	2012	2013	2014	2015
Annual Objective	19.0	17.0	14.4	13.0	13.0
Annual Indicator	17.1	14.6	13.3	14.7	11.9
Numerator	182	151	140	139	131
Denominator	10,632	10,375	10,555	9,448	11,029
Data Source	Wyoming Vital Statistics Services	Wyoming Vital Statistics	Wyoming Vital Statistics	Wyoming Vital Statistics	Wyoming Vital Statistics
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2015
	Field Note:	Data reported from 2014 Wyoming Vital Statistics. Denominator from 2014 annual estimates of resident population by single year of age and sex for Wyoming.
		http://eadv.state.wy.us/pop/ST_AS14.htm
2.	Field Name:	2014
	Field Note:	Data reported from 2013 Wyoming Vital Statistics.
3.	Field Name:	2013
	Field Note:	Data reported from 2012 Wyoming Vital Statistics Services.
4.	Field Name:	2012
	Field Note:	Data reported from 2011 Wyoming Vital Statistics Services.
5.	Field Name:	2011
	Field Note:	Data reported for 2010 births from the Wyoming Vital Statistics Service.

Data Alerts: None

NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

	2011	2012	2013	2014	2015
Annual Objective	55.0	50.0	50.0	50.0	50.0
Annual Indicator	49.1	49.1	49.1	49.1	49.1
Numerator	2,570	2,570	2,570	3,338	3,937
Denominator	5,230	5,230	5,230	6,799	8,018
Data Source	2009/2010 Wyoming Third Grade Oral Health Survey	2009/2010 Wyoming Third Grade Oral Health Survey	2009/2010 Wyoming Third Grade Oral Health Survey	2009/2010 Wyoming Third Grade Oral Health Survey	2009/2010 Wyoming Third Grade Oral Health Survey
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2015
	Field Note:	An oral health survey, including BMI data, was conducted was during school year 2009/2010. A baseline survey was conducted in 2000 and showed that 71.3% of Wyoming third graders had protective sealants. The oral health program did not have the staffing to conduct another survey until 2008/2009 and again in 2009/2010. The current survey was developed to estimate the percentage of third graders who have received sealants.
2.	Field Name:	2014
	Field Note:	An oral health survey, including BMI data, was conducted was during school year 2009/2010. A baseline survey was conducted in 2000 and showed that 71.3% of Wyoming third graders had protective sealants. The oral health program did not have the staffing to conduct another survey until 2008/2009 and again in 2009/2010. The current survey was developed to estimate the percentage of third graders who have received sealants.
3.	Field Name:	2013
	Field Note:	An oral health survey, including BMI data, was conducted was during school year 2009/2010. A baseline survey was conducted in 2000 and showed that 71.3% of Wyoming third graders had protective sealants. The oral health program did not have the staffing to conduct another survey until 2008/2009 and again in 2009/2010. The current survey was developed to estimate the percentage of third graders who have received sealants.

4.	Field Name:	2012
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Field Note:

An oral health survey, including BMI data, was conducted was during school year 2009/2010. A baseline survey was conducted in 2000 and showed that 71.3% of Wyoming third graders had protective sealants. The oral health program did not have the staffing to conduct another survey until 2008/2009 and again in 2009/2010. The current survey was developed to estimate the percentage of third graders who have received sealants.

5.	Field Name:	2011
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Field Note:

An oral health survey, including BMI data, was conducted was during school year 2009/2010. A baseline survey was conducted in 2000 and showed that 71.3% of Wyoming third graders had protective sealants. The oral health program did not have the staffing to conduct another survey until 2008/2009 and again in 2009/2010. The current survey was developed to estimate the percentage of third graders who have received sealants.

Data Alerts: None

NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

	2011	2012	2013	2014	2015
Annual Objective	3.0	2.5	1.7	2.2	2.0
Annual Indicator	3.0	1.8	2.4	3.2	3.8
Numerator	10	6	8	11	13
Denominator	329,735	337,002	340,353	342,476	344,531
Data Source	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2015
	Field Note:	Data from Wyoming Vital Statistics Services provided as three-year rolling rates (2012-2014) due to small numbers.
2.	Field Name:	2014
	Field Note:	Data from Wyoming Vital Statistics Services provided as three-year rolling rates (2011-2013) due to small numbers.
3.	Field Name:	2013
	Field Note:	Data from Wyoming Vital Statistics Services provided as three-year rolling rates (2010-2012) due to small numbers.
4.	Field Name:	2012
	Field Note:	Data from Wyoming Vital Statistics Services provided as three-year rolling rates (2009-2011) due to small numbers.
5.	Field Name:	2011

Field Note:

Data from Wyoming Vital Statistics Services provided as three-year rolling rates (2008-2010) due to small numbers.

Data Alerts: None

NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.

	2011	2012	2013	2014	2015
Annual Objective	53.0	50.0	53.0	56.0	56.5
Annual Indicator	48.2	52.5	55.6	56.6	58.1
Numerator	3,635	3,853	4,212	4,311	4,470
Denominator	7,541	7,339	7,576	7,617	7,693
Data Source	National Immunization Survey	National Immunization Survey	National Immunization Survey	National immunization Survey	National immunization Survey
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2012
	Field Note:	
		The National Immunization Survey (NIS) reports breastfeeding percentages based on the year of birth. The denominator is the number of live births in 2011. The numerator is estimated by using the percentage reported by NIS for the 2009 birth cohort.
2.	Field Name:	2011
	Field Note:	
		The National Immunization Survey (NIS) reports breastfeeding percentages based on the year of birth. The denominator is the number of live births in 2010. The numerator is estimated by using the percentage reported by NIS for the 2008 birth cohort.

Data Alerts: None

NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.

	2011	2012	2013	2014	2015
Annual Objective	95.0	99.5	99.5	99.5	99.5
Annual Indicator	99.5	96.3	96.0	97.2	98.6
Numerator	6,676	6,605	6,660	6,796	7,016
Denominator	6,710	6,858	6,939	6,992	7,113
Data Source	Wyoming Newborn Hearing program/Vital Stats	Wyoming Newborn Hearing program/Vital Stats	Wyoming Newborn Hearing program/Vital Stats	Wyoming Newborn Hearing program/Vital Stats	Wyoming Newborn Hearing program/Vital Stats
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2012
	Field Note:	The numerator is 2012 newborn hearing screening data. The denominator is 2012 occurant Wyoming births.
2.	Field Name:	2011
	Field Note:	Data are from 2011 hearing screening data Wyoming births with occurrent births as the denominator.

Data Alerts: None

NPM 13 - Percent of children without health insurance.

	2011	2012	2013	2014	2015
Annual Objective	9.0	7.5	7.5	9.0	8.5
Annual Indicator	7.9	8.1	9.5	9.5	5.9
Numerator	10,768	11,638	13,185	12,077	8,137
Denominator	136,229	143,103	138,162	127,498	137,296
Data Source	United States Census Bureau	United States Census Bureau	United States Census Bureau	United States Census Bureau	United States Census Bureau
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2015
	Field Note:	Data is from the US census bureau for calendar year 2014.
2.	Field Name:	2014
	Field Note:	Data is from the US census bureau for calendar year 2013.
3.	Field Name:	2013
	Field Note:	Data is from the US census bureau for calendar year 2012.
4.	Field Name:	2012
	Field Note:	Indicator from 2011 US Census estimates.
5.	Field Name:	2011
	Field Note:	Indicator from 2010 US Census.

Data Alerts: None

NPM 14 - Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

	2011	2012	2013	2014	2015
Annual Objective	48.0	16.0	13.0	20.0	19.0
Annual Indicator	16.8	13.3	20.5	22.5	21.7
Numerator	741	1,435	1,742	1,785	1,650
Denominator	4,407	10,773	8,484	7,918	7,595
Data Source	Wyoming WIC Program Data	Wyoming WIC Program Data	Wyoming WIC Program Data	Wyoming WIC Program Data	Wyoming WIC Program Data
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2015
	Field Note:	Data is from WIC clients enrolled in 2015 and include children who are overweight or obese based on risk codes (113 and 114) in the WIC data base.
2.	Field Name:	2014
	Field Note:	Data from 2011 are NOT COMPARABLE to data from previous years. WIC IT staff worked to correct the data query used to collect these data, and the data for 2011 are accurate. Data from previous years are not reliable. Data were not available from Pediatric Nutrition Surveillance System (PedNss), so data were collected directly from the Wyoming WIC program. The Wyoming WIC program collects data for children with a BMI >95th percentile for age and gender. State level aggregate data were confirmed with the Wyoming WIC program.
3.	Field Name:	2013
	Field Note:	Data from 2011 are NOT COMPARABLE to data from previous years. WIC IT staff worked to correct the data query used to collect these data, and the data for 2011 are accurate. Data from previous years are not reliable. Data were not available from Pediatric Nutrition Surveillance System (PedNss), so data were collected directly from the Wyoming WIC program. The Wyoming WIC program collects data for children with a BMI >95th percentile for age and gender. State level aggregate data were confirmed with the Wyoming WIC program.
4.	Field Name:	2012

Field Note:

Data from 2011 are NOT COMPARABLE to data from previous years. WIC IT staff worked to correct the data query used to collect these data, and the data for 2011 are accurate. Data from previous years are not reliable. Data were not available from Pediatric Nutrition Surveillance System (PedNss), so data were collected directly from the Wyoming WIC program. The Wyoming WIC program collects data for children with a BMI >95th percentile for age and gender. State level aggregate data were confirmed with the Wyoming WIC program.

5. **Field Name:** **2011**

Field Note:

Data from 2011 are NOT COMPARABLE to data from previous years. WIC IT staff worked to correct the data query used to collect these data, and the data for 2011 are accurate. Data from previous years are not reliable. Data were not available from Pediatric Nutrition Surveillance System (PedNss), so data were collected directly from the Wyoming WIC program. The Wyoming WIC program collects data for children with a BMI >95th percentile for age and gender. State level aggregate data were confirmed with the Wyoming WIC program.

Data Alerts: None

NPM 15 - Percentage of women who smoke in the last three months of pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	16.0	14.5	14.0	15.5	15.0
Annual Indicator	14.8	15.6	15.9	13.1	13.1
Numerator	1,113	1,145	1,205	998	1,008
Denominator	7,541	7,341	7,576	7,617	7,693
Data Source	Wyoming Pregnancy Risk Assessment Monitoring Sys	Wyoming Pregnancy Risk Assessment Monitoring Sys	Wyoming Pregnancy Risk Assessment Monitoring Sys	Wyoming Pregnancy Risk Assessment Monitoring Sys	Wyoming Pregnancy Risk Assessment Monitoring Sys
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2015
	Field Note:	Data from 2013 PRAMS survey. The data will be updated when 2014 data is made available.
2.	Field Name:	2014
	Field Note:	Indicator data are from the 2013 Wyoming Pregnancy Risk Assessment Monitoring System (PRAMS) survey. Data from years prior to 2008 (2007 PRAMS) may not be comparable.
		Measure has been updated as 2013 data became available in the last year.
3.	Field Name:	2013
	Field Note:	Indicator data are from the 2012 Wyoming Pregnancy Risk Assessment Monitoring System (PRAMS) survey. Data from years prior to 2008 (2007 PRAMS) may not be comparable.
		Measure has been updated as 2012 data became available in the last year.
4.	Field Name:	2012
	Field Note:	Indicator data are from the 2011 Wyoming Pregnancy Risk Assessment Monitoring System (PRAMS) survey. Data from years prior to 2008 (2007 PRAMS) may not be comparable.
5.	Field Name:	2011

Field Note:

Indicator data are from the 2010 Wyoming Pregnancy Risk Assessment Monitoring System (PRAMS) survey. Data from years prior to 2008 (2007 PRAMS) may not be comparable.

Data Alerts: None

NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

	2011	2012	2013	2014	2015
Annual Objective	15.0	18.0	20.0	19.0	18.0
Annual Indicator	18.3	22.5	20.4	20.6	22.4
Numerator	22	26	23	23	25
Denominator	120,546	115,513	112,819	111,680	111,774
Data Source	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2015

Field Note:

Due to numerators less than 20 for individual years, data are reported as three year rolling averages. The data for 2015 includes 2012 - 2014 records from the Wyoming Vital Statistics office.

2. **Field Name:** 2014

Field Note:

Due to numerators less than 20 for individual years, data are reported as three year rolling averages. The data for 2014 includes 2011, 2012, and 2013 records from the Wyoming Vital Statistics office.

3. **Field Name:** 2012

Field Note:

Due to small numerators, data are reported as three-year rates (2009-2011).

4. **Field Name:** 2011

Field Note:

Due to small numerators, data are reported as three-year rates (2008-2010).

Data Alerts: None

NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

	2011	2012	2013	2014	2015
Annual Objective	69.0	70.0	70.0	70.0	70.0
Annual Indicator	68.2	74.7	69.2	65.9	58.2
Numerator	58	59	63	56	46
Denominator	85	79	91	85	79
Data Source	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2015
	Field Note:	There are no tertiary care facilities in Wyoming. These data are from Wyoming Vital Statistics Service for 2014 births.
2.	Field Name:	2014
	Field Note:	There are no tertiary care facilities in Wyoming. These data are from Wyoming Vital Statistics Service for 2013 births.
3.	Field Name:	2013
	Field Note:	There are no tertiary care facilities in Wyoming. These data are from Wyoming Vital Statistics Service for 2012 births.
4.	Field Name:	2012
	Field Note:	There are no tertiary care facilities in Wyoming. These data are from Wyoming Vital Statistics Service for 2011 births.
5.	Field Name:	2011

Field Note:

There are no tertiary care facilities in Wyoming. These data are from Wyoming Vital Statistics Service for 2010 births.

Data Alerts: None

NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

	2011	2012	2013	2014	2015
Annual Objective	73.0	74.2	74.2	75.0	75.0
Annual Indicator	74.2	73.8	72.7	73.7	70.9
Numerator	5,593	5,417	5,511	5,615	5,457
Denominator	7,541	7,341	7,576	7,617	7,693
Data Source	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2015
	Field Note:	This is Wyoming Vital Statics data for births from 2014.
2.	Field Name:	2014
	Field Note:	This is Wyoming Vital Statics data for births from 2013.
3.	Field Name:	2013
	Field Note:	This is Wyoming Vital Statics data for births from 2012.
4.	Field Name:	2012
	Field Note:	Data are from the Wyoming Vital Statitics Service for 2011 births. Wyoming began using the new birth certificate in 2006, which asks about prenatal care differently than the old birth certificate. Therefore, this indicator is not comparable to those prior to 2006.
5.	Field Name:	2011
	Field Note:	Data are from the Wyoming Vital Statistics Service for 2010 births. Wyoming began using the new birth certificate in 2006, which asks about prenatal care differently than the old birth certificate. Therefore, this indicator is not comparable to those prior to 2006.

Data Alerts: None

Form 10d
State Performance Measures (SPMs) (Reporting Year 2014 & 2015)
State: Wyoming

SPM 1 - Percent of women gaining adequate weight during pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	30.0	28.9	29.0	29.0	30.0
Annual Indicator	28.9	28.4	28.4	28.7	28.6
Numerator	2,180	2,085	2,085	2,174	2,178
Denominator	7,541	7,341	7,341	7,576	7,617
Data Source	Wyoming PRAMS	Wyoming PRAMS	Wyoming PRAMS	Wyoming PRAMS	Wyoming PRAMS
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

Field Note:

Indicator data from 2013 Wyoming PRAMS and Wyoming Vital Statistics Service birth year 2013. The numerator is the number of women who gain adequate weight during their pregnancy based on their prepregnancy BMI (Weighted). The denominator is the total number of Wyoming resident live births in reporting year.

2. **Field Name:** **2014**

Field Note:

Indicator data from 2012 Wyoming PRAMS and Wyoming Vital Statistics Service birth year 2012. The numerator is the number of women who gain adequate weight during their pregnancy based on their prepregnancy BMI (Weighted). The denominator is the total number of Wyoming resident live births in reporting year.

This number has been updated this year because 2012 PRAMS data has recently become available.

3. **Field Name:** **2013**

Field Note:

Indicator data from 2011 Wyoming PRAMS and Wyoming Vital Statistics Service birth year 2011. The numerator is the number of women who gain adequate weight during their pregnancy based on their prepregnancy BMI (Weighted). The denominator is the total number of Wyoming resident live births in reporting year.

Currently no data is available from CDC for 2012. We will update when we receive data.

4. **Field Name:** **2012**

Field Note:

Indicator data from 2011 Wyoming PRAMS and Wyoming Vital Statistics Service birth year 2011. The numerator is the number of women who gain adequate weight during their pregnancy based on their prepregnancy BMI (Weighted). The denominator is the total number of Wyoming resident live births in reporting year.

5. **Field Name:** **2011**

Field Note:

Indicator data from 2010 Wyoming PRAMS and Wyoming Vital Statistics Service birth year 2010. The numerator is the number of women who gain adequate weight during their pregnancy based on their prepregnancy BMI (Weighted). The denominator is the total number of Wyoming resident live births in reporting year.

Data Alerts: None

SPM 2 - Percent of postpartum women reporting multivitamin use four or more times per week in the month before becoming pregnant.

	2011	2012	2013	2014	2015
Annual Objective	40.0	38.9	39.0	40.0	40.0
Annual Indicator	38.9	39.8	39.8	39.2	40.0
Numerator	2,936	2,919	2,919	2,970	3,047
Denominator	7,541	7,341	7,341	7,576	7,617
Data Source	Wyoming Pregnancy Risk Assessment Monitoring Sys	Wyoming Pregnancy Risk Assessment Monitoring Sys	Wyoming Pregnancy Risk Assessment Monitoring Sys	Wyoming Pregnancy Risk Assessment Monitoring Sys	Wyoming Pregnancy Risk Assessment Monitoring System
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	Field Name:	2015
	Field Note:	Indicator data is from the 2013 Wyoming Pregnancy Risk Assessment Monitoring System (PRAMS) survey. This is the most recent year of available data.
2.	Field Name:	2014
	Field Note:	Indicator data is from the 2012 Wyoming Pregnancy Risk Assessment Monitoring System (PRAMS) survey. We updated this indicator to reflect the newly available data.
3.	Field Name:	2013
	Field Note:	Indicator data is from the 2011 Wyoming Pregnancy Risk Assessment Monitoring System (PRAMS) survey. Currently no data is available from CDC for 2012. We will update the data as soon as it is available.
4.	Field Name:	2012

Field Note:

Indicator data is from the 2011 Wyoming Pregnancy Risk Assessment Monitoring System (PRAMS) survey.

5. **Field Name:** **2011**

Field Note:

Indicator data is from the 2010 Wyoming Pregnancy Risk Assessment Monitoring System (PRAMS) survey.

Data Alerts: None

SPM 3 - Percent of infants born to women who smoked during pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	17.0	16.6	16.5	16.4	16.3
Annual Indicator	16.6	16.0	15.9	15.6	15.8
Numerator	1,250	1,175	1,203	1,185	1,216
Denominator	7,541	7,341	7,576	7,617	7,693
Data Source	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	Field Name:	2015
	Field Note:	These data are from 2014 vital records.
2.	Field Name:	2014
	Field Note:	These data are from 2013 vital records.
3.	Field Name:	2013
	Field Note:	These data are from 2012 vital records.
4.	Field Name:	2012
	Field Note:	These data are from 2011 Vital Records. Wyoming began using the new birth certificate in 2006, which collectes smoking data differently than the old birth certificate. Therefore, this indicator is not comparable to indicators reported before 2006.
5.	Field Name:	2011
	Field Note:	These data are from 2010 Vital Records. Wyoming began using the new birth certificate in 2006, which collectes smoking data differently than the old birth certificate. Therefore, this indicator is not comparable to indicators reported before 2006.

Data Alerts: None

SPM 4 - The percent of mothers who initiate breastfeeding their infants at hospital discharge.

	2011	2012	2013	2014	2015
Annual Objective	75.0	81.6	82.0	82.0	82.0
Annual Indicator	81.6	81.2	82.3	84.3	84.1
Numerator	6,154	5,964	6,233	6,422	6,470
Denominator	7,541	7,341	7,576	7,617	7,693
Data Source	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	Field Name:	2015
	Field Note:	These data are from 2014 Wyoming Vital Statistics.
2.	Field Name:	2014
	Field Note:	These data are from 2013 Wyoming Vital Statistics.
3.	Field Name:	2013
	Field Note:	These data are from 2012 Wyoming Vital Statistics.
4.	Field Name:	2012
	Field Note:	Data are from the Wyoming Vital Statistics Service for 2011 births. The numerator is the number of Wyoming mothers who initiate breastfeeding their infants at or before hospital discharge in the reporting year. The denominator is the total number of Wyoming resident live births in the reporting year.
5.	Field Name:	2011
	Field Note:	Data are from the Wyoming Vital Statistics Service for 2010 births. The numerator is the number of Wyoming mothers who initiate breastfeeding their infants at or before hospital discharge in the reporting year. The denominator is the total number of Wyoming resident live births in the reporting year.

Data Alerts: None

SPM 5 - Percent of Wyoming high school (grades 9-12) students who ate fruits and vegetables less than five times per day.

	2011	2012	2013	2014	2015
Annual Objective	18.0	80.0	79.0	78.0	77.0
Annual Indicator	80.9	77.9	78.3	78.3	78.3
Numerator	21,355	20,266	20,576	20,576	20,576
Denominator	26,397	26,016	26,278	26,278	26,278
Data Source	2009 Wyoming Youth Risk Behavior Survey	2011 Wyoming Youth Risk Behavior Survey	2013 Wyoming Youth Risk Behavior Survey	2013 Wyoming Youth Risk Behavior Survey	2013 Wyoming Youth Risk Behavior Survey
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

1.	Field Name:	2015
	Field Note:	This measure is not yet calculated with the Wyoming YRBS 2015 data. The data is available but analysis is not yet complete. Data presented here is the 2013 YRBS data.
2.	Field Name:	2012
	Field Note:	Data are from the Wyoming Youth Risk Behavior Surveillance Survey (YRBS), which is conducted every other year. These data are from the 2011 survey of Wyoming high school students. Denominator is the total population of Wyoming 9th through 12th grade students for the 2010-2011 academic year. The numerator is estimated from the indicator and the denominator.
3.	Field Name:	2011
	Field Note:	Data for this measure were reported incorrectly in the 2012 application and the objective for 2011 should be disregarded. Data are from the Wyoming Youth Risk Behavior Surveillance Survey (YRBS), which is conducted every other year. These data are from the 2009 survey of Wyoming high school students. Denominator is the total population of Wyoming 9th through 12th grade students for the 2008-2009 academic year. The numerator is estimated from the indicator and the denominator. Data for this measure are not yet available for the 2011 survey.

Data Alerts: None

SPM 6 - Percent of Wyoming high school (grades 9-12) students who were physically active for at least 60 minutes per day.

	2011	2012	2013	2014	2015
Annual Objective	50.0	50.0	50.0	50.0	50.0
Annual Indicator	49.7	50.1	47.8	48.1	50.6
Numerator	12,995	13,034	12,561	12,651	15,071
Denominator	26,146	26,016	26,278	26,278	29,784
Data Source	2011 Wyoming Youth Risk Behavior Survey	2011 Wyoming Youth Risk Behavior Survey	2013 Wyoming Youth Risk Behavior Survey	2013 Wyoming Youth Risk Behavior Survey	2015 Wyoming Youth Risk Behavior Survey
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	Field Name:	2015
	Field Note:	This data is from the 2015 YRBS survey for Wyoming. This indicator is the % of Wyoming high school (grades 9-12) students who were physically active for a least 60 minutes per day 5 or more days per week.
2.	Field Name:	2012
	Field Note:	Data are from the Wyoming Youth Risk Behavior Surveillance Survey (YRBS), which is conducted every other year. These data are from the 2011 survey of Wyoming high school students. Denominator is the total population of Wyoming 9th through 12th grade students for the 2010-2011 academic year. The numerator is estimated from the indicator and the denominator.
3.	Field Name:	2011
	Field Note:	Data are from the Wyoming Youth Risk Behavior Surveillance Survey (YRBS), which is conducted every other year. These data are from the 2011 survey of Wyoming high school students. Denominator is the total population of Wyoming 9th through 12th grade students for the 2010-2011 academic year. The numerator is estimated from the indicator and the denominator.

Data Alerts: None

SPM 7 - Rate of deaths (per 100,000) to children and youth ages 0-24 due to unintentional injuries.

	2011	2012	2013	2014	2015
Annual Objective	27.5	26.8	26.0	25.5	25.0
Annual Indicator	26.8	26.5	24.8	22.2	36.1
Numerator	49	51	46	41	68
Denominator	182,539	192,468	185,809	184,346	188,152
Data Source	Vital Statistics and Census	Vital Statistics and Census	Vital Statistics and Census	Vital Statistics and Census	Vital Statistics and Census
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	Field Name:	2015
	Field Note:	Data is from the mortality file for 2014 from Vital Statistics.
2.	Field Name:	2014
	Field Note:	Data is from the mortality file for 2013 from Vital Statistics.
3.	Field Name:	2013
	Field Note:	Data is from the mortality file for 2012 from Vital Statistics.
4.	Field Name:	2011
	Field Note:	Indicator data are from 2011 Wyoming Vital Statistics Services and the US Census. The numerator is the number of deaths in children ages 1-24 years due to unintentional injuries. The denominator is the total number of Wyoming children 1-24 years of age.

Data Alerts: None

SPM 8 - Percent of teens reporting that they were hit, slapped, or physically hurt by boyfriend/girlfriend.

	2011	2012	2013	2014	2015
Annual Objective	14.5	14.0	13.5	13.0	12.5
Annual Indicator	14.2	14.2	10.3	10.3	6.3
Numerator	3,713	3,713	2,680	2,680	1,876
Denominator	26,146	26,146	26,016	26,016	29,784
Data Source	2011 Wyoming Youth Risk Behavior Survey	2011 Wyoming Youth Risk Behavior Survey	2013 Wyoming Youth Risk Behavior Survey	2013 Wyoming Youth Risk Behavior Survey	2015 Wyoming Youth Risk Behavior Survey
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

Field Note:

The 2015 YRBS question changed to read 'how many times did someone you were dating or going out with physically hurt you on purpose'. This percentage reflects the percent of teens that reported their partner physically hurt them on purpose greater than 0 times.

2. **Field Name:** **2012**

Field Note:

Data are from the Wyoming Youth Risk Behavior Surveillance Survey (YRBS), which is conducted every other year. these data are from the 2011 survey of Wyoming high school students. Denominator is the total population of Wyoming 9th through 12th grade students for the 2010-2011 academic year. The numerator is estimated from the indicator and the denominator.

3. **Field Name:** **2011**

Field Note:

Data are from the Wyoming Youth Risk Behavior Surveillance Survey (YRBS), which is conducted every other year. these data are from the 2011 survey of Wyoming high school students. Denominator is the total population of Wyoming 9th through 12th grade students for the 2010-2011 academic year. The numerator is estimated from the indicator and the denominator.

Data Alerts: None

SPM 9 - The capacity to collect, analyze and report on data for children and youth with special health care needs (CYSHCN).

	2011	2012	2013	2014	2015
Annual Objective	4.0	4.0	6.0	8.0	11.0
Annual Indicator	1.0	2.0	7.0	7.0	8.0
Numerator					
Denominator					
Data Source	Maternal and Family Health	Maternal and Child Health Program	Maternal and Child Health Program	Maternal and Child Health Program	Maternal and Child Health Program
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	Field Name:	2015
	Field Note:	The numerator for this measure is a score of 8 and there is no denominator. Therefore the indicator is 8 for 2015.
2.	Field Name:	2014
	Field Note:	The numerator for this measure is a score of 7 and there is no denominator. Therefore the indicator is 7 for 2014.
3.	Field Name:	2013
	Field Note:	The numerator for this measure is a score of 7 and there is no denominator. Therefore the indicator is 7 for 2013.
4.	Field Name:	2012
	Field Note:	The numerator for this measure is a score of 2 and there is no denominator. Therefore the indicator is 2 for 2012.
5.	Field Name:	2011

Field Note:

The numerator for this measure is a score of 1 and there is no denominator. Therefore the indicator is 1 for 2011.

Data Alerts: None

Form 11
Other State Data
State: Wyoming

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the current application/annual report.

State Action Plan Table

State: Wyoming

Please click the link below to download a PDF of the full version of the State Action Plan Table.

[State Action Plan Table](#)

Abbreviated State Action Plan Table

State: Wyoming

Women/Maternal Health

State Priority Needs	NPMs	ESMs	SPMs
Prevent Infant Mortality	NPM 2 - Low-Risk Cesarean Delivery	ESM 2.1 ESM 2.2	
Improve access to and promote use of effective family planning			SPM 3

Perinatal/Infant Health

State Priority Needs	NPMs	ESMs	SPMs
Improve breastfeeding duration	NPM 4 - Breastfeeding	ESM 4.1 ESM 4.2 ESM 4.3	
Prevent Infant Mortality			SPM 1

Child Health

State Priority Needs	NPMs	ESMs	SPMs
Reduce and prevent childhood obesity	NPM 8 - Physical Activity	ESM 8.1	
Prevent injury in children			SPM 2
Promote preventive and quality care for children and adolescents	NPM 6 - Developmental Screening	ESM 6.1 ESM 6.2	

Adolescent Health

State Priority Needs	NPMs	ESMs	SPMs
Promote preventive and quality care for children and adolescents	NPM 10 - Adolescent Well-Visit	ESM 10.1	
Promote healthy and safe relationships in adolescents			SPM 4

Children with Special Health Care Needs

State Priority Needs	NPMs	ESMs	SPMs
Promote preventive and quality care for children and adolescents	NPM 11 - Medical Home	ESM 11.1 ESM 11.2	
Promote preventive and quality care for children and adolescents	NPM 12 - Transition	ESM 12.1 ESM 12.2 ESM 12.3	

Cross-Cutting/Life Course

State Priority Needs	NPMs	ESMs	SPMs
Prevent Infant Mortality	NPM 14 - Smoking	ESM 14.1 ESM 14.2	