Maternal and Child Health Services Title V Block Grant

Wyoming

FY 2018 Application/ FY 2016 Annual Report

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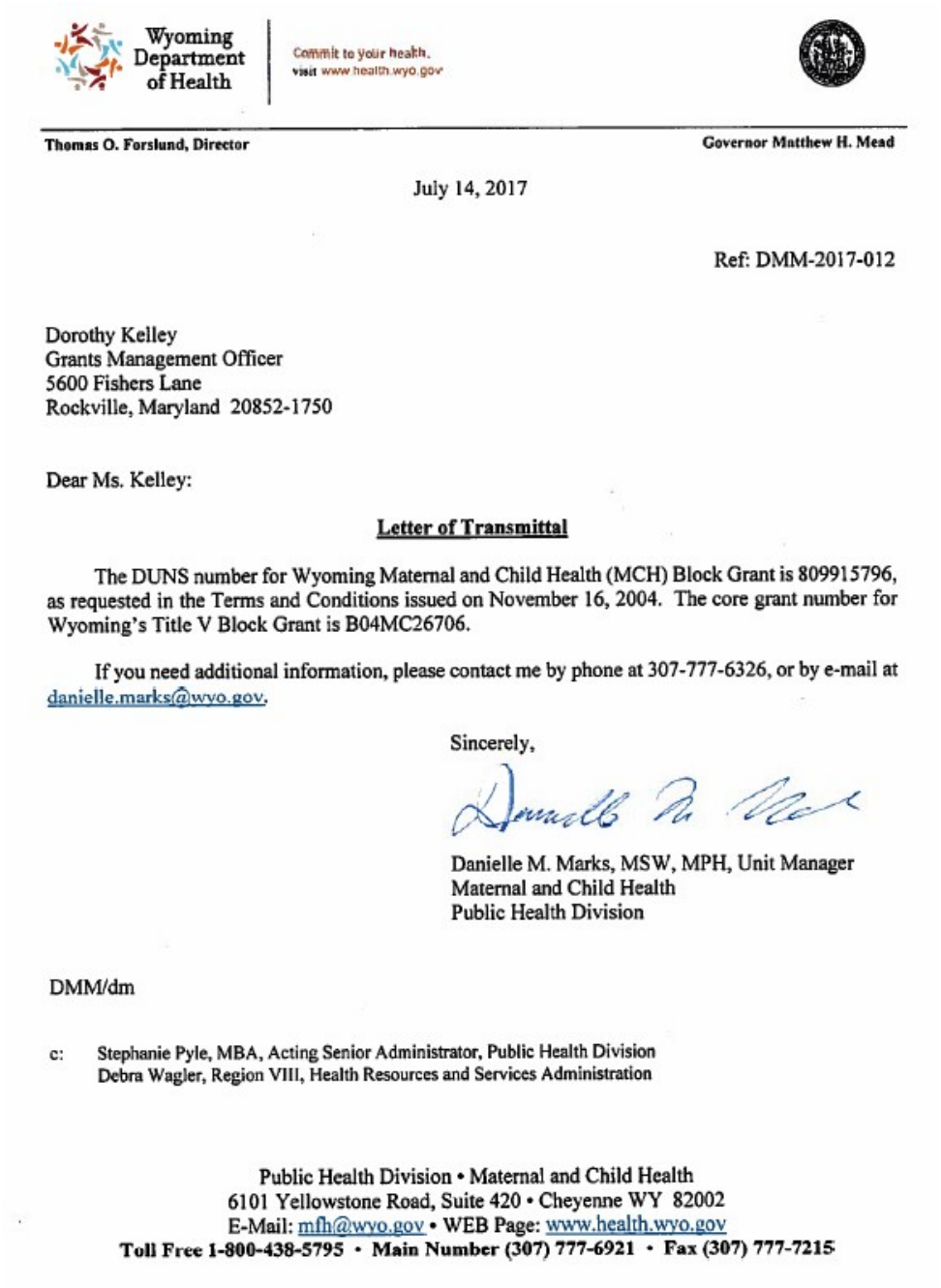
I. General Requirements

I.A. Letter of Transmittal



Wyoming Department of Health

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Thomas O. Forslund, Director — Governor Matthew H. Mead

July 14, 2017

Ref: DMM-2017-012

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 danielle.marks@wyo.gov.

Sincerely,

Danielle M. Marks, MSW, MPH, Unit Manager
Maternal and Child Health
Public Health Division

DMM/dm

c: Stephanie Pyle, MBA, Acting Senior Administrator, Public Health Division
Debra Wagler, Region VIII, Health Resources and Services Administration

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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

Executive Summary

The mission of the Wyoming Maternal and Child Health (MCH) Unit is to improve the health and well-being of Wyoming families and communities by supporting and collaborating on public health activities that benefit the health of mothers, infants, children, youth, and young adults, including those with special health care needs.

From 2013-2015, a Maternal and Child Health (MCH) Planning Group consisting of internal MCH staff (e.g. Title V Director, Program Managers, MCH Epidemiology staff) developed and implemented a needs assessment process based on the six-step Peterson and Alexander Needs Assessment process. The 2015 MCH Needs Assessment resulted in the selection of seven priorities for 2016-2020:

- 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

In 2015-16, to prepare for strategic planning, MCH program managers researched evidence-based strategies to address each priority and accompanying NPM or State Performance Measure (SPM) and participated in technical assistance (TA) opportunities at both the regional and national level related to the development of evidence-based strategy measures (ESMs). A contractor, Lolina, Inc., began facilitating the strategic planning process in early 2016. The strategic planning process included ongoing leadership development activities based on the Strengthsfinder 2.0 assessment, revisions to the MCH vision, mission, and core principles, stakeholder engagement to review potential strategies and ESMs, and the development and ongoing monitoring of a state action plan. Continuing into Fiscal Year (FY) 17, the goal is to hold internal action plan reviews quarterly and convene program-specific advisory groups annually to review and guide each program's action plans.

Accomplishments and Priority Needs by Domain

A summary of MCH accomplishments including 2016-2020 priorities, related NPM or SPM, updated data for these measures, and related strategies are described by domain in the sections below.

Women/Maternal Domain		
Priority	**NPM/SPM**	**Status of NPM/SPM**
Prevent infant mortality	NPM 2: Percent of cesarean deliveries among low-risk first births (National Vital Statistics System)	In 2015, 17.8% of low-risk first births were cesarean deliveries compared to 21.4% in 2014.
Improve access to and promote use of effective family planning	SPM: Number of hospitals billing Medicaid for immediate postpartum (IPP) long-acting reversible contraception (LARC)	Due to this being a new measure, there are no data available for this reporting year.

The Coordinated Efforts to Reduce Preterm Birth Workgroup (now referred to as the Coordinated Efforts to Improve Maternal and Infant Health Workgroup) continued to guide Wyoming's infant mortality reduction efforts in FY16 with a focus on consumer and provider education about the importance of waiting 39 weeks to deliver and provider payment disincentives. As a result of strategic planning in late FY16, the Women and Infant Health Program (WIHP) expanded the group's focus to include efforts to reduce low-risk cesarean deliveries, a newly selected NPM, and to promote the use of 17 alpha-hydroxyprogesterone caproate (17P), an evidence-based strategy to reduce preterm birth. The WIHP also built partnerships in FY16 related to family planning in order to prepare for release of the Association of State and Territorial Health Officials (ASTHO) Increasing Access to Contraception Learning Community application. The team was accepted as a Cohort 3 state in October 2016 and continues to lead efforts to improve access to IPP LARC in Wyoming hospitals.

Perinatal/Infant Domain		
Priority	**NPM/SPM**	**Status of NPM/SPM**
Prevent infant mortality	SPM: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU) (National Vital Statistics System)	In 2016, 62% (62/100) of VLBW infants in Wyoming were born at facilities with the appropriate level of care, well below the 83.7% target set by Healthy People (HP) 2020.
Improve breastfeeding duration	NPM 4a: Percent of infants who are ever breastfed (National Immunization Survey (NIS))	In 2013, 89.7% of infants were ever breastfed compared to 86.3% in 2012.
Improve breastfeeding duration	NPM 4b: Percent of infants breastfed exclusively through 6 months (NIS)	In 2013, 27% of infants were exclusively breastfed through 6 months compared to 25.8% in 2012 and 16.2% in 2011.

As a strategy to improve risk appropriate care, MCH and MCH Epidemiology, with the support and guidance of the Coordinated Efforts Workgroup, piloted the Levels of Care Assessment Tool (LOCATe) in early FY16 to determine levels of neonatal and maternal care for Wyoming hospitals. All Wyoming delivering hospitals completed the LOCATe tool. Currently, facilities are reviewing and verifying facility reports. A state level report will be developed to share neonatal and maternal levels by facility and outcomes aggregated by level of care. Assessment results revealed opportunities for quality improvement efforts with hospitals (e.g. implementation of patient safety bundles) which began in FY17 and will continue into FY18.

In FY16, the WIHP completed an environmental scan of breastfeeding support resources as part of the ASTHO Breastfeeding Learning Community. The scan content was shared on MCH's website and will inform future breastfeeding initiatives. MCH assisted public health nurses (PHN) attendance at Certified Lactation Counselor (CLC) trainings. In partnership with Women, Infants, and Children (WIC) and the Chronic Disease Prevention Program (CDPP), MCH applied to participate in Year 3 of the ASTHO Breastfeeding Learning Community, a project focused on improving breastfeeding supportive hospital practices. In FY17, a hospital mini-grant program, Wyoming's 5 Steps to Breastfeeding Success', was developed and four hospitals will be awarded mini-grants up to $7,500. Project updates will be shared in the FY17 annual report.

Child Domain		
Priority	**NPM/SPM**	**Status of NPM/SPM**
Promote preventive and quality care	NPM 6: Percent of children (10-71 months) receiving developmental screen using a parent-completed tool (National Survey of Children's Health (NSCH))	In 2012, 28.8% of children ages 10 months to 5 years had a development screen completed in a healthcare setting. This is below but not significantly different from the US at 30.8%.
Prevent injury in children	SPM: Rate of hospitalization for (non-fatal) injury per 100,000 children (1-11 yrs) (Wyoming Hospital Discharge Data)	In 2015, the non-fatal injury hospitalization rate for children was 25.3 hospitalizations per 100,000 children 1-11 years.
Reduce and prevent obesity in children	NPM 8: Percent of children (6-11 years) who are physically active at least 60 minutes per day (NSCH)	In 2012, 39.7% of children ages 6-11 years were physically active for at least 60 minutes per day.

Throughout FY16, the Child Health Program Manager (CHPM) worked with the Wyoming Help Me Grow (HMG) Leadership and Sustainability Team to release a Request for Proposals (RFP) to implement HMG in Wyoming. HMG is designed to help states and communities leverage existing resources to ensure communities identify vulnerable children, link families to community-based services, and empower families to support their children's healthy development through the implementation of four Core Components: Child Health Care Provider Outreach, Family and Community Outreach, Centralized Access Point, and Ongoing Data Collection and Analysis. In October 2016, Wyoming 211 was awarded the contract and in January 2017, HMG officially launched.
In FY18, the strategy related to childhood obesity will be revised to include development of a children's physical activity workgroup. In FY17, MCH convened representatives from Wyoming Department of Health (WDH) and Wyoming Department of Education (WDE) to plan collaborative efforts.

In FY16, the CHPM worked closely with Safe Kids Wyoming (SKW) to identify evidence-based strategies for preventing the top causes of unintentional injury. These strategies were incorporated into the contract with SKW beginning Fall 2016. In FY17, two new staff will join the Wyoming Injury Prevention Program which will greatly enhance the partnership opportunities related to reducing both intentional and unintentional injury among MCH populations.

Adolescent Domain		
Priority	**NPM/SPM**	**Status of NPM/SPM**
Promote healthy and safe relationships in adolescents	SPM: Percent of teens reporting 0 occasions of alcohol use in the past 30 days (Wyoming Prevention Needs Assessment (PNA))	In 2016, 68.2% of Wyoming High School students reported zero occasions of alcohol use in the past 30 days. The target for 2017 is 70%. The target for 2018 is 72%.
Promote preventive and quality care in adolescents	NPM 10: percent of adolescents with a preventive services visit in the last year (NSCH)	In 2012, 81.1% of adolescents ages 12 through 17 had a preventive medical visit in the past year.

In FY16, two staff from WDH began training as coaches in Communities that Care (CTC), an evidence-based framework that uses prevention science to increase protective factors in communities. Youth from CTC communities are more likely to delay initiation of alcohol and tobacco use among other measures. Three communities will be identified through an RFP process in FY17/18 to participate in the CTC strategy to evaluate effectiveness for Wyoming communities.

In order to address NPM 10, the Youth and Young Adult Health Program (YAYAHP) convened a Well-visit/Early Periodic Screening Diagnosis and Treatment (EPSDT) team including representatives from Medicaid, Kid Care Children's Health Insurance Program (CHIP), WDH, Wyoming Family Voices, Wyoming American Academy of Pediatrics (WY-AAP), Wyoming Primary Care Association (WYPCA), Optum (Medicaid contractor), youth, and young adults. In 2016, this team identified barriers to well-visits in Wyoming and applied for Cohort 2 of the Adolescent and Young Adult Health (AYAH) Collaborative Improvement and Innovation Network (CoIIN). In February 2017, the team was notified of acceptance. The team will use the Adolescent Centered Environment Assessment Process (ACE-AP) from the University of Michigan as a strategy to improve the quality of the adolescent clinical environment.

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 as strategies to promote healthy and safe relationships in adolescents.

Children with Special Health Care Needs (CSHCN) Domain		
Priority	**NPM/SPM**	**Status of NPM/SPM**
Promote preventive and quality care in children and adolescents	NPM 11: Percent of children with and without special health care needs having a medical home (NSCH)	In 2012, 63.5% of children (ages 0-17) without special health care needs had a medical home. In 2012, 42.8% of children (ages 0-17) with special health care needs had a medical home.
Promote preventive and quality care in children and adolescents	NPM 12: percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care (National Survey of Children with Special Health Care Needs (NS-CSHCN)	In 2012, 47.4% of adolescents with and without special health care needs received services necessary to make transitions to adult health care.

One of the strategies selected to increase access to medical home is the Wyoming Parent Partner Program (PPP). This evidence-informed program helps medical homes identify/hire a parent within their practice who has a child with a special health care need. In FY16, approximately 217 families were served by Parent Partners in Fremont County, Natrona County and through multiple satellite locations. The CHPM has connected with the Clinical Quality Directors of both the WYPCA and the Wyoming Institute for Population Health to discuss medical home collaborations. In September 2017, MCH will partner to support a PCMH Training. This will give MCH an opportunity to highlight the importance of family engagement policies, EPSDT visits, and other MCH Priorities.

In order to improve transition among children and youth, MCH is leading a team to assess available transition resources from *Got Transition* in order to develop a Wyoming specific toolkit for providers and consumers. A comprehensive training for PHN that work with children and youth with special health care needs (CYSHCN), planned for Fall 2017, will contain a medical transition component to enhance the care coordination provided.

Cross-Cutting/Life Course		
Priority	**NPM/SPM**	**Status of NPM/SPM**
Prevent infant mortality	NPM 14a: Percent of women who smoke during pregnancy	In 2015, 15.2% of women smoked during pregnancy compared to 16.9% in 2014.

During FY16, the WIHP and MCH Epidemiology worked with the Tobacco Prevention and Control Program, the WY Quitline contractor, and a marketing firm hired to promote the WY Quitline services to develop resources specific to the Pregnancy and Postpartum Protocol and the American Indian Commercial Tobacco Protocol.

In FY17, the Women and Infant Health Program Manager (WIHPM) attended a train-the-trainer session for Smoking Cessation and Reduction in Pregnancy (SCRIPT) at the Society for Public Health Education (SOPHE) conference in Denver, CO. The WIHPM will use data to target training on this evidence-based program within PHN offices and possibly within federally qualified health centers (FQHCs). The SCRIPT program will also help to increase referrals to the WY Quitline.

II. Components of the Application/Annual Report

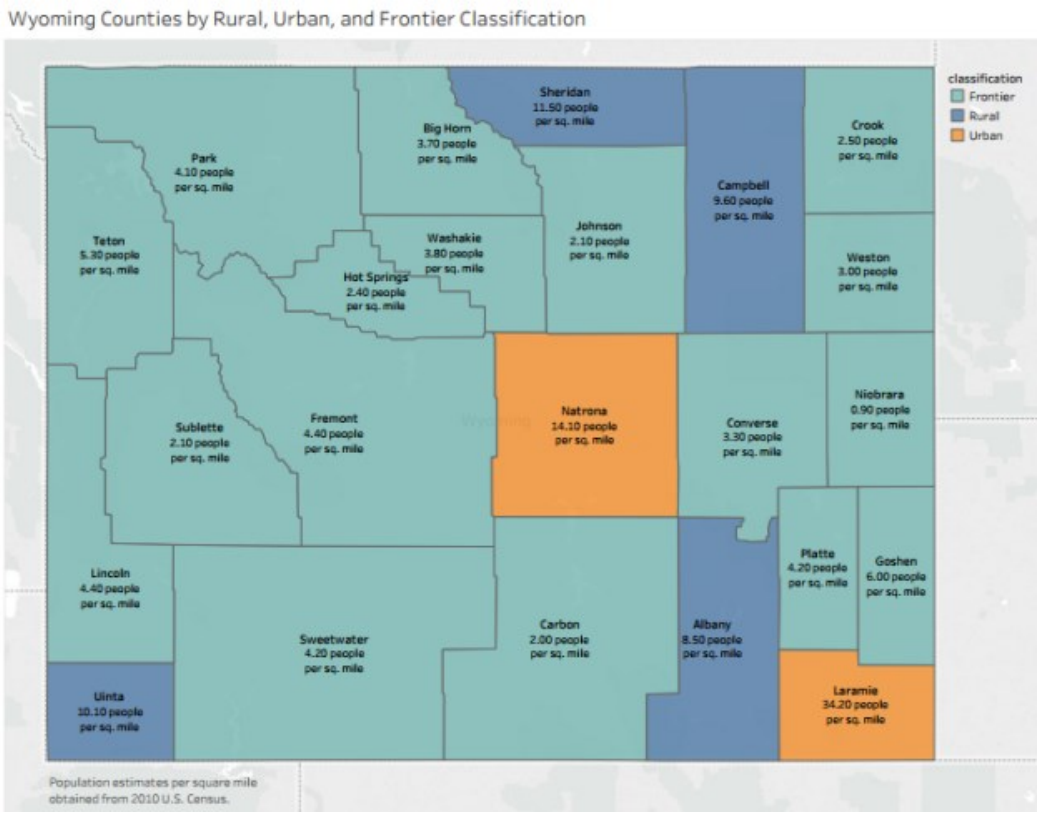
II.A. Overview of the State

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 toward the center of the state, is home to two federally recognized tribes, the Eastern Shoshone and the Northern Arapaho tribes.

Wyoming is the least populous state in the U.S. with an estimated population of 585,501 (2016 estimate, American FactFinder). The population is predominantly White alone (92.8%). The remaining population is Black or African American alone (1.3%), 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 (10%) (2016, 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 $58,840. Persons in poverty are estimated to be 11.1% of the population (U.S. Census Bureau).

Wyoming is a rural/frontier state. Two counties, Laramie and Natrona, each have a town with over 60,000 people and are considered urban. Seventeen of the remaining 21 counties are considered frontier with less than 6 persons per square mile (U.S. Census Bureau). 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 unemployment rate (2017 Quarter One) is 4.7 percent, the same level as in the U.S.. Wyoming experienced a decline of 2.8 percent (or 7,770 jobs) in total employment in the first quarter of 2017 compared to one year earlier. 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 (2016), 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 ages 1-24 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.

In 2015, the percentage of Wyoming citizens (non-institutionalized) without health insurance coverage was 11.5%, not statistically different from a percentage of 12% in 2014.

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. Results of the recently administered Centers for Disease Control and Prevention (CDC)-developed Levels of Care Assessment Tool (LOCATe) found that Wyoming lacks Level III facilities for both neonatal and maternal levels of care. This requires families to travel long distances for health care, 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) Services Title V Block Grant is managed by the MCH Unit within the Community Health Section (CHS) and 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:

- Implement Medicaid reform, including improving health outcomes while containing cost and redesigning waivers to increase access;
- Redesign the mental health and substance abuse system to improve outcomes;
- Focus on Wyoming's significant public health problems (e.g. suicide and tobacco and alcohol use) to improve overall health outcomes;
- 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;

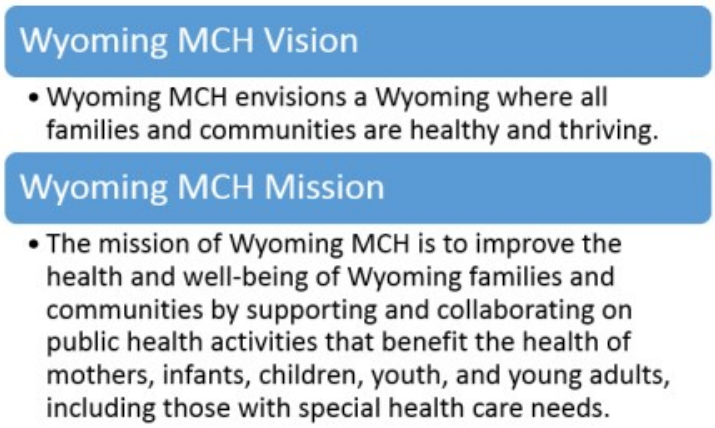
- Support the integration of public health and health care;
- Foster a competent, flexible workforce; and
- Build a sustainable, cohesive organization

Several work groups continue to address each of these PHD strategic priorities. For example, the workgroup working to foster a competent, flexible workforce facilitates completion of an assessment of the Core Competencies for Public Health Professionals by all staff. This valuable tool helps staff identify opportunities for professional development related to public health practice.

As part of the accreditation application, WDH is working to complete the required state health assessment (SHA) and the state health improvement plan (SHIP). A member of the MCH Epidemiology staff is on the leadership team for the assessment. The goal is to incorporate life course indicators as the foundation of the SHA.

The MCH Unit provides leadership for state and local level efforts that improve the health of the maternal and child health population. In 2016, the MCH Unit updated its vision, mission, and core principles.

MCH Vision and Mission



Core Principles:

Wyoming's Title V allocation is based on the total numbers of women of child bearing age (15 to 44 years); infants and children ages 0 to 18; and the number of individuals ages 0 to 44 living in poverty.

The 2015 MCH Needs Assessment resulted in the selection of seven priorities for 2016-2020:

- 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

Medicaid expansion in Wyoming has not been approved by the state legislature. Wyoming has only one plan, Blue Cross Blue Shield (BCBS), participating in the Federal Health Insurance Marketplace.

The MCH Unit's Children's Special Health (CSH) program offers care coordination and limited, gap-filling financial assistance as the payer of last resort for enrolled clients who meet medical and financial eligibility criteria. In order to be eligible for assistance, families must first apply for Medicaid, Kid Care Children's Health Insurance Program (CHIP) and the Federal Marketplace. The program provides reimbursement to eligible providers for covered services provided to eligible clients.

State statutes relating to MCH

Three state statutes impact the work of MCH. The Newborn Screening (NBS) statute, Wyoming Statute (Wyo. Stat). § 35-4-801 and 802, mandates newborn screening be available to all newborns and that WDH provide necessary education on newborn screening 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 analysis and communication 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 second statute, Wyo. Stat. § 35-27-101, 102, 103, 104, Public Health Nurses (PHN) Infant Home Visitation Services, was passed in 2000. The statute directs PHN to contact eligible women to offer home visitation services as part of the Healthy Baby Home Visitation (HBHV) Program, a program consisting of two models. The initial intent of the legislation 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 was provided in 13 counties until State Fiscal Year (SFY) 2017 during which 11 counties implemented NFP. During 2016, MCH and MCH Epidemiology completed a process evaluation of NFP to determine which counties have the birth cohort and capacity to deliver the model with fidelity. As of July 1, 2017, 5 counties (Albany, Campbell, Carbon, Natrona, and Sweetwater) deliver NFP. All counties deliver the program's second model, Best Beginnings (BB), a home-grown home visiting model based on the research-informed Partners for a Healthy Baby curriculum developed at Florida State University. TANF dollars are combined with MCH state general funds to provide MCH services (which include home visiting) in each County. In 2017, the program required counties to complete a funding application to help determine local level budgetary needs. MCH executes a Memorandum of Understanding (MOU) with each county which outlines deliverables required to receive funding.

The third related statute, 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. During the 2017 Wyoming legislative session, restrictions for spending state general funds on contraceptives were added to the budget through a footnote. MCH supported gap-filling contraceptive purchases for counties with little to no Title X services in FY16 and through State Fiscal Year 2017 but will discontinue support in SFY 2018 while we reevaluate best strategies for increasing access to the wide range of contraceptive options. MCH will continue to partner closely with Wyoming's Title X grantee, Wyoming Health Council (WHC), to improve access to family planning services.

II.B. Five Year Needs Assessment Summary and Updates

FY 2018 Application/FY 2016 Annual Report Update

Needs Assessment Summary Update

Process Summary: Between 2013-2015, an MCH Planning Group consisting of internal MCH staff (e.g. Title V Director, Program Managers, MCH Epidemiology staff) involved internal and external stakeholders, including community stakeholders in 10 of 23 counties, in the review of state health indicators and potential priorities, requesting input using a variety of methods (e.g. partner surveys, community meetings) throughout the 2-year process. Potential priorities were assessed according to five key factors: magnitude/extent of the issue, availability of public health strategies and MCH responsibility, health equity, life course impact, and political will/capacity. The team also completed the Capacity Assessment for State Title V (CAST-5) for each potential priority and a strengths, weaknesses, opportunities, and threats (SWOT) analysis for each potential national performance measure (NPM), the results of which were shared with stakeholders and considered in the selection of final priorities. Wyoming MCH Priorities were selected and approved by a steering committee in 2015.

During the next year, program managers researched evidence-based strategies to address each priority and accompanying NPM or State Performance Measure (SPM) and participated in technical assistance (TA) opportunities at both the regional and national level related to the development of evidence-based strategy measures (ESMs), a new requirement of MCH 3.0 and current Title V block grant guidance. To further assist the Unit in strategic planning, 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 in early 2016.

Strategic Planning Update: In April 2016, the MCH Unit met twice with Lolina, Inc. to build a foundation for strategic planning work including assessments of team and individual strengths. Beginning in 2015 and continuing through early 2016, each program reviewed available research on evidence-based strategies for each MCH priority and selected NPM or SPM. The programs relied on the 'Strengthening the Evidence' tools and where available, Collaborative Improvement and Innovation Network (CoIIN) tools such as change packages and driver diagrams to provide guidance for strategy selection. On May 9, 2016, MCH programs met with Lolina, Inc. to complete a first draft of population specific action plans and on May 25, 2016, advisory groups comprising 10-15 stakeholders per program met to review potential evidence-based strategies and measures and provide feedback.

In July, October, December 2016 and April 2017, each program conducted an internal review of progress on their respective action plans. The goal is to hold internal action plan reviews quarterly and convene program-specific advisory groups annually to review and guide each program's action plans.

MCH Population Needs: Updates to data included in our original needs assessment are included below:

Women's/Maternal

- 14.1% of new moms reported smoking during the last three months of pregnancy (Pregnancy Risk Assessment Monitoring System (PRAMS) 2014);
- Among Wyoming reproductive age women (18-44 years), less than half (46.0%) had a healthy Body Mass Index (BMI) (Behavioral Risk Factor Surveillance System (BRFSS), 2016) (cross cutting); and
- In 2014, 26.0% of pregnant women gained adequate weight during pregnancy; 53.7% gained excessive and 20.3% gained insufficient weight (PRAMS).

Perinatal/Infant

- In 2016, Wyoming (9.5%) met the preterm (<37 weeks) Healthy People (HP) 2020 goal of 11.4% (Vital Statistics Services (VSS));
- In 2015, 17.8% of Wyoming births were low-risk Cesarean deliveries (VSS); and
- Between 2012-2016, the Wyoming infant mortality rate was 4.7 per 1,000 live births compared with 5.8 in the US in 2014 (VSS)

Child

- 59.4% of children received care in a medical home (National Survey of Children's Health (NSCH), 2011-2012) (cross cutting);
- Among children ages 10-11 years old in Wyoming, 40.6% were reported to be overweight or obese; 73.8% of children 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 Wyoming, 56.1% reported being bullied on school property, the highest of any participating state (Youth Risk Behavior Surveillance System (YRBSS) middle school, 2013); and
- Leading causes of death among children include: unintentional injury, malignant neoplasms, congenital anomalies, and homicide (Web-based Injury Statistics Query and Reporting System (WISQARS), 2005-2015).

Adolescent

- The teen birth rate in Wyoming is 26.2 per 1,000 teens girls aged 15-19 (VSS, 2016);
- 8.0% of Wyoming high school students reported intimate partner violence (YRBSS, 2015);
- Wyoming adolescents are less likely than the adolescents nationally to self-report being overweight or obese (28.9% v. 31.5%), and more likely to report meeting the physical activity recommendations of 60 minutes per day, 5 or more days per week (YRBSS, 2015) (cross cutting);
- Parents reported that 60% of adolescents 12-17 had experienced at least one adverse childhood experience in Wyoming (NSCH, 2011-2012);
- Wyoming's suicide rate among teens is more than double the national rate (19.2 compared to 8.7 per 100,000 teens) (VSS and WISQARS, 2004-2015); and
- Wyoming's death rate due to motor vehicle crashes (MVC) is double the national rate (29.7 v. 15.5 per 100,000) (VSS and WISQARS, 2004-2015).

Children with Special Health Care Needs

- Only 42.8% of children with special health care needs (CSHCN) received care in a medical home compared with 63.5% of non-CSHCN (NSCH, 2011-2012); (cross cutting)
- 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 (National Survey of Children With Special Health Care Needs (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/Life Course

- Cross cutting measures are reported within individual populations

1. **State's Health Care Delivery Environment Updates**

Medicaid expansion in Wyoming has not been approved by the state legislature. No efforts to expand Medicaid took place during Wyoming's 2017 session due to uncertainty around the future of the Affordable Care Act (ACA).

2. **Title V Program Capacity Updates**

   a. **Organizational Structure**

   An updated organizational structure is attached. The primary updates related to Title V is the hiring of a new MCH Unit Manager/Title V Director in October 2016, new MCH epidemiologists in Summer 2016, and a new WIHPM in February 2017. In addition, one CSH Benefits and Eligibility Specialist now spends 50% of her time supporting the PRAMS program.

   b. **Agency Capacity Updates**

   Beginning July 1, 2017, WDH and Wyoming Department of Family Services (DFS) will be combined under current WDH leadership.

   In 2016, the WDH State Epidemiologist position became vacant and was filled in 2017. The new State Epidemiologist and Public Health Sciences Section Chief is a board certified pediatrician and trained epidemiologist and was previously an Epidemiologic Intelligence Service Officer in Wyoming where she worked closely with the MCH Unit and MCH Epidemiology Program. She is also the current acting State Health Officer.

   In 2017, the WDH State Health Officer and PHD Senior Administrator resigned after 5 years with the department.

   MCH continues to have a direct presence in 22 of 23 counties through an MCH MOU which provides funding to counties to provide home visiting and other MCH services related to Wyoming MCH priorities.

3. **MCH Workforce Development and Capacity Updates**

   The Youth and Young Adult Health Program (YAYAHP) is hoping to increase the number of paid youth volunteers supporting MCH programs and the number of youth and young adult members of the Wyoming Youth Council.

   Currently, MCH does not have a family/parent representative on staff. As discussed in the Family/Consumer Partnership section, family engagement remains a priority and will be a focus in FY18.

   MCH Unit staff tenure varies from 35 years to 4 months. It is expected that a couple staff may retire in the next five years. Staff are encouraged to maintain updated desk manuals to plan for expected and unexpected staff turnover.

4. **Partnership, Collaboration, and Coordination Updates**

   a. **Other MCHB investments**

   Wyoming was not selected to receive Early Childhood Comprehensive Systems (ECCS) funding in 2016. However, carry-over funds continue to support the work of Help Me Grow (HMG).

MCH continues to partner with Parents as Teachers, the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) grantee in Wyoming to build a network of home visiting organizations.

The State Systems Development Initiative (SSDI) supports the data work of Title V by partially funding an MCH Epidemiologist. SSDI also supports data collection and quality efforts; including partially funding Wyoming Vital Records participation in the State and Territorial Exchange of Vital Events program, improving quality control in the Vital Records data collection system, and gaining access to necessary WIC data.

b. Other Federal investments

MCH continues to partner with Wyoming's Title X grantee, WHC, to ensure optimal coordination of activities related to family planning. Quarterly meetings are ongoing. Since the last annual report was submitted, we have begun collaborative efforts to increase access to long-acting reversible contraception (LARC).

c. Other HRSA programs

The Wyoming Primary Care Association (WYPCA) is a key partner in MCH's infant mortality reduction and family planning promotion efforts. The Child Health Program (CHP) is partnering with WYPCA to provide training on the new National Committee for Quality Assurance Patient Centered Medical Home (PCMH) standards released in early 2017.

d. State and Local MCH programs

MCH continues to have a direct presence in 22 of 23 counties through an MCH MOU which provides funding to counties to provide home visiting and other MCH services related to Wyoming MCH priorities. Services are provided by PHNs.

e. Other programs within the Department of Health

In order to improve communication and collaboration between MCH and MCH Epidemiology and ensure that the MCH needs assessment is an ongoing process, the MCH Unit Manager and MCH Epidemiology Program Manager re-instituted monthly staff meetings in 2017.

In late 2016, the MCH Unit Manager and Unit Manager of the Rural and Frontier Health (RFH) Unit began discussions about possible collaboration. Two key areas of collaboration arose: (1) collaborating to incorporate telehealth into the provision of regional genetics clinics, and (2) identifying common goals between the MCH supported HBHV Program and the RFH Unit administered Community Service Block Grant.

f. Tribes

MCH and MCH Epidemiology continues to provide support to members of the Fremont County Fetal and Infant Mortality Review (FIMR) Advisory Committee (formerly the planning committee) to implement FIMR in Fremont County, the county where the WRIR is located.

The Wyoming PRAMS project continues to sample all births to Native American women. In September 2016, MCH Epidemiology staff and the Director of the Northern Arapaho Recovery program presented the use of PRAMS data to inform efforts of the Tribal Tobacco Prevention and Control Program.

g. Public Health and Health professional educational programs and universities

Several MCH and MCH Epidemiology staff participated in graduate level MCH courses at the

Colorado School of Public Health through the MCH-Link Scholarship Program.

MCH Epidemiology participated in the CDC-University of Illinois, Chicago (UIC) analytic Capacity Building course. The Wyoming team chose to focus their project for the course on analysis of hospital discharge data an unintentional injuries in children.

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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
    - **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
    - **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
    - **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
  - **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
  - **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
  - **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
  - **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
  - **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
- **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
- **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
  - **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
  - **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
  - **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
(as submitted with the FY 2016 Application/FY 2014 Annual Report)

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 CoIIN 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 CoIIN 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 CoIIN, 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 CoIIN. 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 CoIIN 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 CoIIN and the PHD Tobacco Program is involved with the CoIIN.
- **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 (CoIIN) for Infant Mortality expanded to include all states. Following the Infant Mortality CoIIN 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 CoIIN. 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 CoIIN 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.

Incrsing 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 CoIIN 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 CoIIN. The PCA is kept informed of activities occurring within the CoIIN.

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 CoIIN 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 CoIIN 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

State Selected Priorities

State Selected Priorities have not changed since the submissions of Application/Annual Reports for FY2017/2015 or FY2016/2014.

Prevent Infant Mortality: Infant mortality reduction was a priority in 2011-2015 and continues as a priority in 2016-2020. Though infant mortality rates statewide are similar to the nation, disparities exist by geography and race/ethnicity. Strategies will continue to address these disparities including the Fremont County FIMR pilot.

Improve Breastfeeding Duration: Improving breastfeeding was a priority in 2011-2015 and continues as a priority in 2016-2020 with greater emphasis on duration. Since selecting this state priority, Wyoming met the HP 2020 for NPM4b. Evidence-based hospital-based breastfeeding improvement efforts are underway in FY17 to continue positive trends in improving breastfeeding initiation and duration.

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 (WIHP) and the YAYAHP. Increasing capacity to offer and provide immediate postpartum (IPP) LARC is the current focus of the priority. In FY18, the programs will also focus on consumer education on the wide range of contraceptive methods.

Reduce and Prevent Childhood Obesity: Reducing childhood obesity was a priority in 2011-2015 and continues as a priority in 2016-2020 with a narrowing focus on improving physical activity. Childhood obesity has continued to increase in Wyoming. Collaborative efforts between MCH and the Chronic Disease Prevention Program (CDPP) are warranted to prevent negative life course effects resulting from childhood obesity.

Promote Preventive & Quality Care for Children & Adolescents: This priority contains separate foci for the child and adolescent populations. For the child population, this priority has two focus areas ensuring children have access to a medical home and receive age-appropriate developmental screenings as recommended by the American Academy of Pediatrics (AAP). For the adolescent population, the priority focuses on increasing adolescent well-visit rates and improving transition to adult health care for adolescents with and without special health care needs.

Promote Healthy and Safe Relationships in Adolescents: This priority builds on the 2011-2015 priority to "design and implement initiatives that address interpersonal violence (IPV)." The 2016-2020 priority was selected due to Wyoming's high teen birth rate, early initiation of sexual activity, incidence of teen dating violence, and alcohol and drug use prior to sexual activity. The updated priority focuses beyond IPV to include prevention of risky sex behavior. Through a shared risk and protective factor approach, Wyoming is implementing strategies that support healthy sexuality and sexual violence prevention and promote positive youth development.

Prevent Injury in Children: Preventing injury in children was a priority in 2011-2015 and continues as a priority in 2016-2020 with a narrowing focus on the top three causes of unintentional injury. Injury represents two of the top five causes of death among children one to eleven in Wyoming. Unintentional injury is first and homicide is third.

The selection of Wyoming MCH priorities considered the relevance and availability of NPMs. The following table aligns the state selected priorities, domains, NPMs and SPMs.

Wyoming MCH State Selected Priorities and Related National Performance Measures			
State Selected Priority	**Domain**	**NPM #**	**SPM**
Prevent Infant Mortality	**Women/Maternal**	2 (Low Risk C-Section)	No
	Perinatal/Infant	No	Yes; Risk appropriate perinatal care
	Cross-Cutting/ Life Course	14a (Smoking during pregnancy)	No
Improve Breastfeeding Duration	**Perinatal/Infant**	4a/4b (Breastfeeding initiation and exclusivity)	No
Improve Access to and Promote Use of Effective Family Planning	**Women/Maternal**	No	Yes; IPP LARCs billed to Medicaid
Reduce and Prevent Childhood Obesity	**Child**	8 (childhood physical activity)	No
Promote Preventive and Quality Care for Children and Adolescents	**Child**	6 (Developmental screening)	No
	Adolescent	10 (Adolescent well-visit)	No
	CSHCN	11 (Medical home)	No
	CSHCN	12 (Transition)	No
Promote Healthy and Safe Relationships in Adolescents	**Adolescent**	No	Yes; Teen alcohol use
Prevent Injury in Children	**Child**	No	Yes; non-fatal injury hospitalizations in children

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

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

Wyoming selected eight required NPMs, listed below, that closely matched the state selected priorities.

NPM 2 - Percent of cesarean deliveries among low-risk first births
Cesarean delivery can be a life-saving procedure for certain medical indications. However, for most low-risk pregnancies, cesarean deliveries are associated with increased risk for both mother and infant and have the potential to complicate subsequent pregnancies. Cesarean deliveries are more costly to the health care system. This NPM aligns closely with 'Prevent Infant Mortality' priority. Through Wyoming's participation in the CoIIN to Reduce Infant Mortality, three focus areas were identified within this priority. NPM 2 aligns well with the focus area of preventing pre and early term births.

NPM 4a - Percent of infants who are ever breastfed
NPM 4b - Percent of infants breastfed exclusively through six months
Breastfeeding duration was chosen as a priority for Wyoming. The AAP recommends all infants exclusively breastfeed for about six months as human milk supports optimal growth and development by providing all required nutrients during that time. Foundational work for this priority began in FY16 through a grant from the Association of State and Territorial Health Officials (ASTHO) to complete an environmental scan of breastfeeding resources. The provision of breastfeeding support is essential to assist with improving duration of breastfeeding. Despite recent improvements in Wyoming's exclusive breastfeeding rates, work is ongoing to sustain improvements to now include hospital-based improvement efforts to improve breastfeeding supportive maternity care practices.

NPM 6 - Percent of children (10-71 months) receiving developmental screen using a parent-completed tool
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. MCH capacity and partnerships necessary to address this NPM are strong due to the focus on developmental screening activities through the ECCS grant, the CSH program and partnership with other home visiting programs across the state that prioritize developmental screening.

NPM 8 - Percent of children (6-11 years) who are physically active at least 60 minutes per day
Prevention and reduction of childhood obesity was selected as a Wyoming priority for 2016-2020. Physical activity in children reduces the risk of cardiovascular disease, hypertension, Type II diabetes, and osteoporosis. NPM 8 aligns with current activities within MCH and the CDPP and presents opportunities for collaboration. Due to the strength of partnerships between MCH and statewide early childhood partners, MCH will also track progress on the Prevent and Reduce Childhood Obesity priority for the early childhood period by using Women, Infants, and Children (WIC) data on the percent of children ages 2-5 receiving WIC with a BMI at or above the 85th percentile.

NPM 10 - Percent of adolescents (12-17 years) with a preventive medical visit in past year
Connecting youth and young adults to preventive medical care is an integral step in promoting wellness. Adolescent well-visits are essential to providing quality and preventive care for adolescents. Youth with special health care needs enrolled in the CSH program are encouraged to have an annual well-visit. Additionally, well-visits are critical to adequate transition planning and access to contraception, two additional Wyoming MCH priorities.

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

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

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 into adulthood. Transition to adulthood is a component of the priority to promote preventive and quality care for children and adolescents.

NPM 14a - Percent of women who smoke during pregnancy

Wyoming's high rates of tobacco use made this NPM selection essential. Smoking among pregnant women in Wyoming is approximately 16%. Maternal smoking contributes to infant mortality and is one of the focus areas of the infant mortality prevention priority selected in Wyoming. Through Wyoming's participation in the CoIIN to Reduce Infant Mortality, three focus areas were identified within this priority. NPM 14a aligns with the focus area of reducing maternal smoking. MCH plans to work with the WDH Tobacco Control and Prevention Program and tribal partners to reduce disparities among pregnant American Indian women.

The following table aligns the state selected priorities, domains, and NPMs.

Wyoming MCH State Selected Priorities and Related National Performance Measures		
State Selected Priority	**Domain**	**NPM #**
Prevent Infant Mortality	**Women/Maternal**	2 (Low Risk C-Section)
	Cross-Cutting/ Life Course	14a (Smoking during pregnancy)
Improve Breastfeeding Duration	**Perinatal/Infant**	4a/4b (Breastfeeding initiation and exclusivity)
Improve Access to and Promote Use of Effective Family Planning	**Women/Maternal**	No
Reduce and Prevent Childhood Obesity	**Child**	8 (childhood physical activity)
Promote Preventive and Quality Care for Children and Adolescents	**Child**	6 (Developmental screening)
	Adolescent	10 (Adolescent well-visit)
	CSHCN	11 (Medical home)
	CSHCN	12 (Transition)
Promote Healthy and Safe Relationships in Adolescents	**Adolescent**	No
Prevent Injury in Children	**Child**	No

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

- SPM 1 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
- SPM 2 - Rate of hospitalization for non-fatal injury per 100,000 children ages 1 through 11
- SPM 3 - Number of Wyoming birthing hospitals billing Medicaid for immediate postpartum LARCs
- SPM 4 - Percentage of teens reporting 0 occasions of alcohol use in the past 30 days

Linkage of State Selected Priorities with State Performance Measures (SPM).

Wyoming selected two additional NPMs as SPMs to measure identified priorities resulting from the needs assessment and two unique SPMs. The selected SPMs are listed below within the appropriate domain.

SPM: # of hospitals billing Medicaid for IPP LARC

Access to effective contraception is essential to improve pregnancy timing and spacing, and health outcomes for women and children. Wyoming selected this priority with a specific focus on improving access to most and moderately effective contraception while assuring all women receive information about the wide range of available methods.

SPM: % of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Informed by the Title V needs assessment and Wyoming's participation in the CoIIN to Reduce Infant Mortality, the MCH Unit and partners identified risk appropriate perinatal care as Title V focus area within the 'Reduce Infant Mortality' priority due to the fact that Wyoming has no level III obstetric or NICUs within the state. Without an in-state Level III facility, many families must receive their care at a tertiary care facility and require a system to coordinate and facilitate this care before, during and after pregnancy. Title V is well-positioned to lead this work.

SPM: Rate of hospitalization for (non-fatal) injury per 100,000 children (ages 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 and the Safe Kids Wyoming (SKW) program to address this issue. This performance measure is associated with the identified childhood injury priority.

SPM: Percent of teens reporting 0 occasions of alcohol use in the past 30 days

Alcohol and drug use are underlying risk factors for many risky adolescent behaviors. This SPM relates to the state priority to promote healthy and safe relationships for adolescents. In February 2016, legislation passed to no longer accept federal funding to conduct the YRBSS. This SPM is available through another state source, the Wyoming Prevention Needs Assessment (PNA).

The following table aligns the state selected priorities, domains, and SPMs.

Wyoming MCH State Selected Priorities and Related State Performance Measures		
State Selected Priority	**Domain**	**SPM**
Prevent Infant Mortality	**Perinatal/Infant**	Yes; Risk appropriate perinatal care
Improve Breastfeeding Duration	**Perinatal/Infant**	No
Improve Access to and Promote Use of Effective Family Planning	**Women/Maternal**	Yes; IPP LARCs billed to Medicaid
Reduce and Prevent Childhood Obesity	**Child**	No
Promote Preventive and Quality Care for Children and Adolescents	**Child**	No
	Adolescent	No
	CSHCN	No
Promote Healthy and Safe Relationships in Adolescents	**Adolescent**	Yes; Teen alcohol use
Prevent Injury in Children	**Child**	Yes; non-fatal injury hospitalizations in children

II.F. Five Year State Action Plan

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

State Action Plan Introduction

This section presents strategies and activities identified to address the 2016-2020 MCH priorities. Following the completion of the Needs Assessment and determination of priorities in 2015, program managers researched evidence-based strategies to address the performance measure(s) assigned to each domain and/or state selected priority. Several staff also attended the two-day TA Meeting in April 2016 to aid ESM development. Selection of strategies and their corresponding ESM were determined through a strategic planning process which begin in Spring 2016.

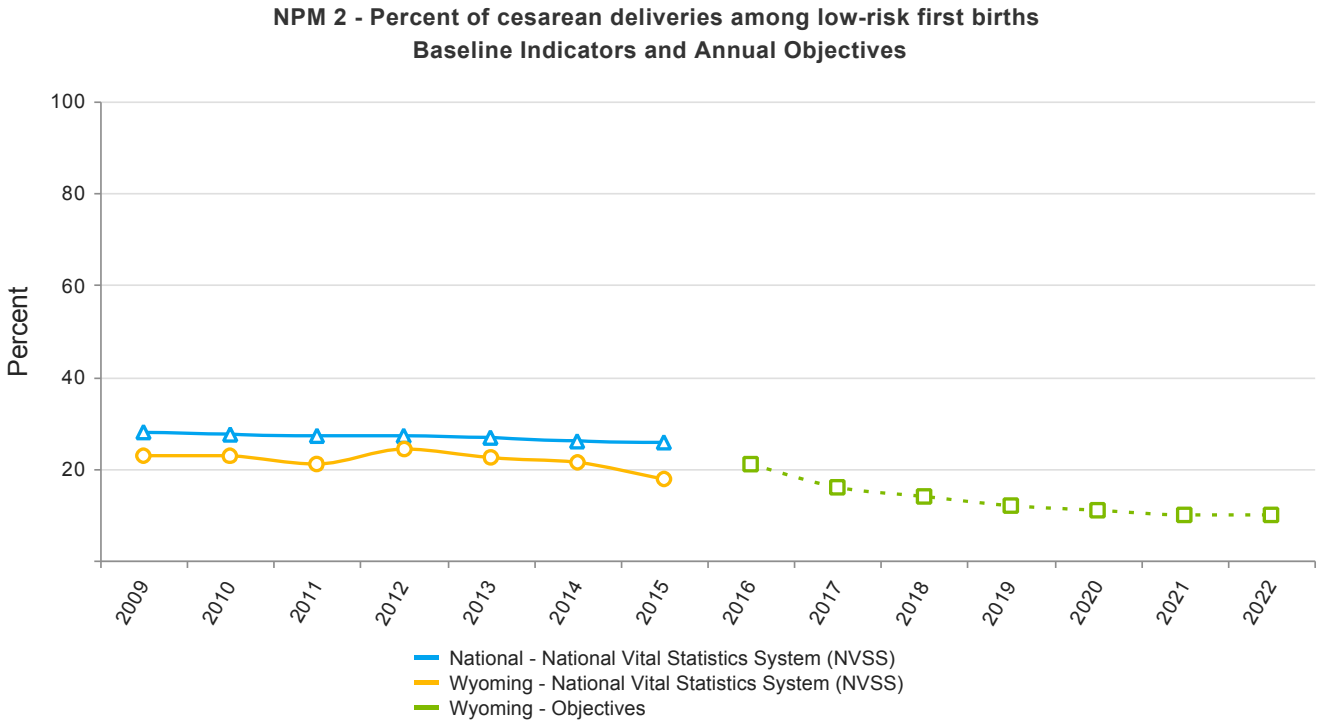
This action plan, a living document, will be reviewed internally once a quarter to monitor progress, identify challenges, and make adjustments if needed. Action plan review meetings took place in July 2016, November 2016, and April 2017. Currently, program managers are revisiting the action plan template to assure alignment with other performance management documentation requirements at the department and division level. Program managers are also working with their respective 'advisory groups' to communicate about progress and seek guidance/direction as needed, an activity to be completed at least annually.

Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2014	122.5	NPM 2
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2011_2015	Not Reportable	NPM 2

National Performance Measures



Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2016
Annual Objective	21
Annual Indicator	17.8
Numerator	418
Denominator	2,347
Data Source	NVSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	16.0	14.0	12.0	11.0	10.0	10.0

Evidence-Based or –Informed Strategy Measures

ESM 2.1 - Development of facility-specific prevalence data

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	No
Numerator	
Denominator	
Data Source	Wyoming Vital Statistics Services
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

ESM 2.2 - # of YouTube hits for HBWW video

Measure Status:	Inactive - Replaced

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	100.0	100.0	100.0	100.0	100.0	

State Performance Measures

SPM 3 - Number of Wyoming birthing hospitals billing Medicaid for immediate postpartum LARCs

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Medicaid Billing Data
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	2.0	6.0	9.0	13.0	16.0	17.0

State Action Plan Table

State Action Plan Table (Wyoming) - 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

Support quality improvement efforts to identify areas of improvement for hospitals to decrease % low-risk cesarean births

ESMs	Status
ESM 2.1 - Development of facility-specific prevalence data	Active
ESM 2.2 - # of YouTube hits for HBWW video	Inactive

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 (Wyoming) - Women/Maternal Health - Entry 2

Priority Need

Improve access to and promote use of effective family planning

SPM

Number of Wyoming birthing hospitals billing Medicaid for immediate postpartum LARCs

Objectives

Increase access to provide immediate postpartum long acting reversible contraceptives (LARCs) in hospitals as measured by the # of Wyoming birthing hospitals billing Medicaid for IPP LARC.

Strategies

Apply to participate in learning collaborative on LARC

Work with Medicaid and private payers to increase education on coverage and reimbursement for immediate postpartum LARCs

Develop IPP LARC toolkit and work with the Wyoming Hospital Association (WHA) for distribution.

Develop and disseminate consumer education on contraception options

Develop and implement provider education on contraceptive counseling

Develop and implement an environmental scan and needs assessment regarding general LARC implementation in federally qualified health centers (FQHC), Indian Health Services (IHS) clinics, Title X clinics and rural health center (RHC) settings.

Women/Maternal Health - Plan for the Application Year

A. **Application Fiscal Year 2018:** 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
NPM 2: Percent of cesarean deliveries among low-risk first births

In FY18, we plan to impact 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:

1. Develop and release facility-specific prevalence data on cesarean deliveries among low-risk first births
    a. Development of facility-specific prevalence data (Yes/No)
    b. # of facilities receiving facility-specific reports
2. Develop and implement quality improvement strategies focused on reducing low-risk cesarean deliveries
    a. # of facilities engaged in quality improvement strategies

In FY18, the WIHP will compile facility-specific prevalence data for low-risk cesarean deliveries across Wyoming. Facility-specific reports will be distributed to Wyoming hospitals with the assistance of Coordinated Efforts to Reduce Maternal and Infant Health workgroup partners, including the Wyoming Hospital Association (WHA) and Wyoming Medicaid. This will help to inform facilities where they stand in terms of low-risk cesarean deliveries, and will allow the WIHP to target quality improvement efforts. Through an ongoing partnership with the University of Utah, and the potential development of a Wyoming MCH Project ECHO (Extension for Community Healthcare Outcomes), the development and implementation of patient safety bundles focused on low-risk cesarean will target facilities with high rates of cesarean delivery among low-risk first births.

Priority: Improve Access to and Use of Effective Family Planning
SPM: # of hospitals billing Medicaid for IPP LARC

Beginning in FY18, we plan to impact the SPM -- # of hospitals billing medicaid for IPP LARC -- by implementing the following selected strategies paired with their associated evidence-based/informed strategy measures, where applicable:

1. Develop and release a comprehensive IPP LARC toolkit for Wyoming hospitals
    a. # of TA requests from hospitals regarding IPP LARC toolkit
2. Develop and disseminate consumer education on contraception options
    a. # of materials distributed
3. Develop and implement provider education on contraceptive counseling
    a. # of providers engaged in education opportunities
4. Develop and implement an environmental scan and needs assessment regarding general LARC

implementation in federally qualified health centers (FQHC), Indian Health Services (IHS) clinics, Title X clinics and rural health center (RHC) settings.

a. Completion of scan

Wyoming's participation in the ASTHO Increasing Access to Contraception learning collaborative which began in November 2016 will continue to inform the work surrounding IPP LARCs and has generated partner broad interest in increasing access to the range of methods as a way to improve maternal and infant outcomes. MCH will lead future work related to building capacity for LARC use and billing and will ensure a reproductive justice lens is applied to this work.

The WIHP is working with the YAYAHP to increase well-visits for youth and young adults. This partnership will allow the WIHP to develop strategies for implementing reproductive life planning in young adult well-visits. This effort can help young women think about family planning early in their reproductive years. This effort, part of the Association of Maternal and Child Health Programs (AMCHP) funded Adolescent and Young Adult Health (AYAH) CoIIN, is a collaboration between providers, Medicaid and several key partners in the community, and is expected to be funded through 2018.

The WIHP will continue to support the Fremont County FIMR pilot project. In FY16-17, the Case Review Team (CRT) reviewed all 2015 fetal and infant deaths in Fremont County and compiled recommendations for review by the Community Action Team (CAT) prioritized a recommendation related to preconception health and will develop an action plan related to future work. The WIHP is prepared to provide TA and resource as the CAT plans next steps, which tentatively may include training on and implementation of One Key Question, a relevant activity within this priority area.

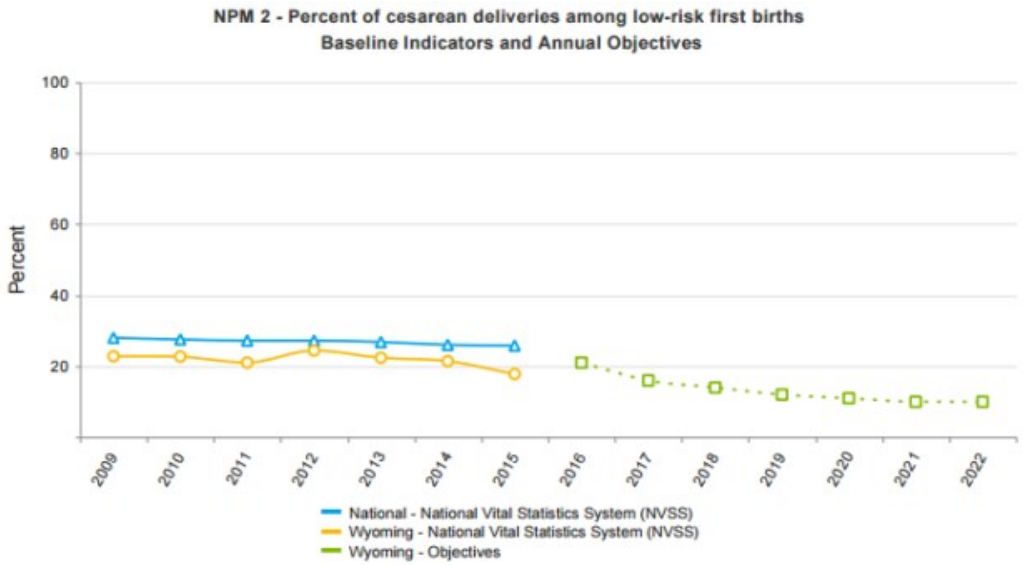
Domain: Women/Maternal Health

B. **Annual Report Fiscal Year 2016:** This section provides a summary of FY16 activities, accomplishments, and challenges related to priorities, NPMs, and SPMs for the Women/Maternal Health Domain.

Priority: Prevent Infant Mortality

NPM 2: Percent of cesarean deliveries among low-risk first births (National Vital Statistics System)

In 2015, 17.8% of low-risk first births were cesarean deliveries compared to 21.4% in 2014. The target for 2017 is 16 percent. The target for 2018 is 14 percent.



In spring 2015, the MCH Unit selected Prevent Infant Mortality as one of its 2016-2020 priorities. This priority l been guided by the infant mortality CoIIN and the selection of three focus areas (i.e. learning networks) by the Wyoming State Infant Mortality Reduction Team. The specific focus area addressed in this domain is the reduction of pre- and early-term birth. In FY16, pre- and early-term birth prevention efforts were guided by the Coordinated Efforts to Reduce Preterm Birth Workgroup. Two additional infant mortality reduction focus areas maternal smoking and risk appropriate perinatal care, will be addressed in the life course and perinatal/infant domain, respectively.

In FY16, the WIHP continued to promote and distribute the March of Dimes (MOD) Healthy Babies Are Worth the Wait (HBWW) materials, including a 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 WIC. The ESM selected for this strategy was the # of Youtube video views. The video has been viewed 336 times since its release. This ESM will not continue in FY18.

Another activity of the Coordinated Efforts workgroup was the development of a non-payment policy for early elective, non-medically indicated deliveries prior to 39 weeks. The WIHP will continue to work with Medicaid to educate providers on this disincentive policy. BCBS committed to a similar policy through their participation in the Coordinated Efforts workgroup.

In FY16, the WIHP provided the Coordinated Efforts workgroup with information about an available patient safety bundle on the safe reduction of primary cesarean births. With program manager turnover and the prioritization of another patient safety bundle due to its ready use as part of a Utah Department of Health Project Extension for Community Healthcare Outcomes (ECHO), the low risk cesarean births bundle has not been implemented yet. Therefore, the selected strategy and ESM for this NPM will change in FY18. See Application narrative for more details.

MCH continued to coordinate efforts with the WHA, Wyoming Medical Society (WMS), Wyoming Medicaid, Wyoming Business Coalition on Health (WyBCH), MOD and other partners to reduce preterm birth. In addition to work aimed at reducing low-risk cesarean deliveries among low-risk first births and reducing early, non-medically indicated deliveries, the Coordinated Efforts to Reduce Preterm Birth workgroup aimed to increase utilization of 17 Alpha-hydroxyprogestrone caproate (17P), an evidence-based strategy for reducing preterm births in women with a previous preterm birth. The resources provided by the CoIIN supported and guided this work. The workgroup developed a provider's guide that covers eligibility, coverage, and billing of 17P. Following the completion of the provider's guide, the workgroup worked with Wyoming Medical Center, a centrally located Wyoming hospital, to plan a Grand Rounds presentation on preterm birth and 17P. MCH and MCH Epidemiology provided Wyoming-specific data for the presentation which was held on October 11, 2016 and coordinated with the hospital to provide continuing education credits for the event. A recording of the presentation was created and may be used for future educational efforts.

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. 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. Required program education includes the importance of waiting 39 weeks to deliver and the availability of 17P to reduce recurrent preterm birth.

Priority: Improve Access to and Promote Use of Effective Family Planning
SPM: # of hospitals billing Medicaid for IPP LARC

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 number of hospitals billing Medicaid for IPP LARCs.

During strategic planning, the WIHP learned of an ASTHO Learning Collaborative on LARC and proposed applying for Cohort 3 of the collaborative as the first action step of this new state priority. During FY16, the WIHP began discussions with Medicaid regarding the upcoming opportunity. When the request for applications was released, MCH formed a core team comprised of the Wyoming Medicaid Medical Director, MCH Epidemiologist, MCH/Title V Director, and a local OBGYN recommended for participation by Medicaid partners to submit a letter of interest. In October 2016, Wyoming was accepted into the ASTHO learning collaborative on IPP LARCs and work began in November of 2016. The ASTHO collaborative has and will continue to provide valuable technical assistance to Wyoming on many topics relevant to IPP LARC use in the state, including administrative support and infrastructure, clinical leadership, billing management, and medicaid billing and policy. The collaborative has also identified opportunities for improving access to most and moderately effective contraception beyond IPP LARC.

In December 2016, the Wyoming core team attended a launch meeting and developed an initial action plan as part of the ASTHO LARC collaborative, with the following goals:

1. Increase provider education in Wyoming
2. Build the capacity to monitor progress of LARC implementation measured by the creation of a dashboard

In order to accomplish these goals, Wyoming convened a priority-specific stakeholder workgroup to inform the development of action steps to meet these goals. This group, made up of key stakeholders across the state, including Wyoming Medicaid, providers, facilities and WDH staff, helped the Wyoming team to refine the action plan to include the following:

1. Work with a pilot facility to increase access to IPP LARCS
    a. Create an internal process for coding and billing related to LARCs, specifically looking at IPP
    b. Work with facility-based pharmacy to address issues related to stocking of LARCs in facility

To date, Wyoming has been successful in identifying champions for this work, and is still working with the chosen pilot facility to ensure all barriers to stocking, billing, counseling and insertion are worked through. This will inform the development of a Wyoming-specific IPP LARC toolkit that will be distributed to all Wyoming providers later in 2017. The toolkit will include guidance from Medicaid on billing for IPP LARC insertion outside of the labor and delivery bundle, information from the pilot facility on challenges and barriers, and content created by the South Carolina IPP LARC toolkit.

To inform this work, MCH Epidemiology completed factsheets using PRAMS data regarding LARC use and unintended pregnancies. The work was distributed to our PRAMS listserv as well as directly with partners of this work. They factsheets are publicly available on our website.

Perinatal/Infant Health

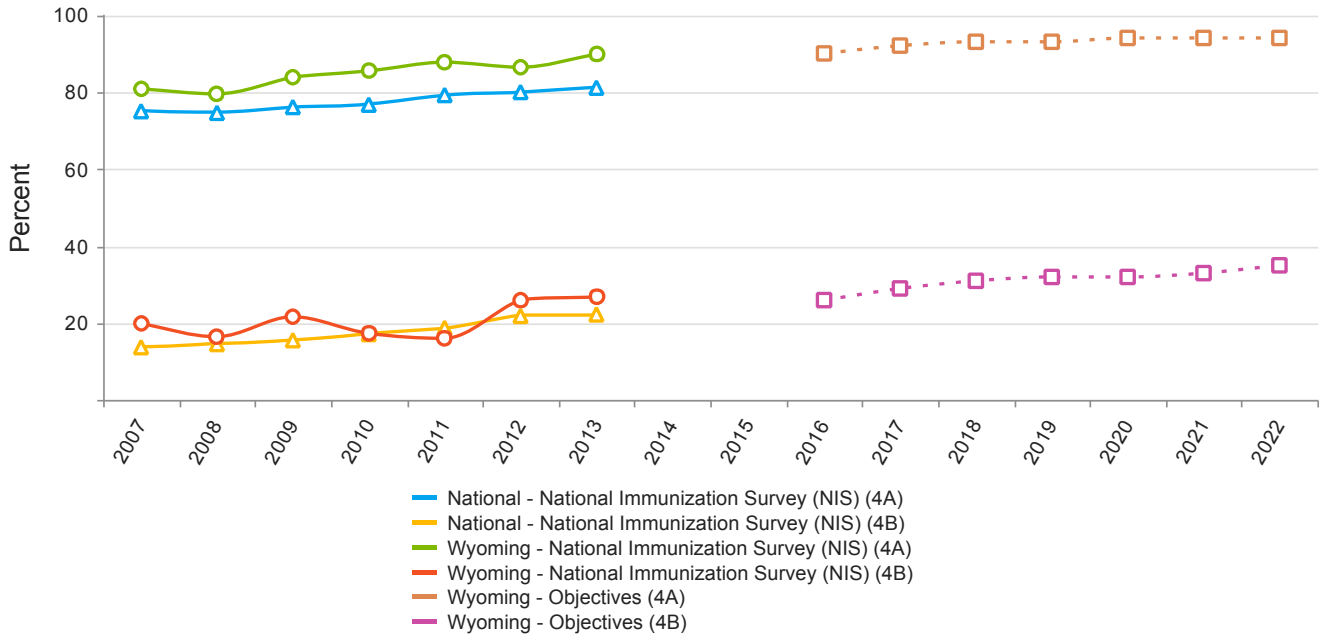
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	Not Reportable	NPM 4
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2014	Not Reportable	NPM 4

National Performance Measures

NPM 4 - A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Baseline Indicators and Annual Objectives



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

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	90
Annual Indicator	89.7
Numerator	5,817
Denominator	6,486
Data Source	NIS
Data Source Year	2013

State Provided Data	
	2016
Annual Objective	90
Annual Indicator	91
Numerator	
Denominator	
Data Source	PRAMS
Data Source Year	2014
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	92.0	93.0	93.0	94.0	94.0	94.0

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

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	26
Annual Indicator	27.0
Numerator	1,693
Denominator	6,263
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	29.0	31.0	32.0	32.0	33.0	35.0

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Mini-grant program structure developed

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	Yes
Numerator	
Denominator	
Data Source	Women and Infant Program
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

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

Measure Status:	Inactive - Completed

State Provided Data	
	2016
Annual Objective	
Annual Indicator	Yes
Numerator	
Denominator	
Data Source	Final Report
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

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

Measure Status:	Inactive - Completed

State Provided Data	
	2016
Annual Objective	
Annual Indicator	Yes
Numerator	
Denominator	
Data Source	MCH Website
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

ESM 4.4 - Implementation of Wyoming 5-Steps to Breastfeeding Success Program

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	4.0	4.0	4.0	4.0	4.0	4.0

ESM 4.5 - Hospitals Recognized by Wyoming 5-Steps Program

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	2.0	4.0	6.0	8.0	10.0	12.0

State Performance Measures

SPM 1 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	51.9
Numerator	42
Denominator	81
Data Source	Wyoming Vital Statistics Services
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	54.0	57.0	60.0	62.0	64.0	66.0

State Action Plan Table

State Action Plan Table (Wyoming) - 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
Complete environmental scan of available state and local level breastfeeding support resources
Develop and disseminate a resource directory of local lactation support services
Develop and release annual Wyoming 5-Steps to Breastfeeding Success mini-grant application
Work with WHA and the WDH Public Information Office to develop and implement hospital recognition program based on the Wyoming 5-Steps to Breastfeeding Success

ESMs	Status
ESM 4.1 - Mini-grant program structure developed	Active
ESM 4.2 - Completion of environmental scan and incorporation of findings into strategic planning	Inactive
ESM 4.3 - Breastfeeding support resource map and web page with county level data developed	Inactive
ESM 4.4 - Implementation of Wyoming 5-Steps to Breastfeeding Success Program	Active
ESM 4.5 - Hospitals Recognized by Wyoming 5-Steps Program	Active

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 (Wyoming) - Perinatal/Infant Health - Entry 2

Priority Need

Prevent Infant Mortality

SPM

Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

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. Continue to offer pregnancy-focused risk appropriate care ECHO opportunities through an ongoing collaboration with the Utah Department of Health.

Develop and disseminate facility-specific and statewide reports on hospital levels of care based on LOCATe results.

Build capacity for development of a perinatal quality collaborative (PQC)

Develop standard process for delivering appropriate perinatal care, including the use of an evidence-based perinatal risk screening tool

Perinatal/Infant Health - Plan for the Application Year

A. **Application Year Plan** (FY18): This section presents strategies/activities for 2016-2020 MCH priorities relat 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 Duration

Priority: Prevent Infant Mortality
SPM (NPM 3): Percent of VLBW infants born in a hospital with a Level III+ NICU

Current infant mortality prevention efforts are guided by the Coordinated Efforts to Improve Maternal and Infant Health (Coordinated Efforts) Workgroup. This group is comprised of members from a wide variety of key stakeholders, including the WHA, WYPCA, Medicaid, MOD, BCBS, American College of Obstetricians and Gynecologists (ACOG), local providers, WYHealth, WMS, and several key partners from within WDH. The grou will guide future work within the WDH by helping to identify priority needs and target efforts where they will be n effective.

In FY18, we plan to impact NPM 3 (selected as a SPM in Wyoming)--percent of VLBW infants born in a hospital with a Level III+ NICU-- by implementing the following selected strategies paired with their associated evidence-based/informed strategy measures, where applicable:

- Use LOCATe results to develop and disseminate facility-specific and statewide reports on hospital levels of care
    - # of facility-specific and statewide reports created and disseminated.
- Build capacity for development of a perinatal quality collaborative (PQC)
    - Collaboration with Wyoming hospital labor and delivery staff, providers, and other stakeholders to work towards the creation of a PQC. This work will be guided by the CDC PQC toolkit.
- Develop standard process for delivering appropriate perinatal care, including the use of an evidence-based screening tool (e.g. MOD Preterm Labor Assessment or the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) Maternal-Fetal Triage Index)
- Continue to offer pregnancy-focused risk appropriate care ECHO opportunities through an ongoing collaboration with the Utah Department of Health
    - # of hospitals participating in ECHO sessions
    - Improvement from baseline assessment for participating facilities

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.

The WIHP will continue to support the Fremont County FIMR Pilot Project. The project proposal developed in 2015/16 will be updated as the first year of the pilot concludes and will become a toolkit for use by other communities. 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. In 2017, the Wyoming IPP reorganized and expanded and will assume some FIMR

program management responsibilities, in partnership with MCH. MCH will continue 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.

Priority: Improve Breastfeeding Duration
NPM 4: A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months (National Immunization Survey (NIS))

Future work surrounding improving breastfeeding duration will be centered around the implementation of a Wyoming-branded breastfeeding program targeted at hospitals. The program, the Wyoming 5-Steps for Breastfeeding Success, was based off the evidence-based methods outlined in the Baby Friendly Hospital Initiative and the Colorado Can Do 5. This program will be ongoing, with grant funding offered yearly (when possible) via Request for Applications (RFA) for hospitals throughout the state.

In FY18, 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) Release annual Wyoming 5-Steps to Breastfeeding Success mini-grant application
    a) # of applications received
    b) # of mini-grants awarded
    c) # of TA meetings
    d) # of hospitals demonstrating improvement (survey)
2) Work with WHA and the WDH Public Information Office to develop hospital recognition program based on the Wyoming 5-Steps to Breastfeeding Success.
    a) # of applications received for recognition
    b) # of hospitals awarded 5-Steps recognition

The WIHP will also begin partnering with the CDPP on a worksite wellness grant opportunity for Wyoming businesses. The grant program will include a section on creating and promoting a breastfeeding friendly workplace, and will utilize the tools outlined in Health Resources and Services Administration (HRSA)'s *The Business Case for Breastfeeding*. The Women and Infant Health Program Manager (WIHPM) will offer ongoing TA in the development of breastfeeding friendly policies and practices for those awarded the worksite wellness grant under the CDP.

MCH Epidemiology continues to collaborate with WIC staff to develop WIC specific products about breastfeeding initiation and duration among women enrolled in WIC. This information will be used to address barriers and educate staff to improve breastfeeding rates among women enrolled in WIC.

B. **Annual Report Fiscal Year 2016:** This section provides a summary of FY16 activities, accomplishments, and challenges related to priorities, NPMs, and SPMs for the Perinatal/Infant Health Domain.

Priority: Prevent Infant Mortality
SPM (NPM 3): Percent of VLBW infants born in a hospital with a Level III+ NICU

In 2016, 62% (62/100) of VLBW infants in Wyoming were born at facilities with the appropriate level of care, well below the 83.7% target set by HP 2020.

As a strategy to improve risk appropriate care, MCH and MCH Epidemiology piloted LOCATe in early FY16 to determine levels of care for Wyoming hospitals. Wyoming is lacking a formal system to designate or define neonatal or maternal levels of care. Some facilities have self-designated a neonatal level. LOCATe was developed by the CDC based on the 2012 AAP Policy Statement on Levels of Neonatal Care, the 2012 AAP/ACOG Publication of Guidelines for Perinatal Care, and the 2015 ACOG/Society for Maternal and Fetal Medicine publication of Maternal Levels of Care. The CDC designed the LOCATe tool to help states and other jurisdictions monitor neonatal and maternal risk-appropriate care using the minimum information necessary. The tool is a standardized assessment which uses the facility's responses about their capabilities, including equipment and specialist availability. The information gleaned from LOCATe will expand knowledge about the perinatal care in Wyoming, facilitate conversations among stakeholders about risk appropriate care, and identify quality improvement initiatives. The tool is not meant to be used for regulatory purposes and is not a comprehensive assessment. The levels of care assigned from the assessment reflect minimal capabilities.

A letter signed by WDH, WHA, WMS, MOD, and the WyBCH was sent to hospital leadership to encourage their participation. All Wyoming delivering hospitals completed the LOCATe tool. We have created a facility level report for each hospital explaining their assessed level of neonatal and maternal care and are in the process of scheduling meetings with the facilities to discuss their results. Once the facilities have received their reports and had the chance to discuss the findings, a state level report will be created to share the neonatal and maternal levels of care of each facility. The state level report will also share some neonatal and maternal outcomes aggregated by level of care. The report will be used to help educate prenatal care providers of the importance of risk appropriate care. Since Colorado (CO) and Utah (UT) have also implemented LOCATe, we hope to be able to include the assessed levels of care in CO and UT facilities where Wyoming women frequently deliver.

LOCATe assessment results revealed that only 40% of hospitals had a maternal hypertensive emergency protocol in place, 72% had a maternal hemorrhage protocol in place and 56% had a thromboembolism protocol in place. While sharing Wyoming's LOCATe experiences and initial findings with colleagues at the 2016 MCH EPI/CityMatCH Conference, Wyoming MCH Epidemiology staff learned of Utah's work implementing the Alliance for Innovation on Maternal Health (AIM) patient safety bundles and discovered a partnership opportunity. During 2017, the WIHP is partnering with the Utah Department of Health and the University of Utah to offer a 7-month ECHO project focused on hypertension in pregnancy, which will help Wyoming hospitals established and/or revise their current hypertension protocols and improve overall maternity care practice. Thirteen representatives from 6 Wyoming hospitals participated in the in-person launch of the ECHO project, and all hospitals have been invited to join the ECHO project.

Another activity that has grown from Wyoming's implementation of the LOCATe assessment is the opportunity to participate in an ACOG project that is piloting in person verification of the maternal levels of care. Wyoming is one of three states (Georgia and Illinois are the others). ACOG will visit 6 Wyoming hospitals to conduct a more comprehensive assessment of maternal levels of care during August/September of 2017. These visits will provide additional information to our hospital assessments, and will also help ACOG understand the perspective of rural facilities in the context of maternal levels of care.

The MHR and 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. Promotion of these programs further support efforts to improve risk appropriate perinatal care, especially for families that require out-of-state care at a Level III facility.

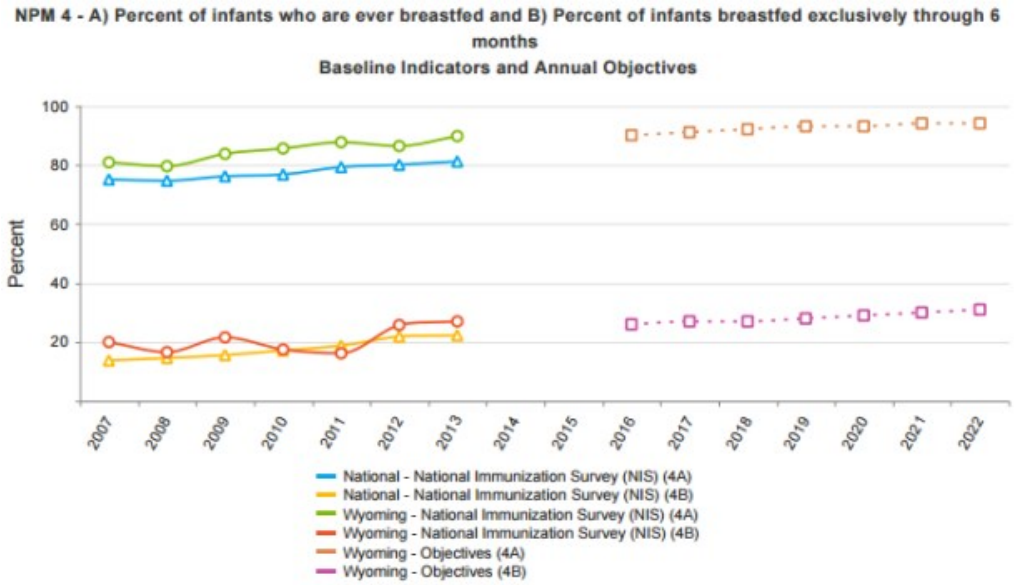
In FY16-17, the Coordinated Efforts group shifted focus to support the Wyoming State Infant Mortality Team in the CoIIN process. Pre- and Early-Term Birth was one of three Learning Networks selected by the state team and the Coordinated Efforts group has been an integral part in developing strategies for FY17. They have also worked together to improve risk appropriate perinatal care, the third Learning Network of the CoIIN.

In early FY17, MCH applied for and received special funding from the MOD to attend the launch meeting of the National Network of PQCs. Resources gained from this meeting as well as the CDC developed toolkit for building a PQC will be used in the coming years to build capacity for a Wyoming PQC.

Priority: Increase Breastfeeding Duration

NPM 4: A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months (National Immunization Survey (NIS))

In 2013, 89.7% of infants were ever breastfed compared to 86.3% in 2012. The target for 2017 is 92 percent. The target for 2018 is 93 percent. In 2013, 27.0% of infants were exclusively breastfed through 6 months compared to 25.8% in 2012 and 16.2% in 2011. The target for 2017 is 29 percent. The target for 2018 is 31 percent.



The HBHV Program aligns with the MCH program priorities including breastfeeding promotion. Home visitation services are among the required activities of a contract held with 22 counties in Wyoming. Through the contract, each county is required to ensure all PHNs delivering MCH services receive 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 sponsored Certified Lactation Counselor (CLC) continuing education for PHNs who were already CLC-trained in FY17. This training was offered in the form of a WIC conference that focused on baby-behavior, and 8 continuing education credits were offered to help PHNs maintain their certification. The MCH Unit will continue to sponsor CLC training for PHNs who deliver MCH services, and plans are in place to send approximately 15 PHNs to CLC training that will be offered in August of 2017 by the Healthy Children Project.

In FY16, a dietitian contracted by WDH completed an environmental scan of breastfeeding resources. The project was part of Year 2 Wyoming's participation in the ASTHO Learning Community to Improve State Health Agency Capacity for Breastfeeding Promotion and Support. The final product of that effort helped the MCH unit to consolidate and share statewide breastfeeding resources with stakeholders, and a statewide map was added to the MCH website in April of 2017. This map will be a key resource in helping partners and stakeholders identify appropriate referral sources for clients throughout the state. The scan also helped the MCH unit identify areas where CLC training needs were high, and combined with other data-gathering efforts such as a PHN survey on training needs, funding for CLC training has been better targeted where it is most needed.

Through an ongoing collaboration with the ASTHO Learning Community to Improve State Health Agency Capacity for Breastfeeding Promotion and Support, in FY17, the MCH unit released a breastfeeding mini-grant opportunity to Wyoming hospitals to increase provider awareness and implementation of evidence-based methods to promote breastfeeding initiation and duration. The program, Wyoming 5-Steps to Breastfeeding Success, was based on the Baby Friendly Hospital Initiative and the Colorado Can Do 5 Program, and uses evidence-based methods to increase breastfeeding initiation and duration within the labor and delivery environment. The development of the grant program, and the review of the RFA were guided by the Breastfeeding Grant Committee, a collaboration between MCH, WIC and the Chronic Disease Unit. The request for applications resulted in 4 applications from facilities across the state, and because of a contribution of funds from ASTHO for this effort, all 4 hospitals will be funded starting in July 2017. Ongoing TA and site visits will ensure barriers to implementation are addressed and adequate evaluation data is collected. The MCH unit will also be developing a recognition program for any hospital that successfully implements the 5-steps program, regardless of whether they received grant funding to do so. The recognition program is expected to launch in the third quarter of CY17.

MCH Epidemiology completed a fact sheet using PRAMS data entitled "Breastfeeding: Information for Hospitals." The fact sheet provides data intended to help hospitals understand their role in improving breastfeeding rates in our state. The fact sheet was completed with input from the WIHPM to reflect the newly released RFA.

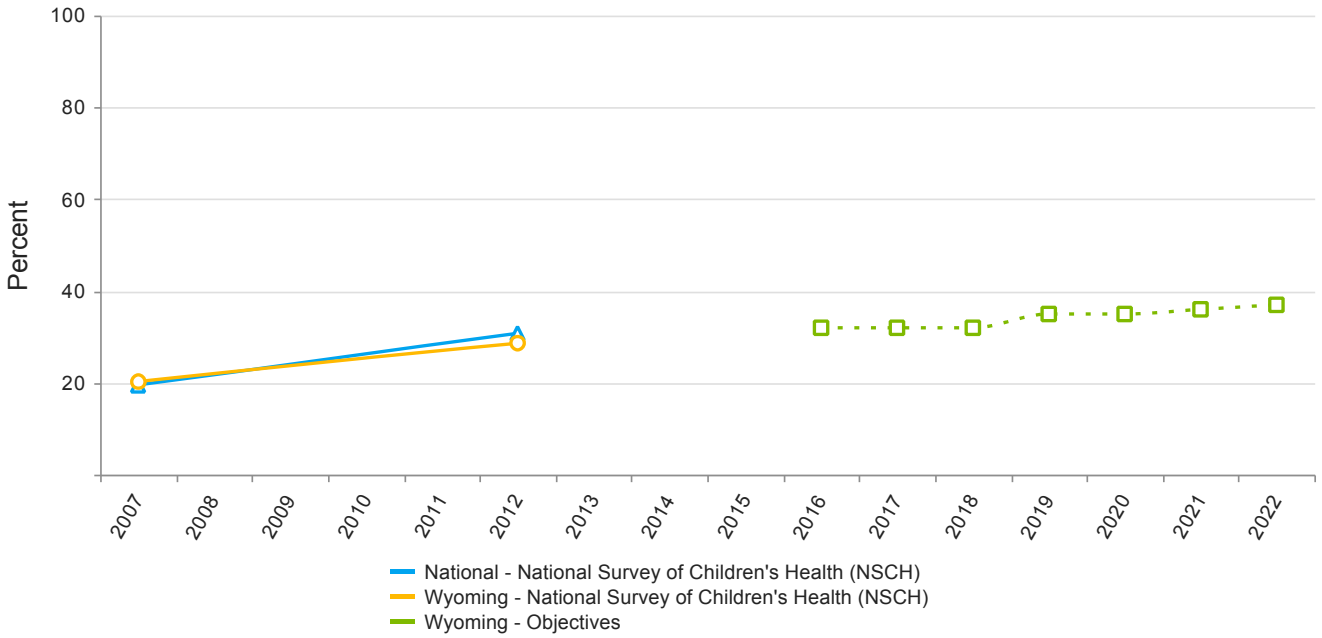
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available	NPM 6
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	87.0 %	NPM 6 NPM 8
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	NSCH-2011_2012	26.7 %	NPM 8
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	WIC-2014	23.7 %	NPM 8
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	YRBSS-2015	25.6 %	NPM 8

National Performance Measures

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



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	32
Annual Indicator	28.8
Numerator	10,655
Denominator	36,969
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	32.0	32.0	35.0	35.0	36.0	37.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Inactive - Completed

State Provided Data	
	2016
Annual Objective	
Annual Indicator	Yes
Numerator	
Denominator	
Data Source	Child Health Program
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

ESM 6.2 - Help Me Grow Implementation plan developed

Measure Status:	Inactive - Completed

State Provided Data	
	2016
Annual Objective	
Annual Indicator	Yes
Numerator	
Denominator	
Data Source	Help Me Grow Program
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

ESM 6.3 - Help Me Grow Calls

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	30.0	60.0	90.0	100.0	100.0	100.0

ESM 6.4 - Number of trained partners entering into the ASQ Enterprise System.

Measure Status:	Active

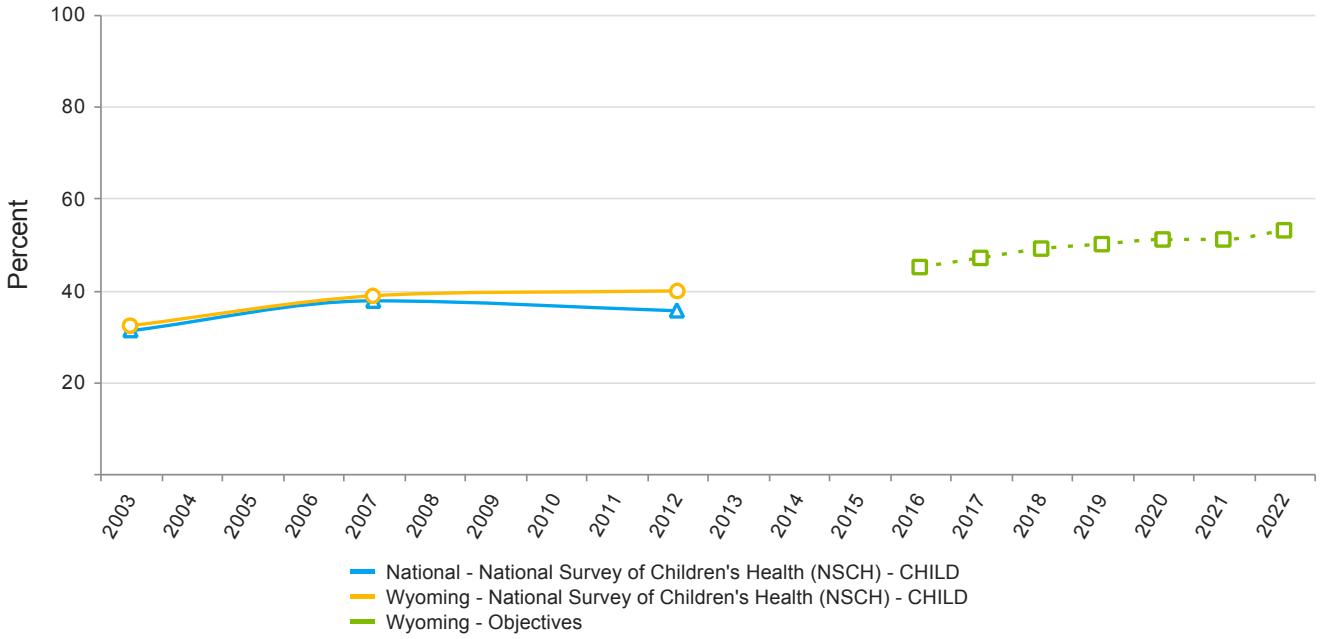
Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	2.0	5.0	7.0	10.0	12.0	15.0

ESM 6.5 - Number of referrals to the HMG system

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	20.0	40.0	60.0	70.0	80.0	80.0

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day
Baseline Indicators and Annual Objectives



NPM 8 - Child Health

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CHILD	
	2016
Annual Objective	45
Annual Indicator	39.7
Numerator	16,986
Denominator	42,831
Data Source	NSCH-CHILD
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	47.0	49.0	50.0	51.0	51.0	53.0

Evidence-Based or –Informed Strategy Measures

ESM 8.1 - # of meetings of the Wyoming Children's Physical Activity Work Group

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Meeting Minutes
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	2.0	4.0	4.0	4.0	4.0

State Performance Measures

SPM 2 - Rate of hospitalization for non-fatal injury per 100,000 children ages 1 through 11

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	25.3
Numerator	22
Denominator	86,903
Data Source	Wyoming Hospital Discharge Data
Data Source Year	FY 2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	20.0	18.0	18.0	16.0	14.0	14.0

State Action Plan Table

State Action Plan Table (Wyoming) - 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 cross agency children's physical activity workgroup, with a focus on improving physical activity, nutrition, and overall child health.

ESMs	Status
ESM 8.1 - # of meetings of the Wyoming Children's Physical Activity Work Group	Active

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 (Wyoming) - 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 HMG activities to increase access to developmental screening tools for families.

Collaborate with Wyoming Medicaid to educate providers about the Bright Futures guidelines (4th ed.) as part of efforts to improve access to and quality of EPSDT/well-visits.

Build capacity to track and monitor ASQ screenings statewide via the ASQ Enterprise System.

ESMs	Status
ESM 6.1 - Help Me Grow contract to Wyoming 211, Inc. executed	Inactive
ESM 6.2 - Help Me Grow Implementation plan developed	Inactive
ESM 6.3 - Help Me Grow Calls	Active
ESM 6.4 - Number of trained partners entering into the ASQ Enterprise System.	Active
ESM 6.5 - Number of referrals to the HMG system	Active

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 (Wyoming) - Child Health - Entry 3

Priority Need

Prevent injury in children

SPM

Rate of hospitalization for non-fatal injury per 100,000 children ages 1 through 11

Objectives

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

Strategies

Provide SKW with targeted evidence-based strategies to address the three major causes of injury/hospitalizations in Wyoming. Require and monitor use of evidence-based strategies as part of contract with SKW.

Child Health - Plan for the Application Year

A. **Application Year Plan** (FY18): This section presents strategies/activities for 2016-2020 MCH priorities relat to Child Health. See Five-Year State Action Plan Table for more information.

Three of the Wyoming MCH 2016-2020 priorities 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
NPM 6: % of children (10-71 months) receiving developmental screen using a parent-completed tool

In the Child Health Domain, this priority will address preventive and quality care for children ages one to eleven years of age. The specific topic area addressed within this domain is developmental screening. Medical home for children will be discussed within the CSHCN Domain.

In FY18, MCH plans to continue to impact NPM 6--the percent of children (10-71 months) receiving a developmental screen using a parent completed tool-- by implementing the following strategy paired with its associated evidence-based/informed strategy measures:

1. Support HMG activities to increase access to developmental screening tools for families.
    a. # of calls to HMG
    b. # of referrals to HMG/211
2. Build capacity to track and monitor ASQ screenings statewide via the ASQ Enterprise System.
    a. # of trained partners entering into the Ages and Stages Questionnaire (ASQ)
3. Collaborate with Wyoming Medicaid to educate providers about the AAP Bright Futures guidelines (4th ed.) as part of efforts to improve access to and quality of EPSDT/well-visits.

Current efforts to increase developmental screenings were initiated with the ECCS grant. This work will continue with additional trainings on ASQ, as needed, and provision of ASQ materials for medical providers, PHNs, home visitors, and early care and education providers. In addition, in FY18 data collection will happen through the ASQ Enterprise account.

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.

In October 2016, the CHP implemented a contract with 211 to pilot the HMG Model in Laramie and Albany Counties. A coordinator was hired, data system put in place, outreach efforts began (January 2017) and the call center went live in February 2017. Wyoming HMG does not currently offer ASQ screenings to families, but

this is expected to begin in the fall of 2017 or early spring 2018. As part of the HMG Leadership and Sustainability Team, the Early Intervention Program will be contributing $30,000 a year towards the HMG contract beginning in FY18. This further highlights our attention to sustainability and cost-sharing among partners. With this increased funding, the HMG Contract will support increased capacity for outreach with planned expansion into another Wyoming county and a focus on screening children birth to 3 years of age.

MCH will continue to work with Medicaid and the Wyoming chapter of the AAP (WY-AAP) to address the low number of Medicaid's well-child checks reported through Early Periodic Screening Diagnosis and Treatment (EPSDT). This topic is receiving department-wide attention through a review of data across Medicaid and PHD. The AYAH CoIIN will offer opportunities for MCH to improve well-visit checks in the population of youth and young adults ages 12-24. It is anticipated that strategies that result from the CoIIN may be appropriate for use in the 1-11 population. The CSH program also promotes well-visits for children and youth with special health care needs through client mailings and care coordination services provided by PHN and Benefit and Eligibility Specialists.

Priority: Reduce and Prevent Childhood Obesity
NPM: % of children (6-11 years) who are physically active at least 60 minutes per day.

The third priority is also continued from 2010-2015, but in 2016-2020 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 strategy paired with its associated evidence-based/informed strategy measures:

1. Support development of a cross agency children's physical activity workgroup, with a focus on improving physical activity, nutrition, and overall child health.
    a. # of meetings of the Wyoming Children's Physical Activity Workgroup.
    b. County level WIC BMI data will be analyzed to determine counties for targeted outreach. (Yes/No)
    c. Analysis of county level WIC BMI data completed (Yes/No)
    d. Counties determined for targeted outreach (Yes/No)

In FY17, the CHP focused on creating the Children's Physical Activity Workgroup. This group is made up of staff from CDPP; Integrated Cancer; MCH; WDE; Wyoming Association for Health, Physical Education, Recreation and Dance (WAHPERD); the Governor's Council on Physical Fitness and Sports; Medicaid; Optum; and WY Outside. All of these stakeholders have goals around increasing activity and decreasing obesity among Wyoming children. The goal of the group is to meet every other month in an effort to communicate our program activities, find opportunities to collaborate and maximize resources and to decrease any chances of confusion or duplication.

The CHP has focused on the early childhood population in Wyoming in part because this is an area of current capacity and partnerships but also because it is believed that early intervention and habits created during the early childhood years will yield children who experience physical activity as the norm in their lives. MCH Epidemiology has worked with WIC to secure data regarding obesity in the 2-5 year old WIC population to help monitor progress toward the goal in this population.

Multiple successes and cross collaboration efforts including an Active Play for Young Children Train the Trainer which was hosted by the CDPP and planning towards a collaborative training to be offered at the upcoming WAHPERD conference will continue into FY18.

MCH shared the Active Play for Young Children Train the Trainer opportunity with PHNs and with other early care and education partners. Discussion is underway to provide trainings for PHNs and child care providers around the state in FY18.

The upcoming WAHPERD conference in November 2017, will offer a pre-training to support schools to implement the Comprehensive School Physical Activity Program (CSPAP). Funding from MCH will be able to supplement CDC funding from the CDPP. CSPAP is a multi-component approach by which school districts and schools use all opportunities for students to be physically active, meet the nationally recommended 60 minutes of physical activity each day, and develop knowledge, skills and confidence to be physically active for a lifetime. The CDC, in collaboration with SHAPE (Society of Health and Physical Educators) America, developed a step-by-step guide for school and school districts to develop, implement, and evaluate the CSPAP. CSPAP training has been part of efforts of the CDPP within their 1305 grant, and is currently implemented in Campbell County.

Priority: Prevent Injury in Children
SPM: Rate of hospitalization for (non-fatal) injury per 100,000 children (1-11 yrs)

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

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

SKW provides Child Passenger Safety Training, car seat installation, and car seat inspections statewide. Bot the CHPM and the Wyoming Injury Prevention Program Manager represent WDH on the SKW Leadership Tea The CHPM will continue to meet monthly with the Wyoming Injury Prevention Program and Emergency Medical Services for Children (EMS-C) Program to identify ways to collaborate and to assure there is no duplication of effort.

Because the leading cause of death due to unintentional injuries for this population is MVC, the CHP continues to track Child Safety Restraint Misuse Rates as one of our performance measures. According to the National Highway Traffic Safety Association (NHTSA), the national misuse average is 80%, yet Wyoming's misuse rate is currently 85.2%, down from 91.4% last year. In addition, the CHP will continue to track the number of car seats distributed, inspected and the number of educational injury prevention efforts focused on the leading causes of injury hospitalizations.

In FY17, a binder of evidence-based strategies specifically addressing the leading causes of unintentional death and injury in children was created through a partnership between SKW, the CHP, MCH Epidemiology, and the Wyoming Injury Prevention Program. A new reporting form was created which will allow for data collection more specific to these approved strategies.

One of the identified strategies was the adoption of a Home Safety Checklist (HSC). A workgroup was

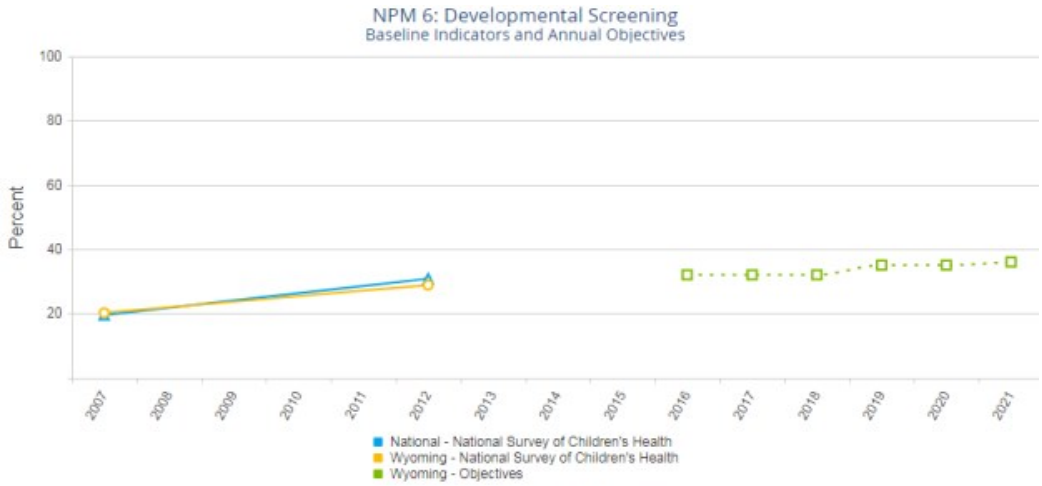
created that included SKW, the CHP, MCH Epidemiology, and all home visiting programs in Wyoming. This group discussed how each program addresses HSCs, reviewed multiple checklists and selected one to move forward. The CHPM took the adopted HSC and put it into survey form and created a Quick Response (QR) code link to help families complete it more easily. Families who complete the survey will be entered into a drawing for a $25 gift card. In FY18, the survey will be offered by home visitors, at SKW events, through EMS-C and put into a poster format where it will be displayed in PCMH waiting rooms, PHN offices, WIC clinics, and in Early Care and Education settings. This survey will not only educate families on how to improve the safety of their home, it will help us determine where the family received the survey, what steps/actions they take as a result of this strategy, and identify home safety needs.

These data will be used in our effort to continually improve the SKW Contract and activities around unintentional death and injury.

B. **Annual Report Fiscal Year 2016:** This section provides a summary of FY16 activities, accomplishments, and challenges related to NPMs and SPMs (2016-2020) for the Child Health Domain.

Priority: Improve Preventive and Quality Care for Children
NPM 6: Percent of children (10-71 months) receiving developmental screen using a parent-completed tool (NSCH)

In 2012, 28.8% of children ages 10 months to 5 years had a development screen completed in a healthcare setting. This is below but not significantly different from the US at 30.8%.



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.

In 2013, the ECCS grant leadership team began researching the HMG Model. HMG is designed to help states and communities leverage existing resources to ensure communities identify vulnerable children, link families to community-based services, and empower families to support their children's healthy development through the implementation of four Core Components: Child Health Care Provider Outreach, Family and Community Outreach, Centralized Access Point, and Ongoing Data Collection and Analysis. HMG was established in 1997 at in Connecticut, at the Connecticut Children's Medical Center.

In 2016, Wyoming became the 26th of 29 total states currently implementing HMG. HMG does not provide direct services. Rather, it is a system for improving access to existing resources and services for children through age eight. ECCS funding will continue to support this work through July 2017.

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

Throughout FY16, the CHPM worked with the Wyoming HMG Leadership and Sustainability Team to address the benchmark activities recommended by HMG National. The National Center's structural requirements and core components are outlined in the HMG System Building Benchmarks and Timeline which is used as a resource to plan activities and track progress. The HMG activities in FY16 focused on working as a leadership team to identify the best way to implement HMG in Wyoming, creating a Request for Proposal for the HMG Contract, evaluating proposals and ultimately awarding the contract to Wyoming 211. The Contract was initiated in October 2016 with a plan to pilot HMG in Albany and Laramie counties, two counties with a strong 211 presence and engaged partners.

Developmental surveillance, screening, and observations are important in all aspects of the child's growth and development. The AAP, Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescent recommends standardized developmental screening be used at 9 month, 18 month, and 2.5 year visits in addition to other times when concerns are identified.

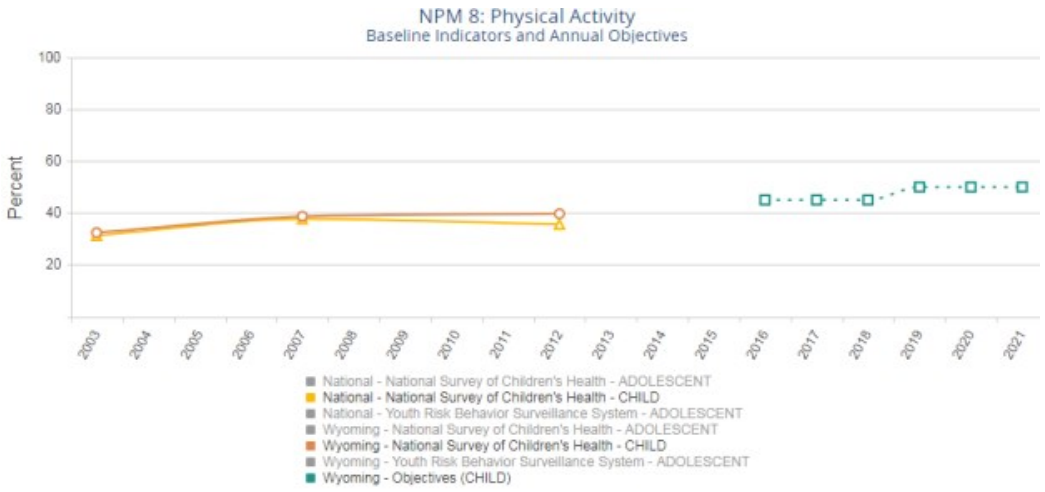
Child Development Centers (CDCs) in Wyoming offer both developmental screenings and evaluations. While they use the "1 before 2" campaign to encourage early screening, many have reported that they struggle to reach the 0-3 population in their communities. Some CDCs also expressed concerns about losing referrals (and possible funding) for their 3-5 age population with the implementation of HMG. Wlth these challenges in mind, the CHP has worked closely with the Early Intervention Program and CDCs Directors to ensure that we are not duplicating efforts. One way we have done this is to create a policy where any families calling HMG with children ages 3-5 will be referred to their local CDCs for a full developmental screening which includes vision and hearing screening in addition to a developmental screening. HMG will then follow up with any families whose child has passed the screening and offer them the next ASQ screening 6 months later. HMG will also remind these families the following year to return to the CDCs for another full screening. These types of follow up calls and care coordination is not something that CDCs have been able to provide and helps the CDCs be able to access Child Find dollars for the yearly screenings. Similarly, any families coming directly to a CDCs for screening whose child does not qualify for services will be referred to 211 for additional resources to support the family.

In addition to the HMG Model, the CHP also provides trainings and ASQ screening tools to CDCs, PHN offices and staff, Home Visitors, Early Care and Education Providers (both home and center based) and Primary Care Medical Home staff. ASQ is the most widely used developmental screening tool across the globe. The ability of the ASQ to identify children with delays is 100% at 4 months, 14 months, 45 months and 60 months - with an overall agreement of 86% for sensitivity and 85% for specificity. The AAP considers high quality developmental screening tests to have sensitivities and specificities of 70% to 80%.

In FY15, the CHP, through the ECCS grant, provided over 117 ASQ3/SE Starter Kits to child care centers and home visitors in Wyoming, with 1,360 screenings reported to the CHP. In FY16, over 115 staff were trained on the ASQ3/SE in nine regional trainings throughout the state, in partnership with MIECHV with 1,994 ASQ3/Social Emotional 2 screenings reported.

Priority: Prevent Childhood Obesity
NPM 8: Percent of children (6-11 years) who are physically active at least 60 minutes per day (NSCH)

In 2012, 39.7% of children ages 6-11 years were physically active for at least 60 minutes per day. The target for 2017 is 47 percent. The target for 2018 is 49 percent.



Prevention and reduction of childhood obesity was selected as a Wyoming priority. Physical activity is a key component in reducing the obesity rate.

The CHP partnered with the YAYAHP to contract with the University of Wyoming to expand the Healthy Pokes Program (HPP) into Laramie County in partnership with Laramie County School District #1 and Laramie County Community College. The contract was initiated in FY15 and continued through FY16.

The HPP is an integrated approach to addressing obesity and overall health of at-risk youth in Wyoming. Developed at the University of Wyoming, in the Kinesiology Department, Healthy Pokes provided a comprehensive approach to addressing child health and obesity. The overall goal of Healthy Pokes is to reduce risk and prevalence of obesity and its associated health outcomes. By having children participate in lessons, activities, and mentoring throughout a 20-week program, the hope is to achieve the following objectives with the HPP:

- To enhance children's physical activity levels and knowledge of fitness concepts
- To improve children's knowledge of nutritional concepts and choices
- To improve children's socio-emotional health

During the pilot period (36 weeks of programming), 48 undergraduate mentors were recruited along with 48 student participants. At this point, the CHP has chosen not to continue contracting with the HPP in exchange for a more population-based approach to increasing physical activity.

In 2016, the CHP participated in strategic planning for this priority and at that time planned to support the development of a healthy schools coalition. In FY18, the strategy will be revised to include development of a cross agency children's physical activity workgroup, with a focus on improving physical activity, nutrition, and overall child health. Cross-agency partnerships began in FY17.

Priority: Prevent Childhood Injury
SPM 2: Rate of hospitalization for (non-fatal) injury per 100,000 children (1-11 yrs)

In 2015, the non-fatal injury hospitalization rate for children was 25.3 hospitalizations per 100,000 children 1-11 years. The target for 2017 is 20 per 100,000. The target for 2018 is 18 per 100,000.

The CHP is committed to preventing injury in Wyoming children. By 2020, the program's goal is to reduce the

rate of hospitalizations due to nonfatal injuries among Wyoming children ages 1-11.

Many childhood injuries are predictable events that can be prevented and can be addressed in the same fashion and fervor as other public health problems. The public health approach includes identifying the magnitude of the problem through surveillance and data collection, identifying risk and protective factors, and, on the basis of this information, developing, implementing and evaluating interventions and promoting widespread adoption of evidence-based practices and policies.

MCH provided financial support to SKW. During FY16, the CHPM worked to improve the SKW contract by providing research and evidence-based strategy support to the SKW county coalitions and partners to addres the leading causes of death and injury in Wyoming children ages 1-11. These leading causes are MVC, Falls, Poisonings. The contract began requiring use of evidence-based strategies along with reporting on activities address these top three causes. Programmatic support was provided by the CHPM and MCH Epidemiology members of the SKW Leadership Team. SKW coalitions, across the state, worked to reduce child and adolescent deaths through local Child Passenger Safety events, Traveling Safely with Newborn classes, informational packets for expectant and new parents containing information on seatbelts and pregnancy, car s 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 MVC and restraint use, helmet use/bicycles, gun safety, drowning, falls, burns, poisoning, hyperthermia, dog bites, and furniture tip over.

MCH participated on the Wyoming EMS-C advisory committee for the Wyoming Responders Safe Transport Initiative. 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.

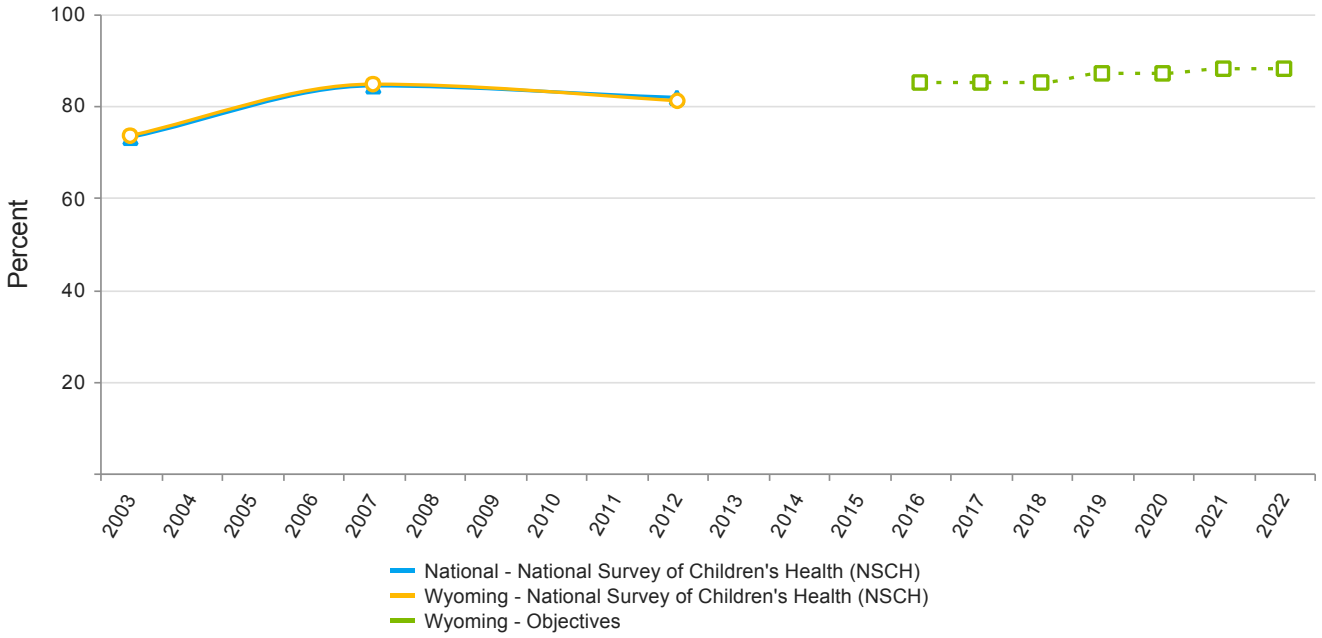
Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000	NVSS-2015	45.9	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000	NVSS-2013_2015	22.4	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000	NVSS-2013_2015	30.4	NPM 10
NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling	NSCH-2011_2012	68.9 %	NPM 10
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	87.0 %	NPM 10
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	NSCH-2011_2012	26.7 %	NPM 10
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	WIC-2014	23.7 %	NPM 10
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	YRBSS-2015	25.6 %	NPM 10
NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza	NIS-2015_2016	41.7 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISF-2015	47.7 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISM-2015	37.1 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2015	87.9 %	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2015	58.7 %	NPM 10

National Performance Measures

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



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	85
Annual Indicator	81.1
Numerator	36,230
Denominator	44,669
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	85.0	85.0	87.0	87.0	88.0	88.0

Evidence-Based or –Informed Strategy Measures

ESM 10.1 - Promotion of Adolescent Champion Model

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	No
Numerator	
Denominator	
Data Source	Program Data
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

State Performance Measures

SPM 4 - Percentage of teens reporting 0 occasions of alcohol use in the past 30 days

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	68.2
Numerator	
Denominator	
Data Source	Prevention Needs Assessment
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	70.0	72.0	75.0	78.0	80.0	82.0

State Action Plan Table

State Action Plan Table (Wyoming) - 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.
Develop a Project ECHO series about adolescent health for providers statewide.

ESMs	Status
ESM 10.1 - Promotion of Adolescent Champion Model	Active

NOMs

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

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

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

NOM 18 - Percent of children 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 (Wyoming) - Adolescent Health - Entry 2

Priority Need

Promote healthy and safe relationships in adolescents

SPM

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

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

Adolescent Health - Plan for the Application Year

A. **Application Year Plan** (FY18): This section presents strategies/activities for 2016-2020 MCH priorities related to Adolescent Health. See Five-Year State Action Plan Table for more information.

Priority: Promote Preventive and Quality Care for Adolescents
NPM 10: % of adolescents with a preventive services visit in the last year.
NPM 12: % adolescents with and without special health care needs who received services necessary to make transitions to adult health care.
(see CYSHCN Narrative and Application)

In December 2016, the Well-visit/EPSDT team applied for Cohort 2 of the AYAH CoIIN and was notified of acceptance in February 2017. At this time the team mobilized quickly and began rapid strategic planning including an extensive SWOT analysis. The multi-pronged approach to addressing adolescent well-visits has potential to be extremely effective. An example of this multi-pronged approach includes involving education for youth by youth, for parents by parents, and for providers by providers. Another example is addressing the problem at the system level, provider level, and consumer level. One approach that promises to be replicable in other states is development of the Wyoming Adolescent and Young Adult Project ECHO in 2018. This telehealth platform, available through the University of Wyoming and Wyoming Institute for Disabilities (WIND), provides educators, service providers, case managers, administrators, families, and others access to expert advice from professionals throughout the state and country, building capacity in home communities to implement best practices and improve outcomes.

In FFY18, the YAYAHP will implement the following strategies within the Promote Preventive and Quality Care for Adolescents priority:

1. The Well-visit/EPSDT Team will continue to develop both short and long-term action plans to address adolescent and young adult well-visits in Wyoming. This begins with identifying current barriers to well-visits from many different perspectives including system, clinic, provider, and consumer perspectives.
2. In FY18, eight pilot clinics will be identified through an RFP process. These pilot clinics will complete an MOU with WDH for a 3-year partnership. During the first 2 years, Cohort A, made up of four clinics, will implement the Adolescent Centered Environment (ACE) model. In the first year, Cohort B (the other four clinics), will provide only data. The second year Cohort B will begin the ACE model.
3. Develop the Project ECHO series about adolescent health for providers statewide.
4. Continue to engage youth and young adults in all aspects of the Well-visit/EPSDT team goals including development of strategies to meet team goals.
5. Develop evaluation for Unlocking the Mysteries of the Adolescent Brain for Healthcare Providers.
6. Promote enhanced provider engagement.
7. Attend the 2018 Society for Adolescent Health and Medicine meeting and continue to build partnerships with global adolescent experts.
8. The CSH Program will continue to send reminders to enrolled clients to attend their annual well-visit.

Priority: Promote Health and Safe Relationships for Adolescents
SPM: % of high schoolers reporting 0 occasions of alcohol use in past 30 days

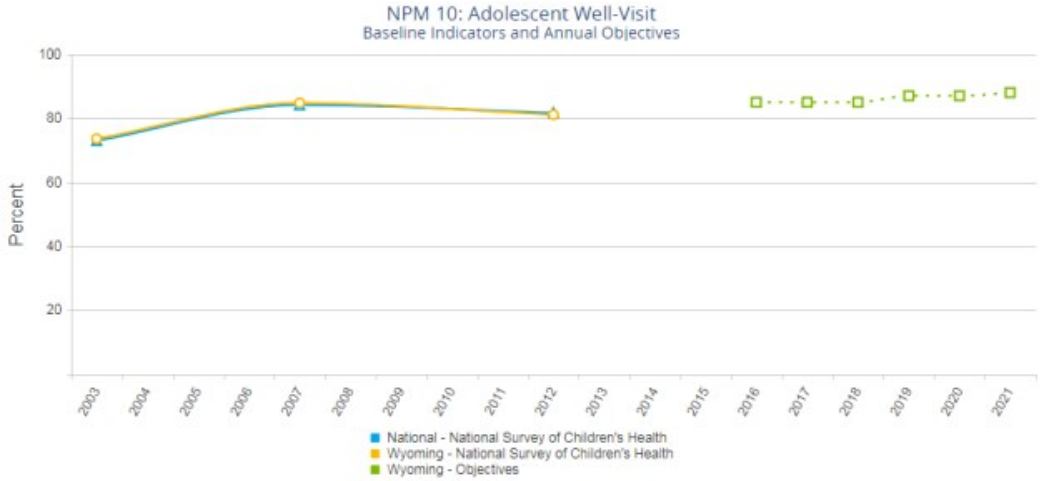
In FFY18, the YAYAHP will implement the following strategies within the Promote Preventive and Quality Care for Adolescents priority:

1. Complete RFP process and community selection for CTC.
2. Begin implementation of the CTC frameworks in two MCH communities.
3. Continue to work with communities in implementation of the Wyoming Personal Responsibility Education Program (WyPREP) curriculum.
4. Release applications, select, and train WDH State Youth Council members.
5. Develop new Rape Prevention and Education (RPE) Program pilot community in the CTC framework.
6. Identify evidence-based strategies that address shared risk and protective factors to address the priority of Promoting Healthy and Safe Relationships for Adolescents.
7. Develop evaluation of Unlocking the Mysteries of the Adolescent Brain.
8. Establish a WyPREP peer education program to involve youth in delivering programming.

B. **Annual Report Fiscal Year 2016:** This section provides a summary of FY16 activities, accomplishments, and challenges related to NPMs and SPMs (2016-2020) for the Adolescent Health Domain.

Priority: Promote Preventive and Quality Care for Adolescents
NPM 10: % of adolescents with a preventive services visit in the last year.

In 2012, 81.1% of adolescents ages 12 through 17 had a preventive medical visit in the past year. The target for 2017 is 85%. The target for 2018 is 85%.



NPM 12: % adolescents with and without special health care needs who received services necessary to make transitions to adult health care.
(see CYSHCN Narrative and Application)

Well-visit/EPSDT Team
Currently, Wyoming is ranked 44th in the nation in adolescent EPSDT visits making this a MCH Unit, PHD, and WDH priority. In order to address NPM 10, the YAYAH program manager formed a Well-visit/EPSDT team. This team includes representatives from Medicaid, Kid Care CHIP, WDH, Wyoming Family Voices, WY-AAP, WYPCA, Optum (Medicaid contractor), youth, and young adults. In 2016, this team began identifying barriers to well-visits in Wyoming and preparing to apply for Cohort 2 of the AYAH CoIIN. The Well-visit/EPSDT team is made up of several different action teams addressing provider and consumer education, data, transition, and clinic engagement.

In FY16, the Adolescent Centered Environment Assessment Process (ACE-AP) from University of Michigan was identified as a strategy to improve the quality of the adolescent clinical environment. The ACE-AP is a facilitated, comprehensive self-assessment and guided improvement process that includes customized resources, recommendations, TA, and implementation plans using Plan, Do, Study, Act (PDSA) improvement cycles. Pilot clinics will be identified through an RFP process to implement the ACE-AP model in order to assess the effectiveness of this strategy. These pilot clinics will complete an MOU with the WDH and provide clinic level and quality improvement data in exchange for the TA provided by WDH and the University of Michigan.

Transition

Transition from pediatric to adult health care for youth with and without special health care needs was identified as a priority for the YAYAHP through the Title V Needs Assessment for 2016-2020. Currently, only 47% of CYSHCN in Wyoming receive the needed transition services. A team from WDH is assessing available resources from Got Transition in order to develop a Wyoming specific toolkit for providers and consumers of transition resources. A comprehensive training for PHN that work with CYSHCN, planned for fall 2017, will contain a medical transition component to enhance the care coordination provided.

Unlocking the Mysteries of the Adolescent Brain for Healthcare Providers
In FY16, the YAYAHP continued training providers in Unlocking the Mysteries of the Adolescent Brain for Health Care Providers, a training developed by the YAYAH program manager (YAYAHPM) in 2014. Sixty (60) providers were trained during FFY16 from a variety of practice types including family practice, pediatrics, FQHC, public health nursing, Title X, and mental health. In FY17, the YAYAH program manager with support from the MCH Epidemiology Program will develop and administer a follow-up survey for all previously trained providers to determine the extent of practice changes that were implemented. The YAYAHP continues to support the WDH Immunization program by attending and presenting this training at the annual Wyoming Immunization Conference.

Society for Adolescent Health and Medicine
The YAYAHPM remains an active member of the Society for Adolescent Health and Medicine (SAHM) and attended the 2016 conference. She continues to build partnerships with national experts to help support the WDH PHD priority of Integration of Public Health and Primary Care.

Priority: Promote Health and Safe Relationships for Adolescents
SPM: % of high schoolers reporting 0 occasions of alcohol use in past 30 days

In 2016, 68.2% of Wyoming High School students reported zero occasions of alcohol use in the past 30 days. The target for 2017 is 70%. The target for 2018 is 72%.

This priority was identified due to Wyoming's high teen birth rate, early initiation of sexual activity, incidence of teen dating violence, and alcohol and drug use prior to sexual activity. Most of these activities were measured on the YRBSS. In FY16, the Wyoming State Legislature eliminated the YRBSS in Wyoming. There is no longer an effective, statewide measure of youth sexual behavior. However, Wyoming does have a statewide risk and protective factor survey called the PNA which includes questions about alcohol and drug use but not sexual health.

Communities of Care
The primary Title V strategy identified to address this priority is CTC from the University of Washington. CTC is an evidence-based framework that uses prevention science to increase protective factors in communities. Youth from CTC communities are more likely to delay initiation of alcohol and tobacco use among other measures. In FY16, two staff from WDH began training as coaches in the CTC model. Three communities will be identified through an RFP process in FY17/18 to participate in the CTC strategy to evaluate effectiveness for Wyoming communities.

Common Risk and Protective Factor Approach
In FY16, the YAYAHP began efforts to integrate messages about healthy sexuality and sexual violence prevention. Traditionally, the teen pregnancy and sexual violence prevention movements have been very siloed. Through a shared risk and protective factor approach, Wyoming is implementing strategies that

support healthy sexuality and sexual violence prevention. In FY16, the Wyoming Sexual Assault Conference was rebranded as the Wyoming Conference for Violence Prevention and Response to reflect a broader reach. Evidence of this integration will appear throughout this narrative.

Wyoming Personal Responsibility Education Program - WyPREP

The YAYAHPM partners with the Communicable Disease Unit (CDU) to manage and implement the WyPREP**.** WyPREP provides training, curricula, and support for implementation of evidence-based, medically accurate curriculum in school and community-based settings. In FY16, contracts with five (5) schools were completed and the first school districts in Wyoming began to implement comprehensive sex education in the classroom. FY16 was the first year in Wyoming history that medically accurate, evidence-based sexual health curricula was implemented in schools. In every community that contracts to implement WyPREP, a team of people is identified to support the implementation. This team includes: school health/PE staff, school nurses, school counselors, public health and/or Title X nurses, and domestic violence/sexual assault program staff. This team supports the implementation and also provides a contact for youth in their community. In 2016 WyPREP reached over 500 Wyoming youth. The YAYAHP partners with MCH Epidemiology for evaluation of the WyPREP program. Each location is provided with a report card detailing the data from their students each school year. A statewide report card is produced for publication and shared with the public and policymakers. In 2016, on exit surveys, half of all WyPREP participants stated that they were much more likely or somewhat more likely to delay initiation of sexual intercourse in the six (6) months following the program.

The YAYAHPM is a trainer of trainers for WyPREP curricula including: Making Proud Choices, Reducing the Risk, and Friendships and Dating (for youth and young adults with intellectual and developmental disabilities). Title V could support this program in the future should federal funding change for the WyPREP program. Intimate partner violence, teen dating violence, and affirmative consent were included in facilitator trainings for the WyPREP curricula. Both response and prevention topics are covered.

Reproductive Health Gap-filling Program

MCH provides contraceptives to seven counties that receive little to no Title X funding. In FY16, the Reproductive Health Program served an average of 300 clients per quarter; 150 were adolescents (12-24 years). In addition to hormonal birth control pills, MCH provided emergency contraception, Depo-Provera, nuva-ring, 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 provide preconception counseling and referrals to family planning services if they are not available at public health nursing clinics.

MCH continues to work with the WHC, Wyoming's Title X grantee, in order to identify opportunities for increasing availability of and access to family planning services in Wyoming. Quarterly collaboration meetings are held when possible.

Rape Prevention and Education Grant

The YAYAHPM is the RPE grant manager and an MCH Epidemiology provides evaluation and data support. The target audience for this work is adolescents ages 12-24. In FY16, CTC was determined to be a viable framework for the pilot communities supported by this grant. The connected risk and protective factor approach allows the program to focus on strategies that will improve the overall environments for adolescents in Wyoming. MCH contracts with the Wyoming Coalition Against Domestic Violence and Sexual Assault

(WCADVSA) to complete the work of the RPE grant in Wyoming communities.

Wyoming Sexual Violence Prevention Council

The YAYAHPM and MCH Epidemiology serve as a steering committee members of the WSVPC. The council is developed as a collective impact project to increase effectiveness of violence prevention efforts in Wyoming. The WSVPC is currently in the process of creating work plans to increase the visibility of sexual violence prevention efforts in Wyoming.

National Sexual Assault Conference

The YAYAHP was a speaker at the 2016 National Sexual Assault Conference presenting alongside several other states on a regional approach to sexual violence prevention work.

College Consortium

In FY16, a team from WDH, WCADVSA, University of Wyoming, and Northwest Community College traveled to the Action Planning Team meeting at the CDC for sexual assault prevention on college campuses. Planning has started for the Wyoming College Consortium. This group will meet and complete a statewide campus climate survey and develop a toolkit to help meet the needs of Wyoming colleges.

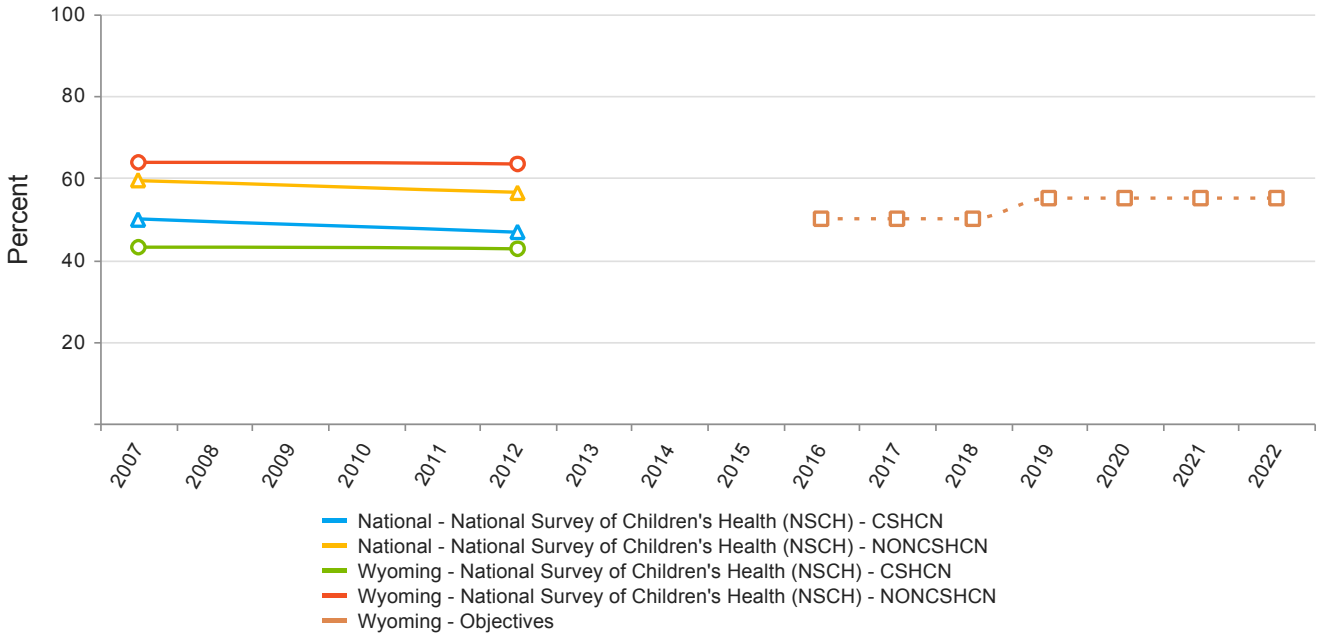
Children with Special Health Care Needs

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system	NS-CSHCN-2009_2010	19.7 %	NPM 11 NPM 12
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	87.0 %	NPM 11 NPM 12
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)	NIS-2015	73.3 %	NPM 11
NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza	NIS-2015_2016	41.7 %	NPM 11
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISF-2015	47.7 %	NPM 11
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISM-2015	37.1 %	NPM 11
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2015	87.9 %	NPM 11
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2015	58.7 %	NPM 11

National Performance Measures

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



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2016
Annual Objective	50
Annual Indicator	42.8
Numerator	11,052
Denominator	25,796
Data Source	NSCH-CSHCN
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	50.0	50.0	55.0	55.0	55.0	55.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Inactive - Completed

State Provided Data	
	2016
Annual Objective	
Annual Indicator	Yes
Numerator	
Denominator	
Data Source	Child Health Program
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

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

Measure Status:	Inactive - Replaced

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	

ESM 11.3 - Number of providers trained in the family engagement components of medical home

Measure Status:	Active

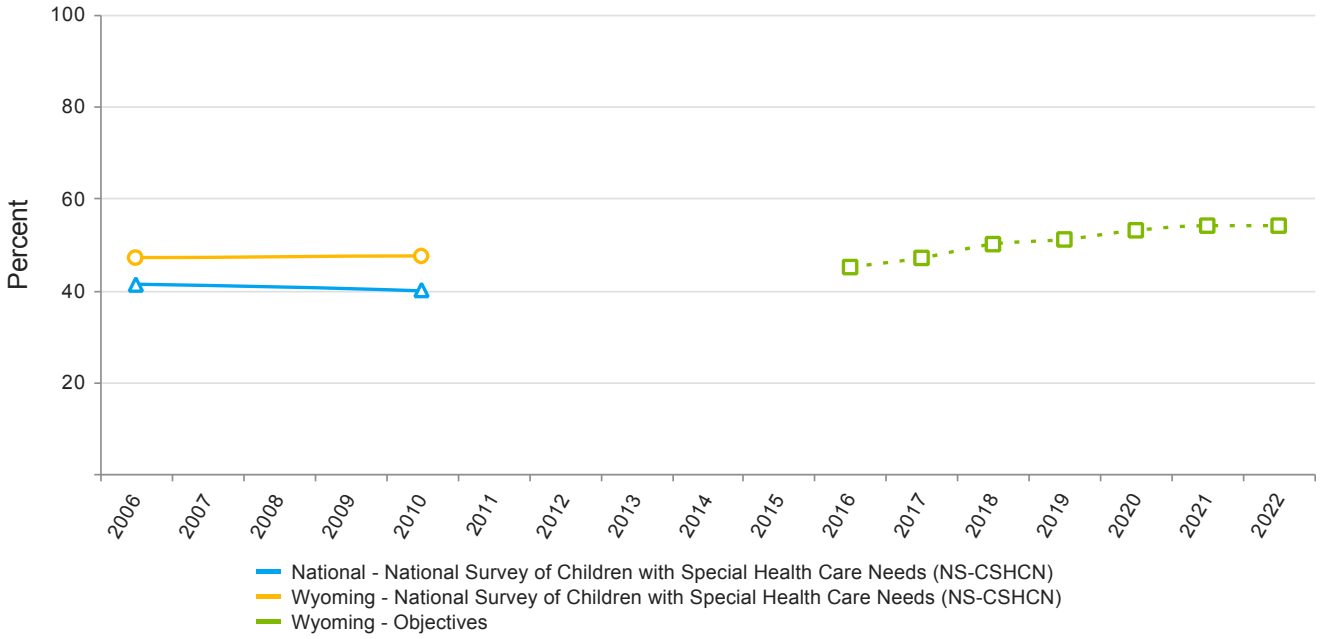
Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	15.0	25.0	35.0	50.0	50.0	50.0

ESM 11.4 - Number of families served through the Parent Partner Program

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	225.0	250.0	250.0	275.0	300.0	300.0

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



Federally Available Data	
Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)	
	2016
Annual Objective	45
Annual Indicator	47.4
Numerator	3,609
Denominator	7,613
Data Source	NS-CSHCN
Data Source Year	2009_2010

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	47.0	50.0	51.0	53.0	54.0	54.0

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - # of meetings of the Transition Action Team of the AYAH CoIIN

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	AYAH CoIIN Meeting Minutes
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	2.0	4.0	4.0	4.0	4.0	4.0

ESM 12.2 - # of provider champions participating on Transition Action Team

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	AYAH CoIIN Minutes
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	2.0	3.0	3.0	3.0	3.0

ESM 12.3 - # of adolescents participating on Transition Action Team

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	CoIIN Meeting Minutes
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	2.0	3.0	3.0	3.0	3.0

State Action Plan Table

State Action Plan Table (Wyoming) - 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 Parent Leadership Training Institute (PLTI) enrollees and graduates regarding availability and benefits of the medical home

Continue to contract with the Wyoming Parent Partner Program (PPP) to provide care coordination to families of CYSHCN within the medical home

ESMs	Status
ESM 11.1 - Completed environmental scan of Medical Homes in WY and what their family engagement policies are in partnership with Medicaid.	Inactive
ESM 11.2 - Medical Home module created and implemented into PLTI Curriculum	Inactive
ESM 11.3 - Number of providers trained in the family engagement components of medical home	Active
ESM 11.4 - Number of families served through the Parent Partner Program	Active

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 (Wyoming) - 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.

Review 'Got Transition' materials and develop and implement distribution plan for selected materials (e.g. distribute materials to families of youth with special health care needs served through the CSH Program).

Establish transition workgroup (action team) as part of the Well-visit/EPSDT team (i.e. AYAH CoIIN Team).

ESMs	Status
ESM 12.1 - # of meetings of the Transition Action Team of the AYAH CoIIN	Active
ESM 12.2 - # of provider champions participating on Transition Action Team	Active
ESM 12.3 - # of adolescents participating on Transition Action Team	Active

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

A. **Application Year Plan** (FY18): This section presents the initial strategies for the 2016-2020 MCH priorities related to Children with Special Health Care Needs. All MCH programs (Women and Infant Health, Child Health, Youth and Young Adult Health, and CSH) support the efforts within this Domain.

Priority: Promote Preventive and Quality Care for Children and Adolescents
NPM 11: Medical home: % of children with and without special health care needs having a medical home.

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, adolescent well-visits, and transition to adulthood.

In FY18, 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 TA to develop and implement family engagement policies
    - Environmental scan of Medical Homes in Wyoming (completed in FY17)
    - # of providers trained in family engagement components of medical home
    - 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
    - # of PLTI enrollees and graduates trained in the components of medical home with emphasis on the family engagement components
    - Collaborate with National Parent Leadership Institute to incorporate medical home into PLTI training options

- Continue to contract with the Wyoming Parent Partner Program (PPP) to provide care coordination to families of CYSHCN within the medical home
    - # of unique families served through the PPP

Priority: Promote Preventive and Quality Care for Children and Adolescents NPM 12: % adolescents with and without special health care needs who received services necessary to make transitions to adult health care.

In FY18, we plan to impact NPM 12--percent adolescents with and without special health care needs who received services necessary to make transitions to adult health care--by implementing the following selected strategy paired with its associated evidence-based/informed strategy measure:

- Review 'Got Transition' materials and develop and implement distribution plan for selected materials (e.g. distribute materials to families of youth with special health care needs served through the CSH Program).
    - # of *Got Transition* distributed to providers and consumers
- Establish transition action team as part of the Well-visit/EPSDT team, or the AYAH CoIIN Team
    - # of Transition Action Team Meetings
    - # of provider champions participation on the Transition Action Team

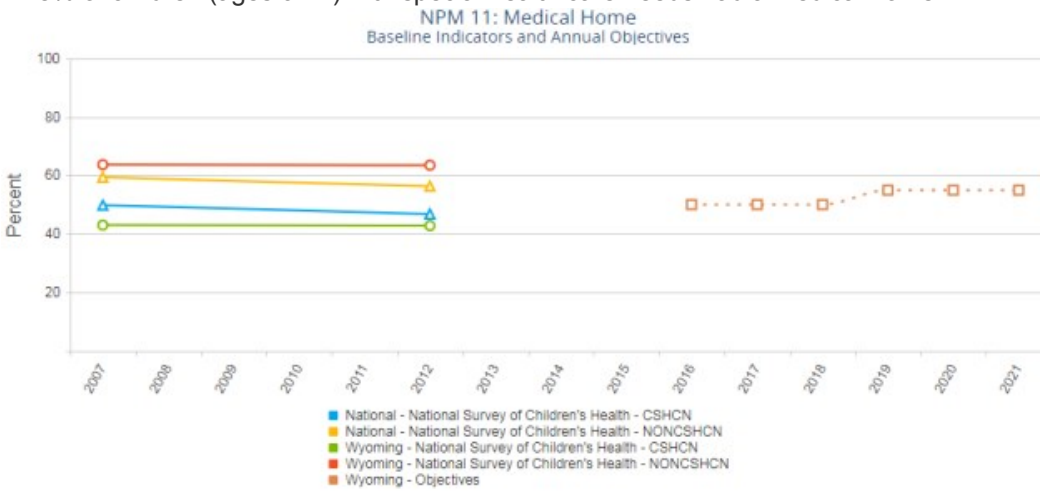
- # of adolescents participating on the Transition Action Team

In FY18, the Transition Action Team will be further developed as an action of the Wyoming Adolescent and Young Adult Health (WAYAH) CoIIN team. In order for adolescent and young adult health care to be considered quality care, transition must be included. The Transition Action Team will review current evidence-based and evidence-informed resources from organizations like Got Transition for their applicability to Wyoming populations. The team will include providers, youth, young adults, and their families. Approved materials will be gathered into separate toolkits for providers and consumers. A dissemination and evaluation plan will be developed.

B. **Annual Report Fiscal Year 2016:** This section provides a summary of FY16 activities, accomplishments, ar challenges related to NPMs and SPMs (2016-2020) for the CSHCN Domain. All MCH programs (Women and Infant Health, Child Health, Youth and Young Adult Health, and CSH) support the efforts within this Domain.

Priority: Promote Preventive and Quality Care for Children and Adolescents
NPM 11: Percent of children with and without special health care needs having a medical home (NSCH)

In 2012, 63.5% of children (ages 0-17) without special health care needs had a medical home. In 2012, 42.8% of children (ages 0-17) with special health care needs had a medical home.



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.

The National Center for Medical Home Implementation defines a medical home as “an approach to providing comprehensive primary care” rather than a physical space or service.

According to the AAP, primary care should be accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective. The Maternal and Child Health Bureau (MCHB) has operationalized this concept for children using five criteria:

1. having a personal doctor or nurse,
2. having a usual source for sick and well care,
3. receipt of family-centered care,
4. no problems getting needed referrals, and
5. receipt of effective care coordination when needed

As the CHP and MCH Epidemiology evaluated available data, we found that, in Wyoming, there are many disparities around children with a medical home:

- Race/Ethnicity: 64.2% of white children report having a medical home, compared to only 43% of Hispanic children and 42% of other, non-hispanic children/families.
- Income: Of families whose income is greater than 400% of poverty level, 67.6% report having a

medical home, while for those at less than 100% of poverty level, only 48% report having a medical home.

- Special Needs: 63.5% of children without special health care needs report having a medical home compared to 43% of those with special health care needs reporting having a medical home.

The evidence based strategy identified to address this priority has been the Wyoming Parent Partner Program (PPP). The PPP came to Wyoming approximately 5 years ago as a partnership between MCH, the Mountain States Genetics Regional Collaborative (MSGRC) and the Hali Project. This evidence informed program helps medical homes identify/hire a parent within their practice who has a child with a special health care need. These parents, called Parent Partners,are on staff approximately 16 hours a week when the provider is seeing CSHCN. The Parent Partner works as a peer mentor to support the families and provide many of the elements of medical home.

In 2015, when the MSGRC funding began to decrease, MCH stepped in to fund a one year contract with the PPP and began to evaluate what data is being collected and how we can ensure this program is effective. MCH and MCH Epidemiology have worked to modify data collected from families with plans to add practitioner evaluations. Meetings with Wyoming Medicaid were held to see how this program is similar to peer mentors and could become funded by Medicaid.

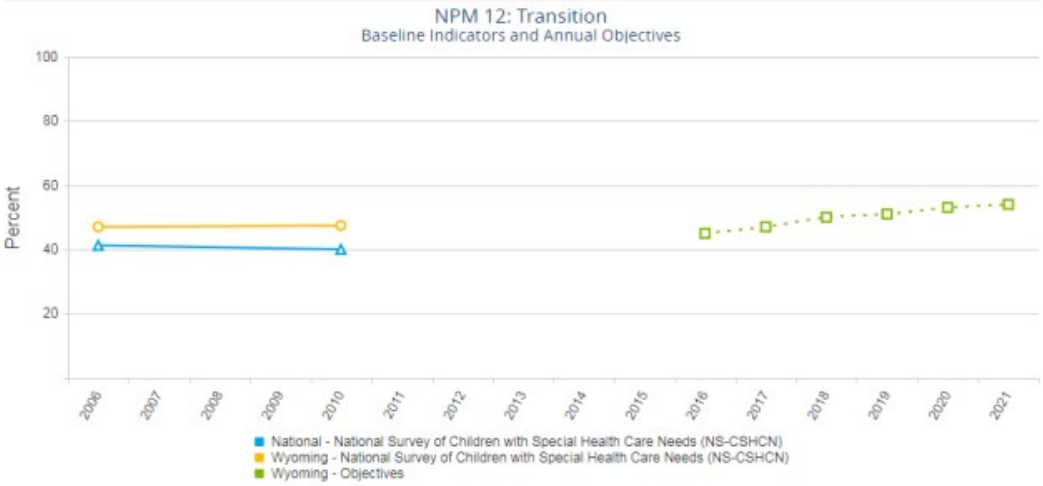
The CHP tracks the number of families served by the Wyoming PPP. In FY16, approximately 217 families were served by Parent Partners in Fremont County, Natrona County and through multiple satellite locations. Planning is underway to expand the PPP to a clinic on the WRIR and on Warren Air Force Base in Cheyenne.

As part of the environmental scan of medical home activities around the state, the CHPM has connected with the Clinical Quality Directors of both the WYPCA and the Wyoming Institute for Population Health. Meetings with the Medicaid PCMH team have resulted in opening doors for collaboration. In September 2017, MCH will partner to support a PCMH Training. This will give MCH an opportunity to highlight the importance of family engagement policies, EPSDT visits, and other MCH Priorities.

PHNs educate the CYSHCN families about using a medical home. As part of care coordination the families in the CSH program are strongly encouraged to select a medical home and follow up on all well-visit checks.

Priority: Promote Preventive and Quality Care for Children and Adolescents
NPM 12: % adolescents with and without special health care needs who received services necessary to make transitions to adult health care.

In 2012, 47.4% of adolescents with and without special health care needs received services necessary to make transitions to adult health care. The target for 2017 is 48%. The target for 2018 is 50%.



In FY16, the YAYAHP continued to develop partnerships to increase health care transition services for adolescents with and without special health care needs. The Well-visit/EPSDT team is considering transition as an integral part of improving health care services for adolescents. A transition action team will be developed as part of the Well-visit/EPSDT team that will work with providers and consumers to develop a Wyoming specific toolkit using Got Transition resources.

In FY17, Wyoming was selected to participate in the AYAH CoIIN. Health care transition is a major focus of the WAYAH CoIIN.

Currently the CSH Program provides care coordination to CYSHCN and limited gap-filling financial assistance. A fact sheet containing transition issues and community contacts is sent to CSH clients turning 18 and at age 19. A comprehensive PHN training, scheduled for fall 2017, will contain a health transition component. Lastly, transition resources are located on the CSH Program website.

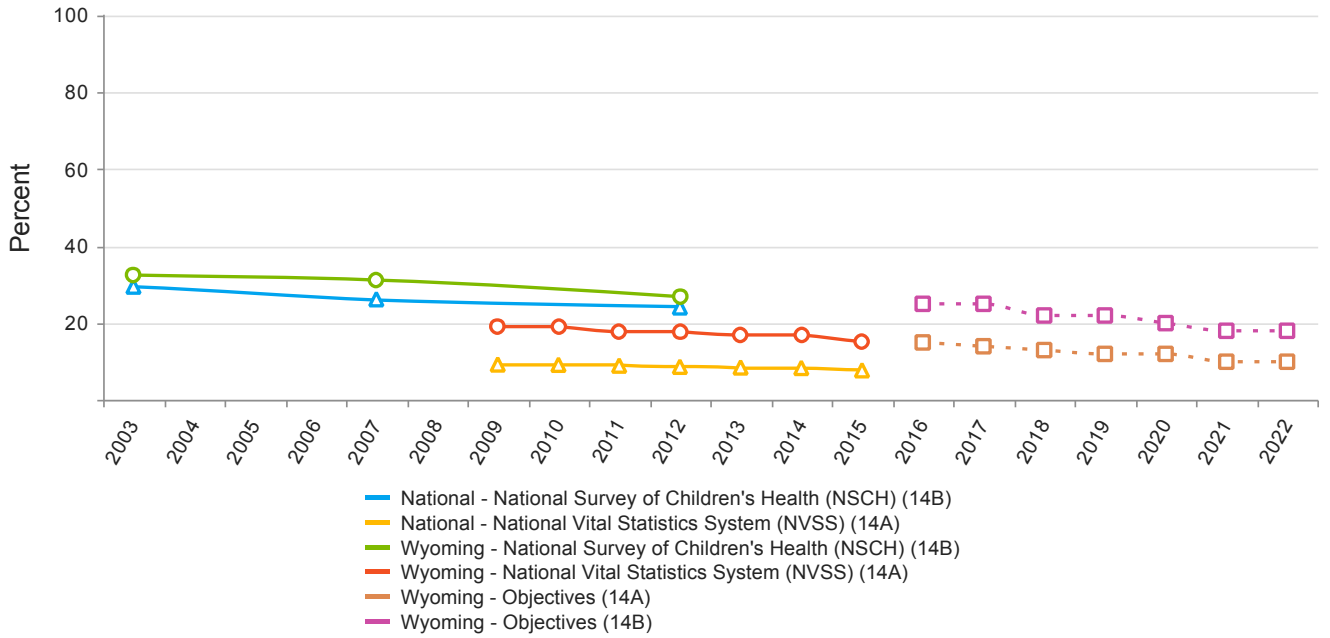
Cross-Cutting/Life Course

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2014	122.5	NPM 14
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2011_2015	Not Reportable	NPM 14
NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2015	8.6 %	NPM 14
NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)	NVSS-2015	1.1 %	NPM 14
NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)	NVSS-2015	7.5 %	NPM 14
NOM 5.1 - Percent of preterm births (<37 weeks)	NVSS-2015	9.8 %	NPM 14
NOM 5.2 - Percent of early preterm births (<34 weeks)	NVSS-2015	2.5 %	NPM 14
NOM 5.3 - Percent of late preterm births (34-36 weeks)	NVSS-2015	7.3 %	NPM 14
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2015	25.6 %	NPM 14
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2014	6.6	NPM 14
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	6.4	NPM 14
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2014	5.2	NPM 14
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	Not Reportable	NPM 14
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2014	155.9	NPM 14
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2014	Not Reportable	NPM 14
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	87.0 %	NPM 14

National Performance Measures

NPM 14 - A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes
Baseline Indicators and Annual Objectives



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

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2016
Annual Objective	15
Annual Indicator	15.2
Numerator	1,148
Denominator	7,540
Data Source	NVSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	14.0	13.0	12.0	12.0	10.0	10.0

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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	25
Annual Indicator	27.0
Numerator	35,902
Denominator	132,791
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	25.0	22.0	22.0	20.0	18.0	18.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Inactive - Replaced

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	4.0	4.0	4.0	4.0	4.0	

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	16
Numerator	
Denominator	
Data Source	Wyoming Quitline Monthly Reports
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	50.0	60.0	70.0	80.0	90.0	100.0

ESM 14.3 - # of focus groups held on Wind River Indian Reservation

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	4.0	4.0	4.0	4.0	4.0	4.0

ESM 14.4 - # of women receiving SCRIPT intervention during Healthy Baby Home Visitation Services

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	15.0	15.0	15.0	15.0	15.0	15.0

State Action Plan Table

State Action Plan Table (Wyoming) - 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

Decrease number of women who smoke during pregnancy We will focus heavily on NPM 14a for this priority.

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 build capacity to implement strategies for smoking cessation during pregnancy

Pilot Smoking Cessation and Reduction in Pregnancy (SCRIPT) in selected PHN offices.

ESMs	Status
ESM 14.1 - # maternal smoking'-focused meetings between the MCH and Tobacco Programs	Inactive
ESM 14.2 - # pregnant women enrolled in the WY Quitline services	Active
ESM 14.3 - # of focus groups held on Wind River Indian Reservation	Active
ESM 14.4 - # of women receiving SCRIPT intervention during Healthy Baby Home Visitation Services	Active

NOMs

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

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

NOM 4.1 - 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

A. **Application Year Plan** (FY18): This section presents the initial strategies for the 2016-2020 MCH priorities related to the Cross-Cutting/Life Course Domain.

Priority: Reduce Infant Mortality
NPM 14: A) Percent of women who smoke during pregnancy B) Percent of children who live in households where someone smokes

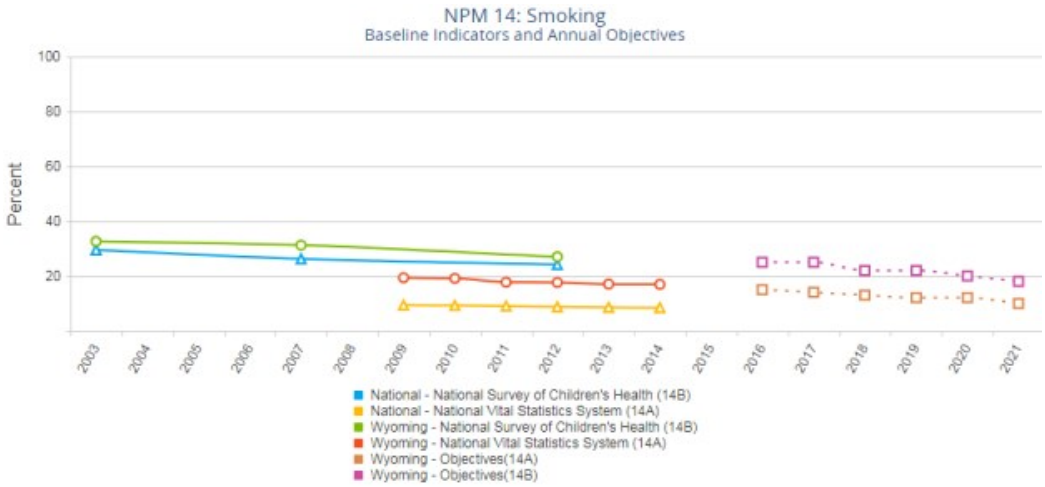
Beginning in FY18, we plan to impact NPM 14A--percent of women who smoke during pregnancy-- and 14B --Percent of children who live in households where someone smokes -- by implementing the following selected strategies paired with their associated evidence-based/informed strategy measures, where applicable:

1. Pilot Smoking Cessation and Reduction in Pregnancy (SCRIPT) in selected PHN offices
    a. # of pilot sites implementing SCRIPT intervention
    b. # of women receiving SCRIPT intervention during HBHV program visits
2. Work with tribal tobacco program to build capacity to implement strategies for smoking cessation during pregnancy
    a. # of focus group trainings held on reservation (Wind River/White Buffalo)
    b. # of people trained to conduct focus groups

B. **Annual Report Fiscal Year 2016:** This section provides a summary of FY16 activities, accomplishments, ar challenges related to National and State Performance Measures (2016-2020) for the Cross-Cutting/Life Cours Domain.

Priority: Reduce Infant Mortality
NPM 14: A) Percent of women who smoke during pregnancy

In 2015, 15.2% of women smoked during pregnancy compared to 16.9% in 2014.



During FY16, the WIHP and MCH Epidemiology worked with the Tobacco Prevention and Control Program, the Wyoming Quitline contractor, and a marketing firm hired to promote Wyoming Quitline services to develop resources specific to the Pregnancy and Postpartum Protocol and the American Indian Commercial Tobacco Protocol. MCH Epidemiology shared PRAMS data on maternal smoking including reasons if, when, and why women quit to inform media materials. Both programs are free to Wyoming residents and offer telephone counseling and quit medications at no cost. The program also provides incentives.

Through an MCH services contract held with all counties, MCH required PHNs ask about smoking status at every home visit. Early in 2017, the contracts came around for revision, and the opportunity was taken to update the contract language around MCH services, including maternal smoking cessation work. The contract language was updated to include clarification surrounding the referral process to the Wyoming Quitline, and a requirement to use the Wyoming Quit Smoking in Pregnancy educational materials, which include information regarding enrolling in the quitline, and details on incentives offered through the program.

The WIHPM partnered with MOD in April of 2017, and attended a train-the-trainer session for SCRIPT at the Society for Public Health Education (SOPHE) conference in Denver, CO. The 8-hour training included the fundamentals of SCRIPT implementation, SCRIPT evaluation, and a certification to train others in SCRIPT implementation. This will enable the WIHPM to begin the process of adopting SCRIPT across the state, in order to implement an evidence-based smoking cessation intervention. The SCRIPT program will also help to increase referrals to the Wyoming Quitline.

Other Programmatic Activities

1. Newborn Screening Program

In FY16, the Wyoming NBS Program continued participation in NewSTEPs 360 (Newborn Screening Technica Assistance and Evaluation Program), a national project providing TA and access to data to improve NBS timeliness. NewSTEPs 360 is an extension of the national CoIIN focused on improving NBS timeliness. In 20 the Wyoming/Colorado team partnered with West Edge Collective, a Wyoming-based digital marketing firm, t develop a 20-minute video on the importance of NBS and NBS timeliness. The video describes the importanc of NBS timeliness through education on processes and personal stories from parents whose children were affected by conditions tested for in the NBS panel. The Wyoming team also collaborated with the New York-Mi Atlantic Consortium for Genetic and Newborn Screening Services to develop a pre and post assessment to be used as a supplement to the NBS video. The video will be released to labor and delivery staff throughout the s in June 2017, and will include a branded hard-copy disk and marketing posters (also created by West Edge Collective) to promote the use of the video and pre/port assessments in hospital staff trainings.

In 2015, the Wyoming NBS Program initiated plans to add Critical Congenital Heart Disease (CCHD) to the state's NBS panel, a 2012 recommendation of the U.S. Department of Health and Human Services (HHS) Secretary. In Fall 2015, the NBS Program partnered with the MCH Epidemiology Program to develop and implement a hospital survey to learn about CCHD screening practices. The survey was adapted from an existing assessment developed by CDC Division of Birth Defects Prevention for use in an Epi-Aid for the state of Georgia as they prepared to implement CCHD screening program and associated programs. 20 of 21 birthing hospitals completed the survey. 85.7% (18) of Wyoming birthing hospitals reported currently screening for CCHD using pulse oximetry. Facilities who reported that they are currently using pulse oximetry for CCHD screening were asked when screening was implemented, timing of screens, how findings are communicated and documented, how positive screens are defined, and details about echocardiography for follow-up of positive screens. The program plans to use this data to inform training of providers on CCHD screening and follow up.

In May 2016, the Wyoming NBS Panel Advisory Committee met to discuss the potential addition of CCHD to the Wyoming NBS panel. Results of the survey described above were presented and representatives from the Colorado School of Public Health presented on CCHD screening at altitude. By unanimous vote, the committee decided to add CCHD to the panel via rules promulgation. Revised rules were approved internally in early 2017, went to public comment in early May, and are expected to go into effect by Summer 2017. The revised rules CCHD to the Wyoming NBS Panel and clarify language to allow midwives to collect blood spots for out-of-hospital deliveries. Current rules do not allow midwives to perform this screening. In response to this rule change, the WIHP and MCH Epidemiology piloted CCHD screening data collection with 2 of the more prominent facilities in Wyoming in order to ensure adequate data collection around CCHD screening, and to begin the process of adding the screening data to birth certificates.

The NBS program will offer a NBS conference, "Every Hour Counts" in June of 2017 as an educational opportunity for labor and delivery staff and midwives. The conference, which will be funded under the NewSTEPS 360 grant, will cover timeliness and collection, quality improvement, CCHD screening education and rule updates, and birth certificate training. Under the updated rules, midwives are responsible for collecting newborn screens for families attended by a midwife, and the conference expects to host a large number of Wyoming midwives to ensure adequate education and preparation for the implementation of this

new rule.

In FY17, the Wyoming NBS team released an RFA for courier services, in order to ensure continued timely delivery of newborn specimens that meets the fiscal requirements of the State. Two contractors applied, and the contract was awarded to a suitable courier contractor in May of 2017.

The NBS Coordinator and the WIHPM attended the Mountain States Genetics Regional Collaborative (MSGR in March of 2017 to represent Wyoming in the collaborative. The Wyoming team presented on current NBS an Genetics QI projects happening in Wyoming, and established key contacts for the development of a forthcomir genetics telehealth pilot with PHN.

2. Women and Infant Health Program

Wyoming Home Visiting Activities

The WIHPM and partners from the PHN 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 activities among its members:

- to promote program collaboration and to raise public awareness about home visiting,
- to expand and sustain home visiting services,
- to provide supplemental home visiting training,
- to collect and share data, and
- to 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, reduce preterm birth, reduce maternal smoking, improve breastfeeding duration, and improve access and use of effective family planning.

Nurse Family Partnership (NFP) Evaluation

For many years, there has been increasing pressure from leadership to increase our ability to demonstrate outcomes of Wyoming's home visiting program, HBHV 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. Wyoming MCH was selected to participate the 2016 CDC MCH Epidemiology and Harvard School of Public Health Program Evaluation Practicum. Wyoming's project was an evaluation of the NFP program. The WIHPM, PHN MCH program consultant, and MCH Epidemiology Assignee participated in one week of evaluation training at CDC and then hosted 2 graduate students in Wyoming. The result of the project was a written evaluation plan to evaluate the implementation of NFP in Wyoming. The evaluation plan was used to guide the NFP evaluation which was recently completed and was used to determine programmatic decisions related to continuation of NFP in five selected counties who were found to have the capacity to implement the program with fidelity to the model.

Fetal and Infant Mortality Review (FIMR)

In FY16, MCH continued development and implementation of the Fremont County FIMR Pilot Project as a result of community-expressed concerns regarding high infant mortality rates.

In December 2015, after years of working with the Fremont County community to develop the FIMR process, MCH wrote a detailed proposal document to help inform our partners and leadership about the FIMR planning process to date and next steps. The proposal was shared with WDH leadership, the Attorney General's (AG) Office, and the Fremont County FIMR Planning Committee members. The proposal recommended that the FIMR project be included under public health authority rules which would allow release of vital records data on infant/fetal deaths for the purposes of preventing fetal and infant mortality. MCH, MCH Epidemiology, WDH leadership, WDH Office of Privacy, Security, and Contracts (OPSC), the AG's office, and VSS met to discuss the proposal and answer questions. The result was a Privacy Rule Analysis, attached below, which provided the MCH Unit authority to move forward with reviewing the first cases of the FIMR pilot project.

Privacy Rule Analysis

The HIPAA Privacy Rule permits covered entities to disclose protected health information, without the individual's written authorization, for public health authorities legally authorized to receive such information for the purposes of preventing or controlling disease, injury, or disability. 45 CFR 164.512(b)(a)(i). In this case, the WDH's VSS is disclosing protected health information to MCH and MCH Epidemiology for purposes of preventing fetal and infant mortality. The disclosure by VSS to MCH and MCH Epidemiology is for a public health purpose and therefore permitted by the Privacy Rule.

The Privacy Rule allows a covered entity to rely on a minimum necessary determination made by a public health authority when the public health authority requests protected health information from the covered entity. 45 CFR 164.514(d)(3)(iii)(A). The FIMR proposal includes a completed data request form completed by MCH and MCH Epidemiology. This completed data request form constitutes a minimum necessary determination made by a public health authority, and therefore VSS may rely on that determination in disclosing the requested information to MCH and MCH Epidemiology.

In June 2016, the first Case Review and Community Action Teams were held. Between June 2016 and January 2017, the CRT met three times to review all 2015 cases of infant or fetal loss occurring in Fremont County. Twenty (20) recommendations resulted from the team's review of seven losses (2 infant and 5 fetal). The CAT began meeting in 2016 and received their first set of recommendations in early 2017. During their February 2017 meeting, the CAT prioritized 5 recommendations:

- Screening and/or risk assessment and risk appropriate education related to chronic disease. Incorporate 'one key question'. Include postpartum education on healthy lifestyles, including weight, pregnancy planning, chronic disease management, nutrition, especially those with existing risk factors
- Ensure families who deliver at out-of-state hospitals are referred to home visiting programs for additional support when they return home. Include need to address access to data tracking. Make connection to WIC. Work with local providers to increase referrals once families return home
- Develop inventory of available bereavement/grief resources in community, especially those specific to infant/child loss
- Provide training to hospital staff on completing fetal death certificate
- More comprehensive education on preterm labor signs and symptoms and pregnancy problems, including when and where to seek care
- Provides safe sleep environment options for families (e.g. Baby Boxes)

In May 2017, the CAT narrowed their focus to one key topic: preconception health with a specific focus on adolescents and implementation of the evidence-based One Key Question initiative. The WIHPM will work with the CAT to develop an action plan around the selected recommendation and provide TA on evidence-based interventions and activities to improve preconception health in the community.

In 2016, the FIMR Advisory Committee informed the community about a maternal interviewer opening on the FIMR team. Members of the team, as well as MCH staff, interviewed and selected one candidate to conduct maternal interviews beginning in 2017. The Maternal Interviewer contract was finalized in September of 2016,

and she received training on appropriate maternal interviewing techniques as informed by the National Fetal Infant Mortality Review (NFIMR) Guide. Fremont County has been fortunate to not have a fetal or infant death since the Maternal Interview contract was established, and services have not yet been needed. The contract with the Maternal Interviewer will be renewed this year so as to ensure she is available should another death occur that will be reviewed by the CRT.

3. **Child Health Program**

Wyoming Vision Collaborative

In 2015, the CHP changed the focus of our vision screening contract with the WIND to create the Wyoming Vision Collaborative for Early Childhood Vision Screening, encompassing all vision screening stakeholders. The goal of the newly formed Vision Collaborative is 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 partnership with the Wyoming Optometric Association, screening protocol/training was created and piloted in 3 communities. The results of these trainings have already become apparent through the Positive Predictive Value (PPV) data. This data reflects how well we are screening and referring children. The PPV is currently at 100%. MCH has worked the Wyoming Early Intervention Program to determine sustainability and consistent data collection.

In FY18, the CHP will continue to support the Wyoming Vision Collaborative for Early Childhood Vision Screening. MCH continues to work with the Wyoming Early Intervention Program to determine sustainability and help ensure consistent data collection. The Wyoming Vision Collaborative is currently offering a free, self-paced training in current best practices for vision screening for preschool aged children. The training provides early care and education staff at the regional CDCs with the tools necessary to conduct screening tests that can help identify the need for follow-up vision care with eye healthcare professionals for the detection of vision disorders.

Parent Leadership Training Institute (PLTI)

MCH assisted several communities to sponsor the Parent Leadership Training Institute (PLTI) model. PLTI is a strategy identified to increase parent engagement and improve children's health and safety at the local level. T WRIR and four counties: Hot Springs, Natrona, Albany and Laramie participated in conference calls during FY 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 graduated in Spring 2016. The Hot Springs County PLTI site chose to take a year and focus on supporting parent leader alumni with their projects.

PLTI Training attendees, which include families of CSHCN, are equipped with a ‘tool kit’ of leadership skills an provided opportunities to put those skills into practice through a community 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.

A Kellogg Foundation grant funded evaluation and modification of the PLTI curriculum to create a rural and frontier protocol. The CHPM and the PLTI Director from Colorado assisted in its development based on experiences from Wyoming and Colorado PLTI sites. These meetings were held throughout 2015 and 2016.

MCH will continue to assist communities to sponsor the PLTI model. The WRIR and two counties (Natrona and

Laramie) anticipate offering classes in the fall of 2017 and winter of 2018.

Child Death Review

An MCH epidemiologist serves as a WDH representative on the current Wyoming Child Death Review team and provides data support to the group. The group reviews major injuries (including sexual assaults) and deaths where children were either in DFS custody at the time of the death/injury or where a substantiated case of child maltreatment occurred. In addition to serving on the committee, the MCH epidemiologist provides annual data on causes of child fatalities to be included in the annual report. Because of the DFS review's focus on maltreatment, the WDH is planning to create an internal process for review of suicides and injury related child deaths. The MCH epidemiologist is involved in the planning of these new programs and processes.

4. **Youth and Young Adult Health Program**

Wyoming Adolescent Health Partnership (WAHP)

Formed in May of 2014 the WAHP Steering Committee includes: WDH YAYAH Program, WDH – Immunizations, Department of Workforce Services (DWS) – Division of Vocational Rehab Transition Specialist, DFS (trainer involved with foster care, child protective services, and youth in juvenile justice), WDE– School Health and Safety, WCADVSA, Eastern Shoshone and Northern Arapahoe youth leaders, 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. MCH serves as the backbone organization for the collective impact partnership. The Vision of the WAHP is: "Empowered youth reaching their full potential in an environment that fosters physical, mental, community, and spiritual wellness." The mission is: "The WAHP Steering Committee inspires and mobilizes youth-adult partnerships by fostering environments for Wyoming youth to exercise their voice and choice." The steering committee is tasked with supporting the WDH State Level Youth Team that will be developed in FY17, serving as the Adolescent Advisory Group for the Needs Assessment, and participating in strategic planning for adolescent health.

Suicide Prevention

The YAYAHP supports the Suicide Prevention Program at WDH through participation on the Wyoming Suicide Prevention Advisory Council (WYSPAC). The YAYAHPM works to ensure that youth suicide efforts remain a priority at WDH and brings adolescent expertise to strategy discussions. Once the Youth Council is established, youth from the council will participate with WYSPAC.

Safe 2 Tell

In 2016, the Wyoming legislature passed a bill to support creation of a statewide school safety tipline. Safe to Tell is modeled after Colorado's successful Safe to Tell program. Anyone can confidentially report anything that concerns or threatens students, their friends, their families, and communities. Safe 2 Tell was launched in November 2016. The YAYAHP plans to support Safe 2 Tell through financial support and promotion. The majority of the reports that have been received since Safe 2 Tell launched have been suicide threats, bullying, and drugs.

Foster Care Recruitment and Retention Committee

The YAYAHPM is active with the DFS Foster Care Recruitment and Retention Committee. Adolescents face particular challenges with placement in Wyoming. Many families are not interested in older youth and these youth often settle in a juvenile justice facility due to lack of suitable homes.

5. **Children's Special Health Program**

Regional Genetics Clinics

In 2016, 24 in-person clinics were held in 7 locations statewide, and in 2017 5 clinics were held in 2 locations. In 2016, 136 clients were seen during the in-person clinics, with approximately 57% of those individuals attending for follow-up consultations. While utilization of these clinics has remained steady over time, the MCH unit is working to move away from the heavily direct-service model of the genetics program, and instead work to improve statewide systems for linking clients to genetic services. In order to further this effort, the MCH unit is working with RFH, PHN and the Wyoming WIND project at the University of Wyoming to develop and implement a telehealth genetics model. This will mean offering a reduced number of in-person clinics annually (4-6 clinics in 2 locations), and facilitating follow-up appointments for genetics clients through telehealth technology. The MCH unit is currently working on establishing pilot sites for this effort, with the intent of launching a telehealth genetics pilot in the Fall of 2017.

6. **Maternal and Child Health Unit**

Oral Health Program Elimination

The Oral Health Program (OHP) elimination included the Cleft Palate Clinics that were conducted twice a year. The MCH Unit worked with the healthcare providers who make up the Cleft Palate Team to train them on the processes conducted by WDH staff to continue facilitation of these clinics going forward without support from WDH. Guardians of active clients were contacted to obtain authorization for transferring their child's records to the Team for continuation of care.

MCH Workforce Development and Capacity

The MCH Unit has a current staff of nine: MCH Unit Manager, WIHPM, YAYAHPM, CHPM, Benefit/Eligibility Specialists (3), Newborn Screening and Genetics Coordinator, and MCH Administrative Assistant. In FY15, the OHP, including four Community Oral Health Coordinators (COHCs), a part-time dentist, and a program manager, moved to the MCH Unit. However, in FY16, the OHP was eliminated as a result of decreasing state revenues and required budget reductions. The cut eliminated the following sub-programs:

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

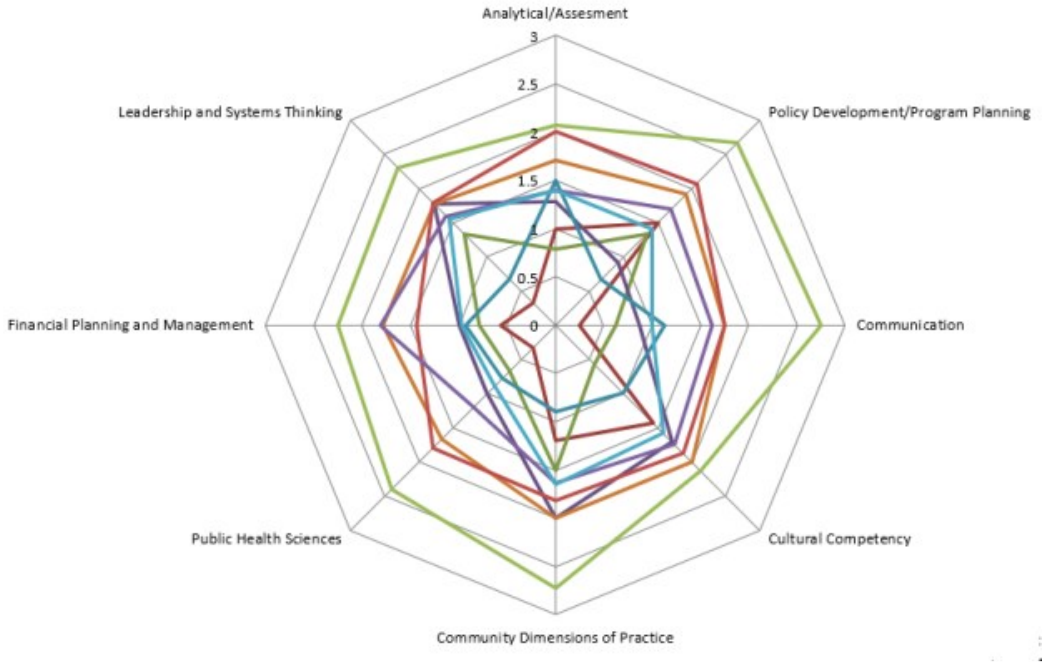
The MCH Unit works very closely with the MCH Epidemiology Program, a program organized within the Public Health Sciences Section of the WDH PHD. The program includes an MCH Epidemiology Manager, an MCH Epidemiologist/PRAMS Coordinator, and an MCH/Injury Epidemiologist. Though organizationally a part of the MCH Unit, one CSH Benefits and Eligibility Specialist provides half-time support to the PRAMS program. A CDC-assigned MCH Epidemiologist and Senior Epidemiology Advisor works closely with both MCH and MCH Epidemiology and is fully funded by Title V.

In FY16, two MCH Epidemiology positions became vacant. Despite hiring limitations due to state budget cuts, both positions were filled by summer of 2016.

In August 2016, the MCH Unit Manager position became vacant. In October 2016, the WIHPM was promoted to MCH Unit Manager, leaving a vacancy in the WIHP. In February 2017, a new WIHPM was hired.

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

The WDH PHD uses the Core Competencies for Public Health Professionals to help employees and their supervisors identify areas for improvement to guide performance and professional development goals. In 2014 and 2016, MCH staff completed the assessment. Results from 2016 are included below, demonstrating individual and Unit strengths and opportunities:



In FY16, MCH program managers and unit manager set performance goals related to Financial Planning and Management as a result of the assessment. MCH Navigator was used to identify webinars and courses that would help increase knowledge regarding public health budgets. All staff used results to inform their professional development planning.

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.

MCH Staff participate on both the PHD QI Council and the Performance Management Council. TA and QI tools are provided to programs to help increase program effectiveness and efficiency.

In 2016, the former WIHPM and current MCH Unit Manager participated in the Next Generation MCH Leaders cohort of the AMCHP Leadership Lab. This is a ten-month program geared toward 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 was nominated by her peers in Region VIII to receive the AMCHP Region VIII 2017 Emerging MCH Professional Award.

The MCH Unit continues to support employee development through the use of 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.

II.F.3. Family Consumer Partnership

Family/Consumer Partnership

MCH staff participate on a variety of councils and advisory groups including those that require parent and/or consumer representation. For example, the WIHPM participates on the Wyoming Governor's Council on Early Intervention (e.g. Wyoming Early Intervention Council (EIC)) whose membership currently includes two parents with special health care needs. Other key councils requiring parent and/or consumer membership include the WECSAC and the Governor's Council on Developmental Disabilities. This provides the opportunity to receive input from the people most affected by the programs developed and supported by the councils.

MCH staff participate in a University of Wyoming sponsored Project ECHO for families related to the topic of autism.

The WIHPM and CHPM participated in the development of the WYHVN since September 2015 and advocated for inclusion of parent and consumer representatives. At this time, WYHVN bylaws recommend membership by "parents currently being served by a home visiting program or who were served by such a program within the past 3 years".

In 2014, MCH invited parents and families directly served by MCH programs (e.g. CSH) to the ten community meetings held across the state. UPLIFT, Wyoming's Family to Family (F2F) Information Network and Family Voices affiliate, and county-level PHNs shared information about the meetings with their 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 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.

In 2015 and 2016, MCH included parent and parent organization representatives in the needs assessment and strategic planning advisory groups for all three programs. The goal is to maintain this level of parent/consumer engagement for future needs assessment and strategic planning efforts.

The YAYAHP continues to work with the WAHP to develop and implement a WDH State Youth Council. The goal of the council is to provide opportunities for youth and young adults to share their expertise and experiences to help inform and guide WDH programs that target youth and young adults including those focused on suicide prevention, substance use, communicable disease, behavioral health, etc. The council members will also learn how to advocate for themselves and their peers in State Government. Lastly, the council's presence and activities will help adults better understand youth and young adult culture and needs. Eight youth/young adults will be selected for participation through an application process and will represent the diversity of the State related to age, gender, geographic location, and race/ethnicity. Two council slots will be filled by representatives from the Eastern Shoshone and Northern Arapaho tribes. The youth council membership will be representative of Wyoming demographics such as rural/frontier, gender, American Indian, and Latino.

The WAYAH CoIIN team includes a youth and young adult representative and strategies related to consumer engagement. The youth and young adult representatives recently led efforts to develop a survey of their peers regarding health care which was distributed during a community event. Feedback will be used to guide future activities to support youth and their families in receiving recommended well-visits and to support providers and

systems to provide care that is responsive to youth and young adult needs.

Through the direction of the CHPM, MCH assisted several communities to sponsor the PLTI model, which is a strateg identified to increase parent engagement and improve children's health and safety at the local level. The WRIR and fo counties: Hot Springs, Natrona, Albany and Laramie participated in conference calls during FY16 and several offered training within their community. PLTI Training attendees, which include families of CSHCN, are equipped with a 'tool l of leadership skills and provided opportunities to put those skills into practice through a community project during the week course. Leadership skills and interpersonal skills provide attendees with information and empowerment to addr the needs of children, within their family and their community. A Kellogg Foundation grant funded evaluation and modification of the PLTI curriculum to create a rural and frontier protocol. The CHPM and the PLTI Director from Colorado assisted in its development based on experiences from Wyoming and Colorado PLTI sites. These meetinç were held throughout 2015 and 2016. Wyoming PLTI graduates are encouraged to participate in training opportunitie with PLTI graduates across the nation. PLTI graduates will be involved in planning specific trainings targeted and educating families about the importance of medical home and ensuring that family voice is recognized within their loc PCMH.

The CHP has implemented the Wyoming Parent Partner Program (PPP) for the past five years through a contract with the Hali Project. This evidence informed program helps medical homes identify/hire a parent within their practice who has a child with a special health care need. In FY16, approximately 217 families were served by Parent Partners in Fremont County, Natrona County and through multiple satellite locations. Planning is underway to expand the PPP to a clinic on the WRIR and on Warren Air Force Base in Cheyenne.

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 nurses within Wyoming to attend the conference at satellite sites across the state. Both school and PHNs applied and received scholarships. In June, the nurses received a survey requesting feedback on the annual report and application narratives for each MCH domain.

In June 2016, WDH released a new website. MCH staff received website design training and continue to work within their individual program sites to improve content and design. In order to ease navigation for website users, most programs separated content by the type of audience. For example, the CSH program page has separate sections based on topic and target audience including CSH parent resources, CSH provider resources, and CSH data.

In early 2017, the MCH Unit applied to become a Public Health Associate Program (PHAP) site to advance community and family engagement strategies. Although the application was not approved, MCH will use the application to guide internal efforts to move engagement strategies forward. See attachment.

In April 2017, Lolina, Inc. facilitated a community engagement session with MCH and MCH Epi staff. The meeting was planned as a result of the new Unit Manager's vision of improving MCH visibility with internal and external stakeholders and building Unit capacity to engage routinely with communities including parents, families, youth, and direct recipients of program services. The one-day meeting included the following:

- Strengthsfinder 2.0 team building exercises;
- Review of Wyoming MCH Vision, Mission, and Core Principles and their application since development in 2016;
- Communication brainstorming session including discussions about the 'why' behind MCH and target audiences for communication;
- Group completion of a Single Overriding Communication Objective (SOCO) worksheet related to what we want stakeholders to know about MCH;

- Development of common definitions of community engagement; and
- Development of an example draft action plan for achieving community engagement.

Health Reform

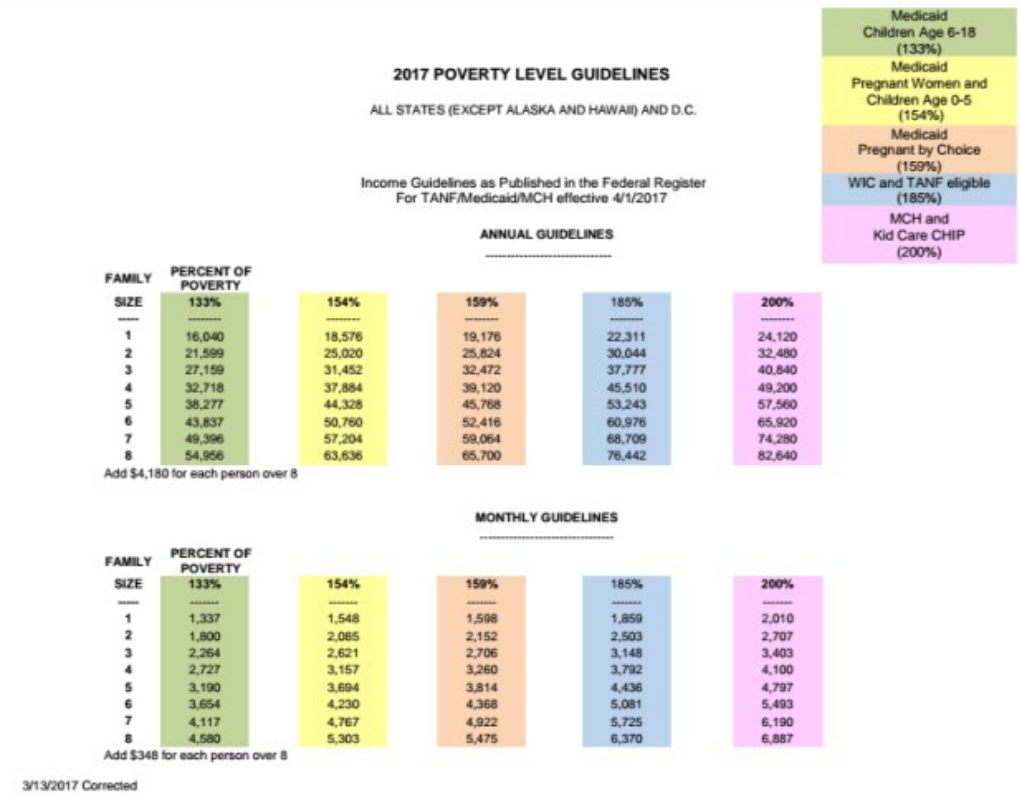
The Wyoming Legislature has not passed Medicaid expansion. In 2015, WDH released the Strategy for Health, Access, Responsibility, and Employment (SHARE) plan to expand Medicaid to adults with incomes up to 138% of the Federal Poverty Level (FPL), but it was rejected by the legislature. More discussions regarding healthcare for Wyoming's uninsured continued leading up to the 2016 session. During the 2016 legislative session, despite the Governor's support of Medicaid expansion and presentation of two different budgets--one with Medicaid and one without to demonstrate the financial impact of expanding Medicaid, the legislature did not pass expansion. No efforts to expand Medicaid took place during Wyoming's 2017 session due to uncertainty around the future of the ACA.

In 2015, Wyoming had two health plans in the Federal Health Insurance Marketplace, BCBS of Wyoming and WINhealth. However, as of January 2016, WINhealth, the second largest Wyoming health insurance company, closed. This leaves BCBS as the sole carrier offering individual and small group plans in the Wyoming exchange. During the 2017 open enrollment period, 24,826 people enrolled in coverage through the Wyoming exchange — a 4 percent increase over the 23,770 people who enrolled in 2016. The average pre-subsidy premium in Wyoming's exchange for 2017 is $614/month, considerably higher than the $476/month average across all the states that use the federally-run exchange. According to an HHS report released in December 2016, there are roughly 20,000 more people with health insurance in Wyoming than there would be without the ACA. (www.healthinsurance.org)

The MCH Unit's CSH program provides care coordination and limited, gap-filling financial assistance to clients served through the following subprograms:

- "Children's Special Health Program", a program which provides limited financial assistance to eligible children and youth (ages 0-18) with special health care needs;
- "Maternal High Risk Program", a program which provides limited financial assistance to a high risk pregnant woman receiving medical care from a perinatologist or at a level III medical facility; and
- "Newborn Intensive Care Program", a program which provides limited financial assistance to a newborn who receives medical care related to intensive respiratory support or a diagnosis of congenital anomalies at a level III medical facility.

CSH is the payer of last resort; in order to be eligible for assistance, families must first apply for Medicaid, Kid Care CHIP and the Federal Marketplace. The program provides reimbursement to eligible providers for covered services provided to eligible clients. Program eligibility is determined based on financial (see image below) and medical criteria.



2017 POVERTY LEVEL GUIDELINES

ALL STATES (EXCEPT ALASKA AND HAWAII) AND D.C.

Income Guidelines as Published in the Federal Register
For TANF/Medicaid/MCH effective 4/1/2017

Medicaid Children Age 6-18 (133%)
Medicaid Pregnant Women and Children Age 0-5 (154%)
Medicaid Pregnant by Choice (159%)
WIC and TANF eligible (185%)
MCH and Kid Care CHIP (200%)

ANNUAL GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY 133%	154%	159%	185%	200%
1	16,040	18,576	19,176	22,311	24,120
2	21,599	25,020	25,824	30,044	32,480
3	27,159	31,452	32,472	37,777	40,840
4	32,718	37,884	39,120	45,510	49,200
5	38,277	44,328	45,768	53,243	57,560
6	43,837	50,760	52,416	60,976	65,920
7	49,396	57,204	59,064	68,709	74,280
8	54,956	63,636	65,700	76,442	82,640

Add $4,180 for each person over 8

MONTHLY GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY 133%	154%	159%	185%	200%
1	1,337	1,548	1,598	1,859	2,010
2	1,800	2,085	2,152	2,503	2,707
3	2,264	2,621	2,706	3,148	3,403
4	2,727	3,157	3,260	3,792	4,100
5	3,190	3,694	3,814	4,436	4,797
6	3,654	4,230	4,368	5,081	5,493
7	4,117	4,767	4,922	5,725	6,190
8	4,580	5,303	5,475	6,370	6,887

Add $348 for each person over 8

3/13/2017 Corrected

CSH Program Benefits and Eligibility Specialists (state MCH staff) work closely with PHNs in all 23 counties to provide care coordination services to families with children or youth with special health care needs. Examples of care coordination services provided through the CSH programs include:

- Working with the client/family to identify needs, concerns, and priorities;
- Supporting families in following the client's plan of care and recommended preventive well-child visits (e.g. tracking and providing appointment reminders based on care plan and Bright Futures periodicity chart);
- Locating, accessing, and connecting families to needed community services and resources;
- Assuring services are coordinated among interdisciplinary team members and across programs and agencies;
- Assuring families have access to health care coverage (e.g. helping families sign up for Medicaid, Kid Care CHIP, Marketplace, etc.);
- Investigating billing problems;
- Providing support for transition to adult health care services;
- Providing support for interpretation and translation services; and
- Evaluating the effectiveness of service delivery in meeting client and family needs.

Beginning in January 2015, eligibility and enrollment for both Medicaid and CHIP were assumed by the WDH Division of Healthcare Financing (i.e. Medicaid), 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 CSH program is exploring multiple program improvements including increasing the number of program

documents available in different languages with Spanish being a first priority, updating our rules to reflect a changing organizational structure and clarify program processes, and working with Department-wide partners to consider updates to our data system. The CSH program is also looking forward to requesting technical assistance to further improve program operations and consider ways to incorporate non-direct services components.

The State of Wyoming benefits from three ACA grants related to MCH.

- The Personal Responsibility and Education Program (PREP) grant is awarded to WDH, Communicable Disease Unit. The MCH YAYAHPM devotes a quarter of her time to the PREP grant.
- Although not awarded to the State of Wyoming, the MIECHV grant supports the state's home visiting capacity. MIECHV is awarded to a non-profit organization, Parents as Teachers National Center (PATNC). MIECHV funding supports direct implementation of home visiting services through 5 local implementing agencies and systems improvement efforts to build a statewide home visiting network.
- The YAYAHP also supports activities of the WDH-administered Preventive Health and Health Services Block Grant.

Emerging Issues

Budget reductions: For the past two fiscal years, the MCH budget has been reduced as a result of sweeping cuts. In 2016, the MCH state general fund budget was cut by $731,807 and in 2017, the legislature cut an additional $235,990. Counties in particular were impacted as funding amounts to counties for the provision of home visiting and other MCH services were reduced. The state general fund reduction came on the heels of a reduction in TANF funding, a cut implemented by DFS due to insufficient spending of previous years' amounts. So far, the cuts have not impacted MCH's ability to meet the required maintenance of effort (MOE). The MCH Unit will continue to improve our partnerships to leverage resources and funding and implement evidence-based practices to ensure efficient and effective use of available funding.

Provider engagement: MCH continues to prioritize improving MCH visibility and engagement with providers and consumers. In particular, MCH is searching for ways to improve provider engagement across all programs and priorities. The MCH Unit is exploring how technology-based tools such as Project ECHO may be useful in spreading best practices and education to providers. The MCH Unit is also hoping to increase engagement with provider groups such as the Wyoming Chapter of the AAP and the Wyoming Chapter of ACOG. Both chapter presidents have been involved in MCH projects this year including efforts to add CCHD to Wyoming's NBS Panel and efforts to use LOCATe assessment results for perinatal quality improvement.

Opioids: MCH is working with the Substance Abuse Prevention Program (SAPP) identify future partnership opportunities. During the 2016 legislative session several bills related to opioids were introduced and both programs were asked to respond. A few months later, in response to the current federal administration announcing state funding to combat the opioid epidemic, MCH reached out to the SAPP Program to offer MCH support and assistance. An MCH Epidemiologist will participate in an opioid-focused data workgroup and the WIHPM will participate in a training workgroup to keep MCH informed and involved. MCH Epidemiology is working to increase capacity to monitor opioid use in MCH populations. WDH does not have a dedicated Substance Abuse Epidemiologist; instead, Substance Abuse Epidemiology responsibility falls on the State Epidemiology Outcomes Workgroup (SEOW). MCH Epidemiology is an active member of this group. The SEOW created a workgroup to write the first State Opioid report, and MCH Epidemiology is a member of the workgroup to ensure that the MCH population is a focus of the analysis/report. Although this topic is not a current MCH priority, it is a topic that we will continue to monitor closely.

Telehealth: Access to care, especially specialty care, is a challenge for many families due to the rural/frontier nature of the State. This emerging issue has led to increased partnerships with the RFH Unit. As previously discussed, the MCH Unit is exploring ways to increase the use of telehealth in the provision of follow up genetics visits. For many years, MCH has contracted with geneticists to offer in-person regional genetics clinics up to 25 times per year. The MCH Unit is hoping that by incorporating telehealth into our services, we can reduce cost and maintain access for families that need genetics services.

Zika: In 2016, MCH and MCH Epidemiology remained informed of WDH activities related to Zika. WDH efforts were led by the Public Health Emergency Preparedness Unit with support from the State Epidemiologist and Infectious Disease Epidemiology Unit. Weekly situation reports were distributed until November 2016 with the expectation that future reports would be developed as necessary. MCH Epidemiology attends the weekly Public Health Rounds to stay informed of Zika activity.

Critical Congenital Heart Disease (CCHD): In 2015, the AHA approached WDH regarding the fact that Wyoming was among the last states to require CCHD screening. As a result, the Wyoming NBS Program initiated plans to add CCHD to the state's NBS panel, a 2012 recommendation of the U.S. Department of Health and Human Services (HHS) Secretary. In May 2016, the Wyoming NBS Advisory Committee voted to approve the addition of CCHD and in 2017, the rules requiring hospitals and qualified healthcare professionals to perform CCHD screening will become effective.

Maternal Mortality: Wyoming submits data annually to CDC's Pregnancy Related Mortality System by sending copies of death certificates for all women who died during pregnancy or within 1 year of pregnancy. The number of pregnancy related deaths was relatively low for several years, but in 2014 we noticed an increase that persisted into 2015. Wyoming's rate from 2011-2015 was 60/100,000. Preliminary data for 2016 indicate a decrease in the rate. Wyoming is not currently conducting maternal mortality review, but plans to begin building the infrastructure to create a review process.

Maternal Morbidity: In 2015, Wyoming MCH Epidemiology participated in a CDC/UIC sponsored course on claims based data analysis and through this course we were able to gain the skill set to calculate severe maternal morbidity using the state hospital discharge data. Through that analysis we learned that the rate of severe maternal morbidity (SMM) in Wyoming during SFY 2009-2014 was 109 per 10,000 delivery hospitalizations. The SMM rate did not change significantly over the 6 years. The most common cause of SMM in Wyoming was blood transfusion, disseminated intravascular coagulation, hysterectomy, heart failure during procedure/surgery, operations on the heart and eclampsia. SMM rates were significantly higher among women with Medicaid paid deliveries than women whose deliveries were paid by Medicaid. Rates were higher among black and American Indian and Alaska Native women compared to white women. Frontier and critical access facilities have higher rates of SMM than urban and non-critical access hospitals. MCH Epidemiology plans to repeat this analysis to include more recent data, and to implement the SMM macro for ICD10 once it is updated.

Early Periodic Screening Diagnosis and Treatment (EPSDT): EPSDT tracks children enrolled in Medicaid's well child screenings from birth to twenty years of age. Wyoming's EPSDT screening rate among all children is in the worst ten states in the country. Data provided by Medicaid indicate that 98% of infants receive at least one EPSDT screen but that only 7% of young adults aged 19-20 receive an EPSDT screen.

Low EPSDT rates in Wyoming continue to concern MCH and WDH leadership. In 2017, MCH, Wyoming Medicaid, and Immunization Unit were asked to present to WDH leadership on current data and activities related to EPSDT. Fortunately, this topic aligns with three MCH-selected NPMs: NPM 6, NPM 10, and NPM 11.

Our low national ranking and a decrease in screening rates over the last five years prompted review by WDH Director's Office. Further scrutiny of the data highlights disparities in screening by county and provider type. A work group including staff from the director's office, MCH, MCH Epi, and Medicaid are addressing data needs and potential next steps. Additionally, this data will also be used to inform the WAYAH CoIIN efforts spearheaded by our YAYAHP. These data will be used to identify potential pilot clinics and target informational interviews among high and low performing clinics.

This topic is included as an emerging issue because of the opportunity it presents to further build our relationship with Medicaid. It also presents an opportunity to discuss and promote life course theory, as EPSDT rates are a life course indicator. Current activities to increase EPSDT rates are focused on the adolescent population through Wyoming's participation in the AYAH CoIIN to increase adolescent well-visits and on the child population through the CHP's goal of increasing developmental screenings in the healthcare setting.

Youth Suicide: In 2015, Wyoming had the second highest adolescent (15-24 year old) suicide rate (34.4 per 100,000) in the nation and nearly three times higher than the national rate of 12.5 deaths per 100,000. Between 2007-2009 and 2013-2015, the rate of adolescent (ages 15-24) suicide in Wyoming has nearly doubled from 18.0 per 100,000 to 30.4 per 100,000. The rate among male adolescents is 50.0 per 100,000 and among non-metro residents is 32.8 per 100,000 in 2013-2015. The change in the rate over the last decade is high. The YAYAHPM sits on the state's suicide prevention taskforce. MCH is working to ensure that an adolescent voice is represented on the taskforce going forward to provide the young adult perspective to suicide prevention efforts in the state. Additional conversation about MCH's role in suicide prevention is planned for an MCH and MCH Epidemiology joint meeting in the months ahead.

II.F.6. Public Input

Public Input

In February 2015 (in-person), May 2015 (virtually), and May 2016 (in-person), MCH convened meetings with advisory groups representing each of MCH's program areas (WIHP, CHP, and YAYAHP) to seek input on the selection of MCH priorities and the development of an MCH strategic plan. MCH plans to reconvene this set of stakeholders again during Fall 2017 and at least annually thereafter to monitor success on the strategic plan and conduct ongoing assessments of population needs and strengths.

Excerpts from the draft FY2018 application and FY2016 annual report were made available to the public via the MCH website in June 2017. MCH distributed a survey request with a link to the excerpts to parents, including PLTI graduates, and MCH stakeholders, including program-specific advisory group members. The first 50 respondents will receive a $25 gift card if they choose to provide their contact information. The survey asks for general feedback on each NPM and SPM, about services/activities they were not aware of and services/activities that they know about but that were not included in the report, and about challenges and successes related to health in their community. The final two questions listed above were used in the 2015 needs assessment community meetings. Asking these questions of consumers and stakeholders will help ensure our needs assessment process is ongoing.

As of July 12, 2017, the MCH Unit received 20 survey responses, with respondents from 7 of the 23 counties statewide. Approximately 80% of households who responded to the survey reported having women of childbearing age (15-44) and/or infants (ages 0-1) in their household, 75% reported having children (ages 1-11) in their household, and 60% reported having youth or young adults (aged 12-24) in their household.

62% of respondents reported that there are services/programs/activities listed in the Title V Block Grant that they were unaware of and 87% reported that they are willing to be contacted in the future to provide input on issues related to the health of Wyoming women, children, youth and families.

For each priority, opportunities for improvement in areas like program visibility and communication have been identified. The majority of comments received expressed some form of affirmation or support for the ongoing programs and services offered under MCH, and many offered anecdotal suggestions for additional improvement. The most common comment from respondents across all areas pointed to a need for greater community and stakeholder engagement. Many respondents expressed the need for MCH to conduct additional outreach in order to better inform the community regarding available services across all domains. There were also several respondents who indicated a need for greater community education on MCH priorities, and the impact of those issues on the health of our community.

During the 2015 Needs Assessment, MCH collected contact information from community meeting attendees. They were previously contacted regarding the final selection of MCH priorities and will be contacted again to provide feedback on the current annual report and application.

Several school nurses received scholarships to attend the 2017 CSHPC and, in return, have agreed to provide feedback to sections of this application/annual report. A survey request was sent in June 2017.

In FY17, MCH amended a contract with Lolina, Inc. who will continue to provide TA to the MCH Unit related to improving community engagement strategies. The goal is to improve public input seeking strategies each year.

Technical Assistance

The MCH Unit met and discussed potential TA needs. They include:

- **Children's Special Health (CSH) Program**: The CSH program in Wyoming has not changed for many years despite reductions in staff and budgets and a shift nationally away from direct services in favor of population-based, public health services. The program provides gap-filling financial assistance and care coordination to eligible families. There is currently no system-level activities occurring within this program despite efforts over the past couple years to adopt the Standards for Systems of Care for CYSHCN. CSH leadership capacity is also limited. Currently, the CSH program does not have a dedicated program manager; the Title V Director assumes the CYSCHN Director responsibilities. Despite these facts, the program staffs three strong benefits and eligibility specialists who provide quality state-level care coordination. At the local level, PHN provides care coordination for CYSHCN; however, there has not been a formal training provided to these care coordinators for at least 5 years. At all levels, training gaps exist and the MCH Unit is requesting assistance from MCHB and/or other states to provide training and TA related to the Standards for Systems of Care for CYSHCN and their application in states comparable to Wyoming (e.g. rural and frontier).

- **Perinatal Quality Collaborative Development**: See 'Emerging Issues' topics related to maternal mortality/morbidity. The WIHP and MCH Epidemiology have increased hospital engagement with the implementation of 2016-2020 priorities and the increased emphasis on evidence-based practices. The implementation of LOCATe and subsequent quality improvement efforts (e.g. maternal patient safety bundles) have increased our relationship and engagement with hospitals. Two staff also attended the November 2016 National Network of PQC launch meeting. MCH is interested in receiving TA related to building the capacity to develop and support a PQC with consideration of rural and frontier implications and the fact that there are on Level III maternal or neonatal levels present in Wyoming. In addition, the MCH Unit is interested in learning about how other states hire and/or contract with MCH clinical specialists or consultants to guide and advance perinatal quality work and other clinical quality topics. Currently, MCH does not staff a clinical specialist to guide these efforts.

- **Telehealth-based specialty services**: See 'Emerging Issues' topic related to telehealth. For over twenty years, the MCH Unit has funded in-person regional genetics clinics. Due to shifts to more population-based services and shrinking state budgets, the MCH Unit is exploring ways to increase the use of telehealth in the provision of follow up genetics visits as a pilot for potential further work using telehealth to promote access to care in rural and frontier areas of the state. Partnerships with Wyoming's RFH Unit are underway but the MCH Unit would benefit from further TA on this topic. The MCH Unit is interested in TA related specifically to billing and payment for these services.

- **Provider engagement:** All MCH programs prioritize provider and consumer engagement in the promotion of 2016-2020 priorities. The MCH Unit is currently exploring virtual learning tools, including Project ECHO, to increase awareness and use of evidence-based practices throughout our provider communities including but not limited to primary care, family practice, pediatrics, obstetrics and gynecology, IHS, FQHC, Title X, PHN, hospitals, midwifery, etc. The MCH Unit is also hoping to improve consumer, family, and youth engagement especially as we look forward to the next needs assessment process. Potential topics discussed include EPSDT, youth and consumer engagement, genetics, etc.

III. Budget Narrative

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,125,000	$1,156,063	$1,117,686	$1,122,915
Unobligated Balance	$0	$0	$0	$0
State Funds	$2,034,862	$1,809,026	$1,869,786	$1,995,605
Local Funds	$0	$0	$0	$0
Other Funds	$599,483	$566,565	$505,805	$514,865
Program Funds	$0	$0	$0	$0
SubTotal	$3,759,345	$3,531,654	$3,493,277	$3,633,385
Other Federal Funds	$2,141,855		$1,484,162	$1,511,035
Total	$5,901,200	$3,531,654	$4,977,439	$5,144,420

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.

	2016		2017	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,100,000	$1,105,862	$1,125,000	
Unobligated Balance	$0	$0	$0	
State Funds	$1,951,264	$1,815,114	$1,775,473	
Local Funds	$0	$0	$0	
Other Funds	$599,192	$560,477	$600,119	
Program Funds	$0	$0	$0	
SubTotal	$3,650,456	$3,481,453	$3,500,592	
Other Federal Funds	$2,192,704	$1,447,303	$2,179,510	
Total	$5,843,160	$4,928,756	$5,680,102	

	2018	
	Budgeted	Expended
Federal Allocation	$1,125,000	
Unobligated Balance	$0	
State Funds	$1,825,591	
Local Funds	$0	
Other Funds	$550,000	
Program Funds	$0	
SubTotal	$3,500,591	
Other Federal Funds	$1,600,234	
Total	$5,100,825	

III.A. Expenditures

Expenditures

As of July 17, 2017, the unobligated balance for FFY16 funds is $0.

MCH Block Grant expenditures for FY16 were categorized into the following categories:

- Prevention and Primary Care for Children (32.3%);
- Children with Special Health Care Needs (43.6%);
- Administrative (3%); and
- Family (21.1%).

MCH met the 30% requirement for both Prevention and Primary Care for Children and Children with Special Health Care Needs. The Family category supports salary/benefits and key activities of the WIHP and the YAYAHP. The WIHP works closely with PHN to support the HBHV Program. In FY16 and FY17, MCH provided more guidance to nurses regarding how they could support Title V priorities at the local level.

MCH supported gap-filling contraceptive purchases for counties with little to no Title X services in FY16 and through State Fiscal Year 2017 but will discontinue support in State Fiscal Year (SFY) 2018 while we reevaluate best strategies for increasing access to the wide range of contraceptive options. MCH will continue to partner with the WHC to improve access to family planning services.

MCH supported contracts with SKW to enhance efforts to prevent childhood injury with a focus on the top causes of unintentional injury as well as an increased focus on implementation of evidence-based strategies.

In FY16, MCH provided funding to support the Wyoming Vision Collaborative. In FY17, the CHP is looking for ways to leverage other funding sources to continue the collaborative in order to reallocate funds to other CHP priorities including physical activity and medical home.

MCH continues to provide limited gap-filling financial assistance to eligible families served by our CSH program including high risk pregnant women and infants cared for by Level III providers. CSH is a payer of last resort for enrolled clients who meet medical and financial eligibility criteria. In order to be eligible for assistance, families must first apply for Medicaid, Kid Care CHIP and the Federal Marketplace. A portion of FY16 funds supported this activity; however, the MCH Unit is seeking TA to support more population based CSH services and activities.

In FY16, MCH supported a contract with the University of Utah to provide genetics clinics throughout Wyoming. In FY17, the contract amount and services was reduced and efforts began to incorporate telehealth for a portion of these services to reduce costs and improve access for families living in rural communities. Work is ongoing and progress will be shared in next year's report.

A large part of the FY16 Title V expenditures funds salaries and benefits MCH staff including program managers, CSH benefits and eligibility specialists program, and a portion of MCH Epidemiology. The partnership between MCH and MCH Epidemiology is essential to ensure we are continually assessing and monitoring the needs of Wyoming communities as well as the success of our programming.

Wyoming MCH receives direct assistance to support a CDC-assigned MCH Epidemiologist who provides TA and scientific guidance supportive of all MCH programs with a specific emphasis on data support for the WIHP.

See Form 3a for a breakdown of MCH expenditures by population type (pregnant women, infants <1 year, children 1-22 years (including adolescents), CSHCN, and other).

See Form 3b for a breakdown of MCH expenditures by service type (direct, enabling, and public health services and systems.

III.B. Budget

Budget

MCH 3.0, the required MCH needs assessment, and subsequent strategic planning processes provided MCH with direction for leveraging scarce resources to impact the health and wellness of Wyoming's families. Title V funding, combined with other federal dollars (e.g. PREP, RPE) support most MCH Unit positions, including a CDC-assigned MCH Epidemiologist. Three positions, the MCH administrative assistant, MCH 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. Title V also funds SKW for development and oversight of Safe Kids coalitions around the state and with WIND 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 NBS program is managed within MCH. Hospitals are charged a fee set by the NBS advisory committee. From this fee, MCH contracts with CDPHE to analyze the laboratory specimens 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 CDPHE.

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, a combination of state and federal funds provide gap filling services for those children who qualify financially and medically. Local PHNs provide care coordination 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.

Currently, Wyoming is facing an economic downturn and WDH has had to make difficult decisions to address decreasing state revenues. In FY16, the OHP was eliminated. In addition, $731,807 of the MCH State General Fund (SGF), part of the Title V Maintenance of Effort (MOE), was cut. The SGFs used for the infant immunization, Prevnar, will continue to assist with meeting the MOE.

Wyoming's proposed budget for FFY 2018, as reflected on Form 2, includes the following budget items:

- Prevention and Primary Care for Children: $360,000 (32%)
- Children with Special Health Care Needs: $440,000 (39.1%)
- Administrative Costs: $45,000
- State MCH Funds: $1,825,591
- Other Funds (NBS): $550,000
- State MOE: $2,375,591

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 - PHAP 2017 Application.pdf

Supporting Document #02 - PHD Org Chart May 2017 (wo-djd) 05-31-17.pdf

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Wyoming

	FY18 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	$ 440,000	(39.1%)
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)	$ 1,825,591	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 550,000	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 2,375,591	
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)	$ 3,500,591	
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)	$ 1,600,234	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 5,100,825	

OTHER FEDERAL FUNDS	FY18 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	$ 1,177,341
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 97,644
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 130,249
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 195,000

	FY16 Annual Report Budgeted		FY16 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 1,100,000		$ 1,105,862	
A. Preventive and Primary Care for Children	$ 346,850	(31.5%)	$ 358,038	(32.3%)
B. Children with Special Health Care Needs	$ 396,102	(36%)	$ 482,219	(43.6%)
C. Title V Administrative Costs	$ 23,510	(2.1%)	$ 33,929	(3.1%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0		$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 1,951,264		$ 1,815,114	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 599,192		$ 560,477	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 2,550,456		$ 2,375,591	
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)	$ 3,650,456		$ 3,481,453	
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)	$ 2,192,704		$ 1,447,303	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 5,843,160		$ 4,928,756	

OTHER FEDERAL FUNDS	FY16 Annual Report Budgeted	FY16 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	$ 1,760,750	$ 1,021,785
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 121,909	$ 85,681
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 80,000	$ 186,968
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	$ 140,000	$ 53,331
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 90,045	$ 99,538

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1. FEDERAL ALLOCATION**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: Estimate of FFY18 funds	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: Phase FFVEN7 (Phase used for Prevention Funds). Confirmed by M. Daniel.	
3.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: Phase FFCSH7 (Phase used for Children's Special Health Funds). Confirmed by M. Daniel	
4.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: Phase FFADM7 (phase used for administrative costs). Confirmed by M. Daniel.	
5.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: All 0523 (MCH Unit #) State General Fund (SGF) phases including funding for MCH Epi Program. Includes Prevnar funding from Immunization Unit.	
6.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2018**

	Column Name:	**Application Budgeted**
	Field Note: Newborn Screening Trust and Agency Account; fees charged to hospitals for newborn screening are deposited into this account. The current fee is $77 per newborn screen performed.	
7.	**Field Name:**	**7. TOTAL STATE MATCH**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: This is Wyoming's MOE (1989). The MOE is higher than the required match. The dollar represented equals actual expenditures.	
8.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Confirmed by M. Daniel. Total FY16 expenditures. This does not include direct assistance. Direct assistance supports having a CDC assignee in Wyoming.	
9.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Includes FFVEN6 and FFDEN6 phases (prevention and dental sealants) Expended as of 6/30/17: 358,038	
10.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: FFCSH6 (children's special health phases including genetics). Expended as of 6/30/17: 482,219	
11.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**

	Field Note: In FY17, the MCH Unit began using function codes. This will lead to better tracking and budgeting in future years for administrative costs.	
12.	**Field Name:**	**2. UNOBLIGATED BALANCE**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: As of 6/30/17. MCH will spend down 100% of funds before close of FFY16 (before 9/30/17).	
13.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Includes State General Funds for the Children's Special Health program, Administration (MAD), Women and Infant (Now Family), County funds, and MCH Epi. As of 6/24/17 ($1,471,706.74). Vaccines Prevnar (Immunization Unit): $343,408	
14.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Newborn Screening Trust and Agency Funds. October 1, 2015 - September 30, 2016 by service date.	
15.	**Field Name:**	**7. TOTAL STATE MATCH**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Equals State's required MOE. Actual expenditures.	
16.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**

	Field Note: The Wyoming Department of Health receives TANF funding through an interagency agreement with the Wyoming Department of Family Services. The funds help implement Wyoming Statute 35-27-101 through 104, Public Health Nursing Infant Home Visitation Services. FY18 budgeted amount confirmed by M. Daniel 6/24/17.	
17.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: FY18 budgeted amount confirmed by M. Daniel 6/24/17. The SSDI grant is managed by the MCH Epidemiology Program and supports Title V activities.	
18.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: FY18 budgeted amount confirmed by M. Daniel 6/24/17. The PRAMS grant is managed by the MCH Epidemiology Program.	
19.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: FY18 budgeted amount confirmed by M. Daniel 6/24/17. The RPE Grant is managed by the Youth and Young Adult Health Program Manager.	
20.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Confirmed by M. Daniel.	

21.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Confirmed by M. Daniel.	
22.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: RPE Grant cycle is February - January. Carryover of $72,000 in carryover from FY16 to FY17 was requested. The budget in the Wyoming State Budget for this funding source has not typically matched the award due to the way the state budget is set up biannually. Confirmed by M. Daniel.	
23.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Confirmed by M. Daniel. ECCS grant year was 8/1/15 - 7/31/16 with carry-over requested and approved through 7/31/17. This explains why the expenditures are lower than the budgeted amount.	
24.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Confirmed by M. Daniel.	

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	FY18 Application Budgeted	FY16 Annual Report Expended
1. Pregnant Women	$ 70,000	$ 68,014
2. Infants < 1 year	$ 128,000	$ 85,748
3. Children 1-22 years	$ 360,000	$ 358,038
4. CSHCN	$ 440,000	$ 482,219
5. All Others	$ 82,000	$ 77,914
Federal Total of Individuals Served	$ 1,080,000	$ 1,071,933

IB. Non Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Pregnant Women	$ 260,000	$ 253,776
2. Infants < 1 year	$ 1,240,000	$ 1,197,830
3. Children 1-22 years	$ 123,000	$ 123,603
4. CSHCN	$ 277,000	$ 287,082
5. All Others	$ 475,591	$ 513,301
Non Federal Total of Individuals Served	$ 2,375,591	$ 2,375,592
Federal State MCH Block Grant Partnership Total	$ 3,455,591	$ 3,447,525

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, Federal Total of Individuals Served**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: Total FFY18 Budget estimate ($1,125,000) with administrative cost budget removed ($45,000).	
2.	**Field Name:**	**IB. Non Federal MCH Block Grant, Non Federal Total of Individuals Served**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: Confirmed by M. Daniel 6.30	
3.	**Field Name:**	**IA. Federal MCH Block Grant, 1. Pregnant Women**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: FFFAM6. 50% of Women and Infant Health Program Manager salary and supplies for FFAM6. Breastfeeding environmental scan contract. Community Baby Showers.	
4.	**Field Name:**	**IA. Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: FFFAM6. 50% of Women and Infant Health Program Manager salary and supplies for FFAM6.	
5.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Contracts with Safe Kids (child injury), Healthy Pokes (physical activity), WY Vision Collaborative (preventive care for children), and salaries for FFVEN6 (including Child Health Program Manager)	
6.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2016**

	Column Name:	**Annual Report Expended**
	Field Note: Parent Leadership Training Institute, University of Utah (genetics clinics), Hali Project (Parent Partner), CSH benefits for eligible clients, and salaries from FFCSH6 (2.5 FTE for CSH Benefits and Eligibility Specialists)	
7.	**Field Name:**	**IA. Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Cardinal Health expenditures for birth control.	
8.	**Field Name:**	**IB. Non Federal MCH Block Grant, 1. Pregnant Women**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: State General Funds to County Contracts (x Preg Women %) + SGF Epi (split evenly across programs) + 50% SGF Family. Confirmed with M. Daniel 6.30.	
9.	**Field Name:**	**IB. Non Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: State General Funds to County Contracts (x Infant %) + SGF Epi (split evenly across programs) + 50% SGF Family + NBS + Prevnar. Confirmed with M. Daniel 6.30.	
10.	**Field Name:**	**IB. Non Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: State General Funds to County Contracts (x Child %) + SGF Epi (split evenly across programs). Confirmed with M. Daniel 6.30.	
11.	**Field Name:**	**IB. Non Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**

	Field Note: State General Funds to County Contracts (x CSH %) + SGF Epi (split evenly across programs) + SGF CSH phase. Confirmed with M. Daniel 6.30.	
12.	**Field Name:**	**IB. Non Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: State General Funds to County Contracts (x All Others %) + SGF Epi (split evenly across programs) + MCH Unit Manager and Admin salary and benefits. Confirmed with M. Daniel 6.30.	

Form 3b
Budget and Expenditure Details by Types of Services

State: Wyoming

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Direct Services	$ 100,000	$ 281,625
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 10,000	$ 77,685
B. Preventive and Primary Care Services for Children	$ 10,000	$ 35,651
C. Services for CSHCN	$ 80,000	$ 168,289
2. Enabling Services	$ 400,000	$ 277,706
3. Public Health Services and Systems	$ 625,000	$ 546,531
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		$ 108,784
Physician/Office Services		$ 7,126
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 11,662
Dental Care (Does Not Include Orthodontic Services)		$ 35,651
Durable Medical Equipment and Supplies		$ 6,479
Laboratory Services		$ 0
Other		
Clinics		$ 103,500
Travel		$ 7,127
Therapy		$ 1,296
Direct Services Line 4 Expended Total		$ 281,625
Federal Total	$ 1,125,000	$ 1,105,862

IIB. Non-Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Direct Services	$ 90,000	$ 165,516
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 10,000	$ 2,614
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 80,000	$ 162,902
2. Enabling Services	$ 700,000	$ 619,590
3. Public Health Services and Systems	$ 1,035,591	$ 1,590,485
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		$ 11,864
Physician/Office Services		$ 2,718
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 4,449
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 2,472
Laboratory Services		$ 0
Other		
Clinics		$ 139,000
MISC payment		$ 1,800
Travel		$ 2,719
Therapy		$ 494
Direct Services Line 4 Expended Total		$ 165,516
Non-Federal Total	$ 1,825,591	$ 2,375,591

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIA. - 1. Direct Services**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: Confirmed by M. Daniel 6.30.	
2.	**Field Name:**	**IIA. - 1. A. Preventive and Primary Care Services for all Pregnant Women,Mothers, and Infants up to Age One**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: Confirmed by M. Daniel 6.30.	
3.	**Field Name:**	**IIA. - 1. B. Preventive and Primary Services for Children**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: Confirmed by M. Daniel 6.30.	
4.	**Field Name:**	**IIA. - 1. C. Services for CSHCN**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: Confirmed by M. Daniel 6.30.	
5.	**Field Name:**	**IIA. - 2. Enabling Services**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: Confirmed by M. Daniel 6.30.	
6.	**Field Name:**	**IIA. - 3. Public Health Services and Systems**
	Fiscal Year:	**2018**

	Column Name:	**Application Budgeted**
	Field Note: Confirmed by M. Daniel 6.30.	
7.	**Field Name:**	**IIB. - 1. A. Preventive and Primary Care Services for all Pregnant Women,Mothers, and Infants up to Age One**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: Maternal High Risk and Newborn Intensive Care Program costs.	
8.	**Field Name:**	**IIB. - 1. C. Services for CSHCN**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: CSH program costs.	
9.	**Field Name:**	**IIB. - 2. Enabling Services**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: State General Funds for Counties estimated at $1,004,000. 65% is predicted to support enabling services.	
10.	**Field Name:**	**IIA. - 1. Direct Services**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Gap-filling contraceptives: $77,685 Sealants: $35,651.10 Genetics Clinics (84k) and CSH: Total $168,289.00	
11.	**Field Name:**	**IIA. - 1. A. Preventive and Primary Care Services for all Pregnant Women,Mothers, and Infants up to Age One**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Gap-filling contraceptives	
12.	**Field Name:**	**IIA. - 1. B. Preventive and Primary Services for Children**

	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Dental sealants	
13.	**Field Name:**	**IIA. - 1. C. Services for CSHCN**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Genetics Clinics + CSH Direct Payments.	
14.	**Field Name:**	**IIA. - 2. Enabling Services**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Parent Partner, Safe Kids, WIND (vision collaborative), Healthy Pokes, Community Baby Showers $53,550.78 $102,787 $107,474.52 $12,163.51 $1,730.12 Total: $277,706	
15.	**Field Name:**	**IIA. - 3. Public Health Services and Systems**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**

	Field Note: Salaries from the following phases (FAM, VEN, CSH), Lolina (MCH strategic planning consultant), Parent Leadership Training Institute, Environmental Breastfeeding Scan, Support Services $126,953 $92,051.43 $237,036.46 $22,427.47 $15,490.62 $1,620.00 $18,829 $30,716 ($1,408 Lolina and support fees) Total: $546,531	
16.	**Field Name:**	**IIA. - 4. Pharmacy**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Contraceptives ($77,685) + CSH Pharmacy ($31,098.66)	
17.	**Field Name:**	**IIA. - 4. Physician/Office Services**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: CSH Physician/Office Services. 11% of Total.	
18.	**Field Name:**	**IIA. - 4. Hospital Charges (Includes Impatient and Outpatient Services)**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: CSH Hospital Charges. 18% of Total.	
19.	**Field Name:**	**IIA. - 4. Dental Care (Does Not Include Orthodontic Services).**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Dental sealants	
20.	**Field Name:**	**IIA. - 4. Durable Medical Equipment and Supplies.**

	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: CSH Durable Medical Equipment 10% of Total.	
21.	**Field Name:**	**IIB. - 1. A. Preventive and Primary Care Services for all Pregnant Women,Mothers, and Infants up to Age One**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: MHR payments from Phase GFFAM	
22.	**Field Name:**	**IIB. - 1. C. Services for CSHCN**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Genetics Clinics: 139,000 CSH payments: 22,102	
23.	**Field Name:**	**IIB. - 2. Enabling Services**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Payment to Counties (65.54% x Total SGF County Expenditures)	
24.	**Field Name:**	**IIB. - 3. Public Health Services and Systems**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Salaries MCH Salaries Epi NBS Prevnar Payment to Counties (34.46% x Total SGF County Expenditures) Various Support Services for Admin and Epi and WI West Edge Telephone/IT PLTI Misc MISC Professional fees	

25.	**Field Name:**	**IIB. - 4. Pharmacy**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: CSH, MHR and NBIC: 48% of Total	
26.	**Field Name:**	**IIB. - 4. Physician/Office Services**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: CSH, MHR and NBIC: 11% of Total	
27.	**Field Name:**	**IIB. - 4. Hospital Charges (includes inpatient and outpatient services)**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: CSH, MHR and NBIC: 18% of Total	
28.	**Field Name:**	**IIB. - 4. Durable Medical Equipment and Supplies**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: CSH, MHR and NBIC: 10% of Total.	
29.	**Field Name:**	**IIA. - Other - Travel**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: 11% of total.	
30.	**Field Name:**	**IIA. - Other - Therapy**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: 2% of Total.	
31.	**Field Name:**	**IIB. - Other - Clinics**

	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: 3 Quarters	
32.	**Field Name:**	**IIB. - Other - Travel**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: CSH, MHR and NBIC: 11% of Total.	
33.	**Field Name:**	**IIB. - Other - Therapy**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: CSH, MHR and NBIC: 2% of Total.	

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

State: Wyoming

Total Births by Occurrence: 6,709

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	6,430 (95.8%)	6	6	6 (100.0%)

Program Name(s)				
Biotinidase deficiency	Cystic fibrosis	Classic galactosemia	Congenital adrenal hyperplasia	S,S disease (Sickle cell anemia)
Classic phenylketonuria	Medium-chain acyl-CoA dehydrogenase deficiency	Primary congenital hypothyroidism		

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
Newborn Hearing Screeening	6,579 (98.1%)	41	28	28 (100.0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Wyoming does not currently have a mechanism for long-term follow-up past diagnosis.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2016**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: Calendar year 2016.	
2.	**Field Name:**	**Core RUSP Conditions - Receiving At Lease One Screen**
	Fiscal Year:	**2016**
	Column Name:	**Core RUSP Conditions**
	Field Note: The Wyoming NBS computer program only provides break out data on the Core RUSP Conditions identified here. All other conditions fall into an 'other' category which is not included in reporting capabilities. All children regardless of condition are follow until diagnosis.	
3.	**Field Name:**	**Newborn Hearing Screeening - Positive Screen**
	Fiscal Year:	**2016**
	Column Name:	**Other Newborn**
	Field Note: 231 infants failed the initial hearing screening; 185 passed the repeat screening; 41 were referred for audiological evaluation. Three cases were lost to follow-up after the initial screening; one infant died, one family moved out of state, and one family declined a repeat screening. Two repeat screenings are still pending.	
4.	**Field Name:**	**Newborn Hearing Screeening - Confirmed Cases**
	Fiscal Year:	**2016**
	Column Name:	**Other Newborn**
	Field Note: Ten infants were found to have normal hearing and three infants are still pending evaluations.	

Data Alerts: None

Form 5a
Unduplicated Count of Individuals Served under Title V

State: Wyoming

Reporting Year 2016

		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	1,699	37.9	1.0	55.9	5.2	0.0
2. Infants < 1 Year of Age	2,938	43.8	0.0	47.5	8.7	0.0
3. Children 1 to 22 Years of Age	718	24.3	0.0	69.7	6.0	0.0
4. Children with Special Health Care Needs	978	68.8	2.2	25.9	3.1	0.0
5. Others	2,506	13.1	0.0	73.9	13.0	0.0
Total	8,839					

Form Notes for Form 5a:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2016**

Field Note:
This includes women who receive services through the following programs:
Maternal High Risk
Best Beginnings Home Visitation
Nurse Family Partnership Home Visitation

For programs without data on insurance status, PRAMS data was used to estimate the insurance coverage of pregnant women served.

2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2016**

Field Note:
This includes infants who receive services through the following programs:
Newborn Intensive Care
Best Beginnings Home Visitation

For programs without data on insurance status, Current Population Survey data was used to estimate the insurance coverage of infants served.

3.	**Field Name:**	**Children 1 to 22 Years of Age**
	Fiscal Year:	**2016**

Field Note:
This includes children who receive services through the following programs:
Public Health Nursing Contraceptive Services
Home visiting services received by families with children great than 1 year old

For programs without data on insurance status, Current Population Survey data was used to estimate the insurance coverage of children served.

4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2016**

Field Note:
This includes CSHCN who receive services through the following programs:
Wyoming's Children Special Health Program
Parent Partner Program

For programs without data on insurance status, Current Population Survey data was used to estimate the insurance coverage of CSHCN served.

5.	**Field Name:**	**Others**
	Fiscal Year:	**2016**

Field Note:
This includes individuals receiving services through the following programs:
Mothers receiving postnatal home visiting services through Best Beginning Home Visitation
Parents receiving support through the Parent Partner Program

For programs without data on insurance status, Current Population Survey data was used to estimate the insurance coverage of adults served.

Form 5b
Total Recipient Count of Individuals Served by Title V

State: Wyoming

Reporting Year 2016

Types Of Individuals Served	Total Served
1. Pregnant Women	7,593
2. Infants < 1 Year of Age	6,828
3. Children 1 to 22 Years of Age	61,874
4. Children with Special Health Care Needs	978
5. Others	3,976
Total	81,249

Form Notes for Form 5b:

None

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2016**
	Field Note: This includes pregnant women served in the following capacities: Maternal High Risk Program Best Beginnings Prenatal Home Visiting Nurse Family Partnership Home Visiting Occurant births that received an oral health packet Occurant births in hospitals that completed the LOCATe tool	
2.	**Field Name:**	**Infants Less Than One Year**
	Fiscal Year:	**2016**
	Field Note: This includes infants served through the following programs: Newborn Intensive Care Program Best Beginnings Home Visitation Nurse Family Partnership Home Visitation Newborn Screening Immunizations Infants born at hospitals that completed the LOCATe tool To calculate we added the number of resident births screen through NBS, plus those served through NBIC which all infants receive out of state, plus 10% of our home visiting population as about 10% of our births occur out of state and wouldn't have been eligible for NBS in the state.	
3.	**Field Name:**	**Children 1 to 22 Year of Age**
	Fiscal Year:	**2016**
	Field Note: This includes children served through the following programs: Safe Kids Ages and Stages Screening Immunizations Adolescent Contraceptive Recipients Community Oral Health Screenings Home Visiting Family Visits	
4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2016**

	Field Note: CSHCN served through the following programs: Wyoming's Children's Special Health Parent Partner Program	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2016**
	Field Note: This includes mothers who receive home visits in the postpartum period and parents served through the Parent Partner Program.	

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

State: Wyoming

Reporting Year 2016

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	7,714	6,748	62	257	93	16	195	343
Title V Served	1,699	0	0	0	0	0	0	1,699
Eligible for Title XIX	2,586	1,585	37	196	15	8	0	745
2. Total Infants in State	6,631	5,601	0	305	0	0	725	0
Title V Served	2,938	0	0	0	0	0	0	2,938
Eligible for Title XIX	1,007	177	8	32	6	16	0	768

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	6,619	875	220	7,714
Title V Served	0	0	1,699	1,699
Eligible for Title XIX	2,331	255	0	2,586
2. Total Infants in State	5,988	643	0	6,631
Title V Served	0	0	2,938	2,938
Eligible for Title XIX	1,003	4	0	1,007

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2016**
	Column Name:	**Total All Races**
	Field Note: Total Wyoming Resident Births from Wyoming Vital Statistics Services	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2016**
	Column Name:	**Total All Races**
	Field Note: This includes deliveries served through prenatal home visiting and the maternal high risk program.	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2016**
	Column Name:	**Total All Races**
	Field Note: Data from 2015 Medicaid Delivery Claims	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2016**
	Column Name:	**Total All Races**
	Field Note: Data are from the US Census Current Population Survey. No values were given for infants African American, Asian, Native Hawaiian or Other Pacific Islander, or Other. https://www.census.gov/cps/data/cpstablecreator.html	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2016**
	Column Name:	**Total All Races**
	Field Note: This includes infants served through postpartum home visitation and the newborn intensive care program.	
6.	**Field Name:**	**2. Eligible for Title XIX**

Fiscal Year:	**2016**
Column Name:	**Total All Races**

Field Note:
Data from 2015 Medicaid infant claims.

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

State: Wyoming

A. State MCH Toll-Free Telephone Lines	2018 Application Year	2016 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"	Danielle Marks	Danielle Marks
4. Contact Person's Telephone Number	(307) 777-6326	(307) 777-6326
5. Number of Calls Received on the State MCH "Hotline"		251

B. Other Appropriate Methods	2018 Application Year	2016 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/	https://health.wyo.gov/publichealth/mch/
4. Number of Hits to the State Title V Program Website		3,913
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	Danielle Marks
Title	MCH Unit Manager, Wyoming Title V Director, Wyoming CSHCN Director
Address 1	6101 Yellowstone Road
Address 2	Suite 420
City/State/Zip	Cheyenne / WY / 82002
Telephone	(307) 777-6326
Extension	
Email	danielle.marks@wyo.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Danielle Marks
Title	MCH Unit Manager, Wyoming Title V Director, Wyoming CSHCN Director
Address 1	6101 Yellowstone Road
Address 2	Suite 420
City/State/Zip	Cheyenne / WY / 82002
Telephone	(307) 777-6326
Extension	
Email	danielle.marks@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 2018

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
2015	77.6 %	0.5 %	5,912	7,622
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: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	122.5	13.9 %	79	6,449
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
2011_2015	NR	NR	NR	NR
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
2015	8.6 %	0.3 %	666	7,759
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
2015	1.1 %	0.1 %	82	7,759
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
2015	7.5 %	0.3 %	584	7,759
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
2015	9.8 %	0.3 %	762	7,764
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
2015	2.5 %	0.2 %	195	7,764
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
2015	7.3 %	0.3 %	567	7,764
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
2015	25.6 %	0.5 %	1,988	7,764
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
2015/Q2-2016/Q1	5.0 %			
2015/Q1-2015/Q4	4.0 %			
2014/Q4-2015/Q3	4.0 %			
2014/Q3-2015/Q2	6.0 %			
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
2014	6.6	0.9 %	51	7,713
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
2014	6.4	0.9 %	49	7,696
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
2014	5.2	0.8 %	40	7,696
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
2014	NR	NR	NR	NR
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
2014	155.9	45.1 %	12	7,696
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
2014	NR	NR	NR	NR
2013	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	NR	NR	NR	NR
2009	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
2014	6.2 %	1.1 %	465	7,519
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: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	5.6	0.9 %	36	6,488
2013	2.3	0.6 %	15	6,557
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
2015	28.0	6.3 %	20	71,467
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
2015	45.9	7.9 %	34	74,053
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
2013_2015	22.4	4.5 %	25	111,820
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
2013_2015	30.4	5.2 %	34	111,820
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
2014	23.7 %	0.7 %	884	3,731
2012	26.1 %	0.7 %	1,095	4,198
2010	28.5 %	0.7 %	1,256	4,413
2008	24.6 %	0.7 %	858	3,494

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
2015	25.6 %	1.1 %	6,438	25,167
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
2015	6.3 %	1.0 %	8,713	139,430
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
2015	73.3 %	3.6 %	7,484	10,205
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) - Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2016	41.7 %	2.3 %	53,885	129,220
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) - Teen (Female)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	47.7 %	4.9 %	8,283	17,356
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) - Teen (Male)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	37.1 %	4.5 %	6,915	18,654
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) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	87.9 %	2.1 %	31,647	36,011
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) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	58.7 %	3.3 %	21,130	36,011
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

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2016
Annual Objective	21
Annual Indicator	17.8
Numerator	418
Denominator	2,347
Data Source	NVSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	16.0	14.0	12.0	11.0	10.0	10.0

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	90
Annual Indicator	89.7
Numerator	5,817
Denominator	6,486
Data Source	NIS
Data Source Year	2013

State Provided Data	
	2016
Annual Objective	90
Annual Indicator	91
Numerator	
Denominator	
Data Source	PRAMS
Data Source Year	2014
Provisional or Final ?	Final

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	92.0	93.0	93.0	94.0	94.0	94.0

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	26
Annual Indicator	27.0
Numerator	1,693
Denominator	6,263
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	29.0	31.0	32.0	32.0	33.0	35.0

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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	32
Annual Indicator	28.8
Numerator	10,655
Denominator	36,969
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	32.0	32.0	35.0	35.0	36.0	37.0

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)

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CHILD	
	2016
Annual Objective	45
Annual Indicator	39.7
Numerator	16,986
Denominator	42,831
Data Source	NSCH-CHILD
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	47.0	49.0	50.0	51.0	51.0	53.0

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.

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	85
Annual Indicator	81.1
Numerator	36,230
Denominator	44,669
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	85.0	85.0	87.0	87.0	88.0	88.0

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2016
Annual Objective	50
Annual Indicator	42.8
Numerator	11,052
Denominator	25,796
Data Source	NSCH-CSHCN
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	50.0	50.0	55.0	55.0	55.0	55.0

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

Federally Available Data	
Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)	
	2016
Annual Objective	45
Annual Indicator	47.4
Numerator	3,609
Denominator	7,613
Data Source	NS-CSHCN
Data Source Year	2009_2010

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	47.0	50.0	51.0	53.0	54.0	54.0

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2016
Annual Objective	15
Annual Indicator	15.2
Numerator	1,148
Denominator	7,540
Data Source	NVSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	14.0	13.0	12.0	12.0	10.0	10.0

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	25
Annual Indicator	27.0
Numerator	35,902
Denominator	132,791
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	25.0	22.0	22.0	20.0	18.0	18.0

Field Level Notes for Form 10a NPMs:

None

Form 10a
State Performance Measures (SPMs)

State: Wyoming

SPM 1 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	51.9
Numerator	42
Denominator	81
Data Source	Wyoming Vital Statistics Services
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	54.0	57.0	60.0	62.0	64.0	66.0

Field Level Notes for Form 10a SPMs:

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

Field Note:
Wyoming does not have a Level III NICU in state, nor does it have access currently to LOCATe results from surrounding states where Wyoming residents deliver. Assessment of a hospitals Level III status is based on the hospital's claims on their website.

SPM 2 - Rate of hospitalization for non-fatal injury per 100,000 children ages 1 through 11

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	25.3
Numerator	22
Denominator	86,903
Data Source	Wyoming Hospital Discharge Data
Data Source Year	FY 2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	20.0	18.0	18.0	16.0	14.0	14.0

Field Level Notes for Form 10a SPMs:

None

SPM 3 - Number of Wyoming birthing hospitals billing Medicaid for immediate postpartum LARCs

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Medicaid Billing Data
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	2.0	6.0	9.0	13.0	16.0	17.0

Field Level Notes for Form 10a SPMs:

None

SPM 4 - Percentage of teens reporting 0 occasions of alcohol use in the past 30 days

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	68.2
Numerator	
Denominator	
Data Source	Prevention Needs Assessment
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	70.0	72.0	75.0	78.0	80.0	82.0

Field Level Notes for Form 10a SPMs:

None

Form 10a
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Wyoming

ESM 2.1 - Development of facility-specific prevalence data

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	No
Numerator	
Denominator	
Data Source	Wyoming Vital Statistics Services
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 2.2 - # of YouTube hits for HBWW video

Measure Status:	Inactive - Replaced

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	100.0	100.0	100.0	100.0	100.0	

Field Level Notes for Form 10a ESMs:

None

ESM 4.1 - Mini-grant program structure developed

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	Yes
Numerator	
Denominator	
Data Source	Women and Infant Program
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	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

Measure Status:	Inactive - Completed

State Provided Data	
	2016
Annual Objective	
Annual Indicator	Yes
Numerator	
Denominator	
Data Source	Final Report
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	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

Measure Status:	Inactive - Completed

State Provided Data	
	2016
Annual Objective	
Annual Indicator	Yes
Numerator	
Denominator	
Data Source	MCH Website
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 4.4 - Implementation of Wyoming 5-Steps to Breastfeeding Success Program

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	4.0	4.0	4.0	4.0	4.0	4.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**Annual Objective**

Field Note:
The women and infant health program will distribute grant funds to support four hospitals annually with the implementation of the Wyoming 5-Steps to Breastfeeding Success Program.

ESM 4.5 - Hospitals Recognized by Wyoming 5-Steps Program

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	2.0	4.0	6.0	8.0	10.0	12.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**Annual Objective**

Field Note:
Each year the Women and Infant Health Program will support up to four hospitals seeking to improve policies and practices related to the Wyoming 5-Steps to Breastfeeding Success Program. We aim to have at least 2 hospitals each year meet the criteria to be recognized through the program.

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

Measure Status:	Inactive - Completed

State Provided Data	
	2016
Annual Objective	
Annual Indicator	Yes
Numerator	
Denominator	
Data Source	Child Health Program
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 6.2 - Help Me Grow Implementation plan developed

Measure Status:	Inactive - Completed

State Provided Data	
	2016
Annual Objective	
Annual Indicator	Yes
Numerator	
Denominator	
Data Source	Help Me Grow Program
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 6.3 - Help Me Grow Calls

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	30.0	60.0	90.0	100.0	100.0	100.0

Field Level Notes for Form 10a ESMs:

None

ESM 6.4 - Number of trained partners entering into the ASQ Enterprise System.

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	2.0	5.0	7.0	10.0	12.0	15.0

Field Level Notes for Form 10a ESMs:

None

ESM 6.5 - Number of referrals to the HMG system

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	20.0	40.0	60.0	70.0	80.0	80.0

Field Level Notes for Form 10a ESMs:

None

ESM 8.1 - # of meetings of the Wyoming Children's Physical Activity Work Group

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Meeting Minutes
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	2.0	4.0	4.0	4.0	4.0

Field Level Notes for Form 10a ESMs:

None

ESM 10.1 - Promotion of Adolescent Champion Model

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	No
Numerator	
Denominator	
Data Source	Program Data
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	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.

Measure Status:	Inactive - Completed

State Provided Data	
	2016
Annual Objective	
Annual Indicator	Yes
Numerator	
Denominator	
Data Source	Child Health Program
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

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

Field Note:
Environmental scan of Medical Home initiatives and efforts across the state were completed. Efforts are currently underway through the Primary Care Association, the Population Health Institute, and Wyoming Medicaid. No family engagement policies were identified.

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

Measure Status:	Inactive - Replaced

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	

Field Level Notes for Form 10a ESMs:

None

ESM 11.3 - Number of providers trained in the family engagement components of medical home

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	15.0	25.0	35.0	50.0	50.0	50.0

Field Level Notes for Form 10a ESMs:

None

ESM 11.4 - Number of families served through the Parent Partner Program

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	225.0	250.0	250.0	275.0	300.0	300.0

Field Level Notes for Form 10a ESMs:

None

ESM 12.1 - # of meetings of the Transition Action Team of the AYAH CoIIN

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	AYAH CoIIN Meeting Minutes
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	2.0	4.0	4.0	4.0	4.0	4.0

Field Level Notes for Form 10a ESMs:

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

Field Note:
The program manager determined it was best to wait for the CoIIN award to begin prior to development of the action team. The award was given in February 2017; therefore, no meetings were held in 2016.

ESM 12.2 - # of provider champions participating on Transition Action Team

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	AYAH CoIIN Minutes
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	2.0	3.0	3.0	3.0	3.0

Field Level Notes for Form 10a ESMs:

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

Field Note:
The program manager determined it was best to wait for the CoIIN award to begin prior to development of the action team. The award was given in February 2017; therefore, no meetings were held in 2016.

ESM 12.3 - # of adolescents participating on Transition Action Team

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	CoIIN Meeting Minutes
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	2.0	3.0	3.0	3.0	3.0

Field Level Notes for Form 10a ESMs:

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

Field Note:
The program manager determined it was best to wait for the CoIIN award to begin prior to development of the action team. The award was given in February 2017; therefore, no meetings were held in 2016.

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

Measure Status:	Inactive - Replaced

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	4.0	4.0	4.0	4.0	4.0	

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	16
Numerator	
Denominator	
Data Source	Wyoming Quitline Monthly Reports
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	50.0	60.0	70.0	80.0	90.0	100.0

Field Level Notes for Form 10a ESMs:

None

ESM 14.3 - # of focus groups held on Wind River Indian Reservation

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	4.0	4.0	4.0	4.0	4.0	4.0

Field Level Notes for Form 10a ESMs:

None

ESM 14.4 - # of women receiving SCRIPT intervention during Healthy Baby Home Visitation Services

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	15.0	15.0	15.0	15.0	15.0	15.0

Field Level Notes for Form 10a ESMs:

None

Form 10b
State Performance Measure (SPM) Detail Sheets

State: Wyoming

SPM 1 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	Increase the 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 - Rate of hospitalization for non-fatal injury per 100,000 children ages 1 through 11
Population Domain(s) – Child Health

Measure Status:	Active
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:	Numerator: Hospital Discharge Data (HDD) Denominator: Census population estimates 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.
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 - Number of Wyoming birthing hospitals billing Medicaid for immediate postpartum LARCs
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	Increase capacity of Wyoming birthing hospitals to bill Medicaid for immediate postpartum LARCs
Definition:	**Numerator:** Number of Wyoming birthing hospitals billing Medicaid for immediate postpartum LARCs **Denominator:** No Denominator **Unit Type:** Count **Unit Number:** 23
Data Sources and Data Issues:	Numerator: Medicaid billing data 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 - Percentage of teens reporting 0 occasions of alcohol use in the past 30 days
Population Domain(s) – Adolescent Health

Measure Status:	Active
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 Measures (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

Measure Status:	Active
Goal:	Develop facility-specific low-risk cesarean delivery prevalence
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 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. The program may also track # of facilities engaged in quality improvement strategies as a result of receiving their facility-specific prevalence data.

ESM 2.2 - # of YouTube hits for HBWW video
NPM 2 – Percent of cesarean deliveries among low-risk first births

Measure Status:	Inactive - Replaced
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

Measure Status:	Active
Goal:	Award mini-grants and provide technical assistance to hospitals for participation in Wyoming 5-Steps to Breastfeeding Success, a Wyoming-developed initiative based on the Baby Friendly Hospital Initiative
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. mPINC data was used to determine Wyoming's 5 selected steps for focus. 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

Measure Status:	Inactive - Completed
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

Measure Status:	Inactive - Completed
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 4.4 - Implementation of Wyoming 5-Steps to Breastfeeding Success Program
NPM 4 – A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase the number of hospitals participating in the Wyoming 5-Steps to Breastfeeding Success Mini-Grant Program
Definition:	**Numerator:** Number of hospitals participating in the Wyoming 5-Steps to Breastfeeding Success Program **Denominator:** N/A **Unit Type:** Count **Unit Number:** 26
Data Sources and Data Issues:	Survey of hospital policies and grant reporting
Significance:	Supporting changes to hospital polices can significantly impact breastfeeding initiation and duration rates for mother's who deliver in the hospital. Wyoming is promoting it's 5-Steps to Breastfeeding Success Program which is modeled off the Baby-Friendly Hospital Initiative and the Colorado Can Do 5 Initiative. The Women and Infant Program will support hospitals as they engage in policy change and quality improvement efforts around these five steps to improve the breastfeeding rates among the new moms they serve.

ESM 4.5 - Hospitals Recognized by Wyoming 5-Steps Program
NPM 4 – A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase the number of hospitals meeting the requirements to be recognized by the Wyoming 5-Steps to Breastfeeding Success Program.
Definition:	**Numerator:** Number of hospitals meeting the requirements to be recognized by the Wyoming 5-Steps to Breastfeeding Success Program. **Denominator:** n/a **Unit Type:** Count **Unit Number:** 23
Data Sources and Data Issues:	Survey of Hospital Policy, Grant Reporting Requirements for Wyoming 5-Steps to Breastfeeding Success Program
Significance:	Hospital policies and practices significantly impact the rates of breastfeeding initiation and duration rates for the new moms they serve. Increasing the number of hospitals that meet the recognition requirements increases the number of new moms exposed to maternity care practices supportive of breastfeeding.

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

Measure Status:	Inactive - Completed
Goal:	Support Help Me Grow activities to make developmental screening tools accessible to families - 1
Definition:	**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

Measure Status:	Inactive - Completed
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 6.3 - Help Me Grow Calls
NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Measure Status:	Active
Goal:	Increase the number of Help Me Grow calls to 211
Definition:	**Numerator:** Number of Help Me Grow Calls to 211 **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	HMG calls are tracked through the 211 data system
Significance:	The HMG system is designed to ensure developmental screenings and referred and connected to services for children birth through 8. Increasing the number of calls to 211 indicates its acceptance in the community as a source for trusted referral and follow-up. It also indicates partners are referring families to HMG services.

ESM 6.4 - Number of trained partners entering into the ASQ Enterprise System.
NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Measure Status:	Active
Goal:	Increase the number of partners entering data into the ASQ Enterprise System
Definition:	**Numerator:** Number of trained partners entering into the ASQ Enterprise System. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	ASQ Enterprise System; Wyoming is currently in the process of procuring this data system.
Significance:	The strength of HMG is in it's partnership and referral process. Increasing the number of community partners entering into the ASQ Enterprise system shows commitment to the HMG system and strengthens the ability to refer children to necessary services and follow-up on additional services as needed.

ESM 6.5 - Number of referrals to the HMG system
NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Measure Status:	Active
Goal:	Increase the number of referrals to the HMG data system
Definition:	**Numerator:** Number of referrals to the HMG system **Denominator:** N/A **Unit Type:** Count **Unit Number:** 500
Data Sources and Data Issues:	211 data system
Significance:	HMG is most successful with broad community buy-in. Tracking the number of referrals received by 211 for HMG indicates awareness of the program from our partners and a confidence in the HMG's ability to help refer and follow-up with children and families regarding identified needs.

ESM 8.1 - # of meetings of the Wyoming Children's Physical Activity Work Group
NPM 8 – Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Support development of a cross agency children's physical activity workgroup with a focus on improving nutrition, physical activity and overall child health.
Definition:	**Numerator:** Number of meeting of the Wyoming Children's Physical Activity Workgroup **Denominator:** n/a **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	Wyoming Children's Physical Activity Workgroup meeting agendas
Significance:	Partnership with the Wyoming Department of Education and the WDH CDPP 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 cross-agency Wyoming Children's Physical Activity Workgroup. The aim of this committee will be to collaborate on initiatives aimed at improving school health and physical activity within schools and for school-age students.

ESM 10.1 - Promotion of Adolescent Champion Model
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
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

Measure Status:	Inactive - Completed
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:	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.

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

Measure Status:	Inactive - Replaced
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 11.3 - Number of providers trained in the family engagement components of medical home
NPM 11 – Percent of children with and without special health care needs having a medical home

Measure Status:	Active
Goal:	Increase the number of providers trained in the family engagement components of medical home
Definition:	**Numerator:** Number of providers trained in the family engagement components of medical home **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1,000
Data Sources and Data Issues:	Registration for medical home trainings
Significance:	Ensuring providers are aware of the requirements and benefits of medical home is a key factor in increase the quality and quantity of medical home services available to children in Wyoming. Title V is well-positioned to educate providers about the specific family engagement components of the medical home model.

ESM 11.4 - Number of families served through the Parent Partner Program
NPM 11 – Percent of children with and without special health care needs having a medical home

Measure Status:	Active
Goal:	Increase the number of families served through the Parent Partner Program
Definition:	**Numerator:** Number of families served through the Parent Partner Program **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1,000
Data Sources and Data Issues:	Parent Partner Tracking Sheets
Significance:	The Parent Partner Program providers a peer mentorship opportunity which matches a trained parent of a CYSHCN with CYSHCN families in a medical setting. This partnership helps families navigate the medical, social, and educational environment they face and helps to promote family-centered care, a key component of medical home.

ESM 12.1 - # of meetings of the Transition Action Team of the AYAH CoIIN
NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Measure Status:	Active
Goal:	Develop the Transition Action Team
Definition:	**Numerator:** # of meetings of the Transition Action Team of the AYAH CoIIN **Denominator:** n/a **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	Transition Action Team meeting minutes
Significance:	The participation in the Adolescent and Young Adult Health CoIIN 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 an Action Team tasked with developing a transition plan to address identified needs in the state. One of the key tasks of transition action team will be to review Got Transition materials for use and distribution in Wyoming.

ESM 12.2 - # of provider champions participating on Transition Action Team
NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Measure Status:	Active
Goal:	Develop the Transition Action Team
Definition:	**Numerator:** # of provider champions participating on Transition Action Team **Denominator:** n/a **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	Transition Action Team meeting minutes
Significance:	The provider perspective will be critical to the success of the Transition Action 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 Transition Action Team
NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Measure Status:	Active
Goal:	Develop the Transition Action Team
Definition:	**Numerator:** # of adolescents participating on Transition Action team **Denominator:** n/a **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	Transition Action Team meeting minutes
Significance:	The Adolescent and Young Adult Health CoIIN team will be convened to determine best-practice for Wyoming providers in increasing adolescent well-visits and improving adolescent health outcomes. The Transition Action Team will consist of providers, parents, and adolescents. The purpose of the action team is to review current transition resources and create a Wyoming Transition plan and toolkit from current resources that meets the needs of Wyoming consumers and providers.

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

Measure Status:	Inactive - Replaced
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

Measure Status:	Active
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:** 500
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.

ESM 14.3 - # of focus groups held on Wind River Indian Reservation
NPM 14 – A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Measure Status:	Active
Goal:	Conduct focus groups on Wind River Indian Reservation with women of reproductive age and pregnant women regarding smoking habits, particularly during pregnancy
Definition:	**Numerator:** Number of focus groups held **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	Data will come from programmatic scheduling records
Significance:	Native American women in Wyoming smoke at higher rates in the three months prior to pregnancy and in the postpartum period compared with white women. We want to work with our partners at the White Buffalo recovery center and the Wyoming Quit Tobacco program to better understand reasons women smoke, barriers to quitting, and what strategies might be beneficial to help develop to encourage smoking cessation during pregnancy and continued cessation in the postpartum period.

ESM 14.4 - # of women receiving SCRIPT intervention during Healthy Baby Home Visitation Services
NPM 14 – A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Measure Status:	Active
Goal:	Increase the number of women receiving SCRIPT intervention during the Healthy Baby Home Visitation Program among women who smoke
Definition:	**Numerator:** Number of women who smoke in the Healthy Baby Home Visitation Program who receive the SCRIPT intervention **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1,000
Data Sources and Data Issues:	Data will be retrieved from the Best Beginnings database or the Total Health Record which are used by the Public Health Nurses to document their visits with clients
Significance:	Public Health Nursing in Wyoming delivers home visiting services to pregnant women in 22/23 counties across the state. SCRIPT is an evidence-based pregnancy smoking cessation program that takes very little time to implement as part of the home visiting program, and has the potential to have a greater impact on maternal smoking rates than the current model. This indicator will allow us to compare quit rates to comparable counties to assess the effectiveness of the SCRIPT intervention.

Form 11
Other State Data

State: Wyoming

The Form 11 data are available for review via the link below.

Form 11 Data

State Action Plan Table

State: Wyoming

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

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 *Inactive*	
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 *Inactive* ESM 4.3 *Inactive* ESM 4.4 ESM 4.5	
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 *Inactive* ESM 6.2 *Inactive* ESM 6.3 ESM 6.4 ESM 6.5	

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 *Inactive* ESM 11.2 *Inactive* ESM 11.3 ESM 11.4	
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 *Inactive* ESM 14.2 ESM 14.3 ESM 14.4	